After Burnout

A qualitative study on how nurses recover from burnout and how they manage when they return to work

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Preface

Two years as a master's student are soon coming to an end. During these two years, I have learned a lot and the studies have been both interesting and challenging.

After working for several years as a nurse, I had witnessed quite a few within the profession experiencing burnout. Some of them quickly returned to work, some were on sick leave for a long time, and others chose to change careers. I began to wonder what could be done to promote nurses' recovery and return to work after burnout and that became the starting point for this study.

I would like to thank my supervisor, Fungi P. Gwanzura Ottemöller, who guided me through the first part of the process. Thank you for your support, enthusiasm, and encouragement. I would also like to thank Heidi Marie Kirkeng Meling who supervised me in the last part of the process. Thanks for the interest, support, and good advice.

I would like to the participants in the study, the eight nurses who shared their stories and experiences with me. I would also like to thank my fellow students in the supervision group for the cooperation and helpful feedback in the writing process.

At last, I want to thank my family and friends for the encouragement and support throughout this process.

Table of contents

Abstract

Burnout is, according to the World Health Organization (WHO), defined as an "occupational phenomenon" that is a result of prolonged stress in the workplace that has not been successfully managed. Evidence indicates that nurses are exposed to various occupational factors, such as high workload and poor staffing, which increase the risk of experiencing burnout. Previous studies on nurses and burnout focus mainly on the causes and consequences of burnout and there has been little focus on what factors promote recovery and return to work.

This study uses a qualitative method. Data were collected using in-depth narrative interviews. The participants were eight female nurses in Norway who have experienced burnout and returned to work. The study aimed to explore nurses' burnout, with emphasis on how they recover and how they manage when they return to work. The study's research questions are as follows: *1. How do nurses who have been on sick leave due to burnout experience the process of returning to work?, 2. what are the main coping strategies and resources they identify in the process of returning to work?* and *3.what are the main challenges/stressors they identify when they return to work, and how do they deal with these challenges?*

The study's findings indicate that receiving adequate help and strengthening coping skills, as well as good communication with managers, facilitation in the workplace, support from colleagues and an inner motivation to work as a nurse are important resources for nurses who have experienced burnout. The study's findings also indicate that a more holistic approach to nurses' burnout, recovery, and return to work process could be valuable to promote a successful and sustainable return to work.

Keywords: Burnout, nurses, return to work, coping strategies, salutogenesis, JD-R model

Abstrakt

Utbrenthet er, ifølge Verdens helseorganisasjon (WHO), definert som et "yrkesfenomen" som følge av langvarig stress på arbeidsplassen som ikke har blitt håndtert på en vellykket måte. Forskning indikerer at sykepleiere er utsatt for ulike yrkesmessige faktorer, som for eksempel høy arbeidsbelastning og dårlig bemanning, som øker risikoen for å oppleve utbrenthet. Tidligere studier om sykepleiere og utbrenthet fokuserer hovedsakelig på årsaker og konsekvenser av utbrenthet blant sykepleiere og det har vært lite fokus på hvilke faktorer fremmer bedring og hjelper sykepleiere på veien tilbake til arbeid.

Denne studien bruker kvalitativ metode. Data ble samlet inn ved bruk av narrative dybdeintervjuer. Deltakerne var åtte kvinnelige sykepleiere i Norge som har opplevd utbrenthet og er tilbake i jobb. Formålet med studien var å utforske utbrenthet blant sykepleiere, med vekt på hvordan de kommer seg etter utbrenthet og hvordan de klarer seg når de kommer tilbake til jobb. Studiens forskningsspørsmål er som følger: *1. Hvordan opplever sykepleiere som har vært sykemeldt på grunn av utbrenthet, prosessen med å komme tilbake til jobb?, 2. hva er de viktigste mestringsstrategiene og ressursene de identifiserer i prosessen med å komme tilbake til jobb?* og *3. hva er de største utfordringene / stressfaktorene de identifiserer når de kommer tilbake til jobb og hvordan takler de disse utfordringene?*.

Studiens funn indikerer at det å motta tilstrekkelig hjelp og styrke mestringsevner, samt god kommunikasjon med ledere, tilrettelegging på arbeidsplassen, støtte fra kollegaer og en indre motivasjon til å jobbe som sykepleier er viktige ressurser for sykepleiere som har opplevd utbrenthet. Studiens funn indikere også at en mer helhetlig tilnærming til sykepleieres utbrenthet, bedringsprosess og prosessen å komme tilbake til jobb kan være verdifull for å fremme vellykket og bærekraftig retur til arbeid.

Nøkkelord: Utbrenthet, sykepleiere, tilbake til jobb, mestringsstrategier, salutogenese, JD-R model

1.0 Introduction

1.1 Work and health promotion

According to the World Health Organisation (WHO), *health is created and lived by people within the settings of their everyday life; where they learn, work, play, and love* (WHO, 1986). This study examines nurses' experience with burnout, with emphasis on how they recover from burnout and manage when they return to work. Workplaces have been recognized as important settings for health, and according to WHO (2010), a healthy workplace is *one in which workers and managers collaborate to use a continual improvement process to protect and promote the health, safety, and well-being of all workers and the sustainability of the workplace* (p. 6) by focusing on issues such as a safe physical work environment, building a psychosocial work environment, and a workplace culture that promotes health and well-being and personal health resources in the workplace (WHO, 2010). Based on this, it is clear that in order to promote health in the workplace, one must focus on both the physical work environment, as well as the psychosocial and personal factors.

1.2 Nurses and nursing

This study focuses on nurses as an occupational group. According to the International Council of Nurses (ICN), a nurse is someone who has finished nursing education and received authorization to practice nursing. Nursing involves the *autonomous and collaborative care of individuals of all ages, families, groups, and communities, sick or well, and in all settings* (ICN, 1987). Furthermore, nursing involves the care of physically ill, mentally ill, disabled, and dying people in all health care settings, as well as promotion of health, and prevention of illness (INC, 2002). Nurses and midwives make up about 50% of the world's healthcare professionals, making nursing a large and important healthcare profession (WHO, 2020).

1.3 Nurses sick leave rate and nursing shortage

Nurses are exposed to various occupational stressors through their work. The job involves caring for people through illness and after accidents, responding to emergencies, caring for dying people as well as caring for and communicating with relatives (Zhang et al., 2018, p. 810). Continuous austerity measures, complex patient cases, long hours, increased demands for efficiency, and understaffing are factors that increase work-related stress among nurses (Smith, 2014, p.119). According to numbers from Statistics Norway (SSB) from 2018, nurses are among the professions with the highest rate of sickness absence, with a sickness absence rate of 8,6 %, while the average

sickness absence in Norway is 6,4 %, and professions such as engineers and physicists have the lowest sickness absence rate, of only 1-3% (SSB, 2018). Nursing is a demanding job that often entails significant work stress and high mental load, factors which can increase the chances of burnout and evidence shows that the prevalence of burnout symptoms is high among nurses (Kupcewicz & Józwik, 2019, p. 2). A systematic review and meta-analysis conducted to examine the global prevalence of burnout symptoms among nurses found that more than one out of ten (11,23%) nurses worldwide have symptoms of burnout (Woo et al., 2020, p. 9). There is a shortage of nurses both nationally and globally, and it is predicted that this shortage will be even greater in the years to come (WHO, 2020). Numbers from SSB indicate that there will be a shortage of 28,000 nurses in Norway by 2035 (SSB, 2019, p. 57).

1.4 Burnout

Since burnout was first described in scientific research in the 1970s, numerous studies have been published on the topic (Heinemann & Heinemann, 2017, p. 2). Freudenberger (1974) was a pioneer in the field of burnout research, being one of the first to identify and write about professional burnout and burnout symptoms in scientific research. Another pioneer in burnout research is Mashlac who focused on measurements of burnout. Mashlac developed the Maslach Burnout Inventory (MBI), which focuses on three dimensions of burnout; exhaustion, cynicism, and inefficacy (Maslach & Jackson, 1981). In recent years, interest in burnout research has increased, and an increased number of studies are appearing on the topic. According to Heinemann & Heinemann (2017), who analyzed how burnout has been investigated in health sciences through the years, there has been a lack of clarity about the term. Scientists have debated how to define burnout, what symptoms are associated with burnout, and whether it is a medical condition, a mental disorder, or something else entirely (Heinemann & Heinemann, 2017, p.1). In 2019 WHO included burnout in the eleventh revision of The International Classification of Diseases (ICD-11). WHO defines burnout as*: "a syndrome conceptualized as resulting from chronic workplace stress that has not been successfully managed. It is characterized by three dimensions: feelings of energy depletion or exhaustion; increased mental distance from one's job, or feelings of negativism or cynicism related to one's job; and reduced professional efficacy. Burn-out refers specifically to phenomena in the occupational context and should not be applied to describe experiences in other areas of life"* (WHO, 2019). The understanding of burnout in this study is based on the 2019 WHO definition of burnout as an occupational phenomenon.

1.5 Disposition

This introductory chapter will be followed by a chapter on the theoretical framework of the study, including the theory of salutogenesis and the Job demands-resources model (JD-R model). In chapter three, previous research on nurses' burnout and the return to work process after burnout will be presented. In chapter four, the study's methodology will be presented, where the study's qualitative design, data collecting methods, and analysis will be presented. Chapter five is a presentation of the study's findings, while in chapter six, these findings will be discussed in relation to previous research and the study's theoretical framework. The study's limitations will also be discussed. In the final chapter, a summary of the study's most important aspects will be presented with a conclusion, followed by proposals for further research, and implications for the field of health promotion.

2.0 Theoretical framework

In this chapter, I will present the theoretical framework for this thesis. First, I will present the *theory of salutogenesis* and thereafter I will present the *Job Demand – Resources (JD-R) Model*. These theories will guide me in identifying key issues to examine, as well as what questions should be asked and how data is collected and analyzed (Creswell & Creswell, 2018, p.62-63).

2.1 Salutogenesis

The salutogenic theory was formed by Aaron Antonovsky, a sociologist and academician. The word salutogenesis means origins (genesis) of health (saluto) (Vinje et al., 2017, p. 25). Antonovsky spent many years studying how people cope with stress and challenges in their life and wondered why difficult life experiences led to poor health for some people, while others maintained good health despite adversity (Antonovsky & Sagy, 2017, p. 16). Antonovsky disagreed with viewing health and disease as opposites and argued for a more holistic approach. He introduced a health-ease/dis-ease continuum and emphasized facilitating a movement towards the health end of the continuum (Mittelmark & Bauer, 2017, p. 11-12).

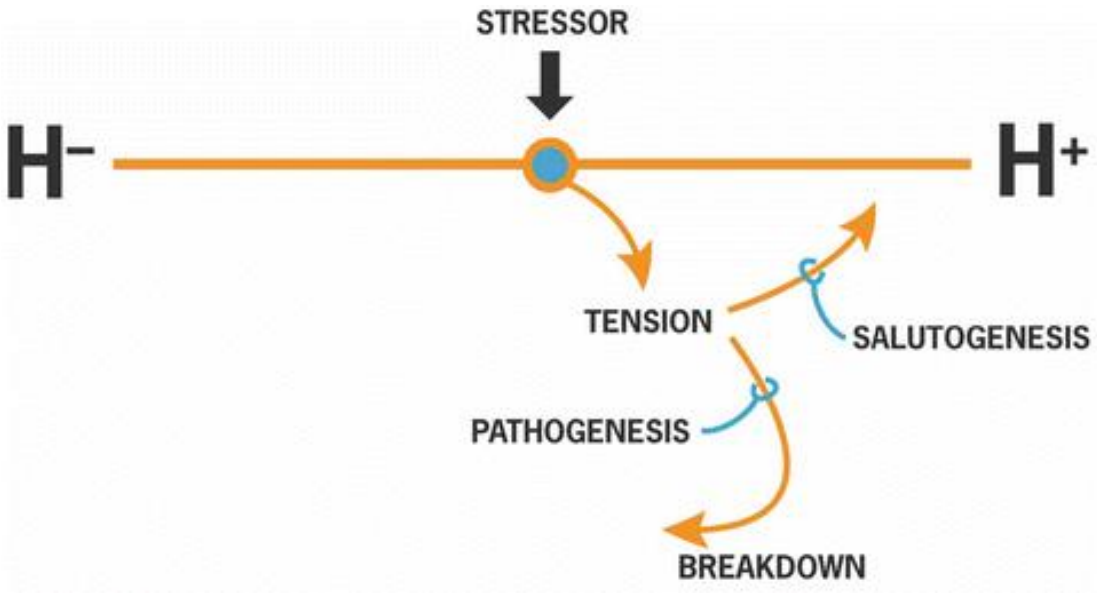

Figure 1. The figure shows Antonovsky's health-ease/dis-ease continuum. The figure is illustrated by Bengt Lindström, Monica Eriksson, Peter Wikström, retrieved from Eriksson, 2017, p. 93.

2.1.1 The salutogenic model

Antonovsky (1996) argued that the field of health promotion lacked a theoretical framework. He suggested that instead of using the traditional pathogenic orientation in health promotion research, it would be better to use salutogenic orientation and thus focus on the origin of health instead of the origin of disease. (p. 18). The Salutogenic model is built on Antonovsky's earlier research. The model is rarely used as a whole within research, as it is both comprehensive and complicated (Mittelmark & Bauer, 2017, p. 11). In the present study, I will focus on three aspects of the salutogenic model: generalized resistance resources (GRRs), sense of coherence (SOC), and specific resistance resources (SRRs).

2.1.2 GRRs

When developing the salutogenic model and figuring out what made people move either towards the health-ease end or the dis-ease end of the continuum, Antonovsky coined the term generalized resistance resources (GRRs) (Idan et al., 2017, p. 57). GRRs refer to *a property of a person, a collective or a situation which facilitates successful coping with the inherent stressors of human existence* (Antonovsky, 1996, p. 15). According to the salutogenic theory, these stressors create tension that can result in stress and illness if not coped with. Generalized resistance resources arise from social and cultural settings, as well as repeated life experiences and examples of such resources are social support, knowledge, material resources, and family. (Vinje et al., 2017, p. 28-29). The GRRs help people to successfully cope and make sense of their surroundings and thus strengthen the sense of coherence (SOC) (Mittelmark et al., 2017, p. 71).

2.1.3 SOC

Antonovsky wondered what the GRRs had in common and why they facilitated successful coping and a move towards health. Subsequently, the concept of sense of coherence (SOC) was introduced. SOC reflects peoples' ability to cope with the inherent stressors of life and human existence (Antonovsky, 1996, p.15 - 16). SOC consists of three components: comprehensibility, meaningfulness, and manageability, and the strength of peoples' SOC is based on their ability to experience their inner and outer environment as comprehensible, manageable, and meaningful. Comprehensibility refers to people's ability to understand internal and external stimuli as clear information instead of chaos; meaningfulness refers to people's willingness and motivation to invest their energy into meeting life's problems and demands; and manageability refers to the formal and informal resources available to people to meet the challenges and demands life offers (Eriksson & Mittelmark, 2017, p. 97). According to Antonovsky (1996), the strength of peoples' SOC has a great

influence on where people find themselves on the health-ease/dis-ease continuum and a strong SOC facilitates movement towards health (p.15). People with high SOC move towards health as they are able to understand their situation (comprehensibility), they are willing to change their situation for the better (meaningfulness), and feel that they have access to resources to make changes (manageability) (Eriksson, 2017, s.93).

2.1.4 SRRs

Both GRRs and SRRs are resistance resources that can be activated to cope with stressors, but there is a fundamental difference between them. While a GRR is a generality, an SRR is a particularity (Mittelmark et al., 2017, p. 75). SRRs are resources that can be activated specifically to meet or adapt to a specific stressor. Examples of such resources are a stress reduction course for people experiencing high levels of stress, a certain medicine to treat a certain illness, or a suicide hotline for suicidal people. Specific resistance resources are not necessary for all cases of tension or all stressors, only when tension or a stressor is likely to cause health-threatening levels of stress (Mittelmark et al., 2017, p 72 - 75). According to the salutogenic model, the possibility to approach and use the SRRs is determined by the GRRs available (Anotnovsky, 1996), this is further explained in the next section.

2.1.5 The connection between GRRs, SOC and SRRs

Mittelmark et al. (2017, p.71) explain the logic of the salutogenic model and the connection between GRRs, SOC, and SRRs as follows:

GRR → ↑ SOC → ↑ use of GRR & ↑ use of SRR
→ ↑ HEALTH

According to this diagram, the generalized resistance resources influence the strength of the sense of coherence, and the strength of the sense of coherence influences the mobilization of generalized resistance resources. However, the mobilization of generalized resistance resources is a prerequisite for identifying and using specific resistance resources. The GRRs and the strength of SOC influence the degree to which one can move towards better health, closer to the health end of the continuum (Mittelmark et al., 2017, p. 72-73).

2.1.6 Critique of the salutogenic model

As mentioned before, the salutogenic model is little used as a whole model within research, as it is both detailed and quite complex. Usually, researchers focus on specific components of the model, such as SOC, GRRs, or SRRs. Based on this, the salutogenic model has received critique for lack of empirical evidence supporting its ideas. Antonovsky himself made little use of the model as a whole, focusing primarily on the SOC part of the model (Mittelmark & Bauer, 2017). The SOC part has also been criticized, for example for being psychometrically unclear, for a lack of evidence supporting the theory, and for being a theory full of contradictions. Erikson & Lindström (2006) conducted a systematic review, looking at the empirical evidence on the relation between SOC and perceived health. They found that SOC is strongly related to perceived health and argue that SOC is an important resource and valuable approach for health promotion.

2.1.7 Salutogenesis and work

Salutogenesis is an asset-based approach, as it and has a positive look on how health can be promoted, and focuses on the resources of people and communities that promote coping abilities (Morgan, 2014, p. 4). Antonovsky meant that SOC developed mainly from childhood and until young adulthood when it became quite stable, but more recent research has shown that SOC develops throughout life and is thought to increase with age (Erikson & Mittelmark, 2017). Although Antonovsky (1987) thought that SOC was quite stable after the age of 30, he believed that it could be modified to some degree through work and working conditions. He meant that certain work characteristics contributed to an employee's experience of meaningfulness, manageability, and comprehensibility. Jenny et al. (2007) claim that SOC is shaped and influenced by different work-related factors and that it also influences work-related outcomes, such as stress level, job satisfaction, and burnout. Vogt et al. (2013) have examined if a context-specific SOC can be used to plan and evaluate health-related interventions at the workplace. Work-related sense of coherence (Work-SoC) is defined as the perceived comprehensibility, manageability, and meaningfulness of an individual's current work situation and it is considered to be more dynamic and sensitive to changes than general SOC (p.1). In a quantitative study, Vogt et al. (2013) found that high values in job resources are related to high values in Work-SoC, while high values in job demands are related to low values in Work-SoC. According to this, Work-SoC can to some degree reflect employees' job resources and job demands, and is partly formed by environmental factors in the workplace.

This study is not intended to measure the participants' sense of coherence, but rather to use the theory of salutogenesis as a guideline to identify salutary factors in the recovery and return to work (RTW) process after experiencing burnout.

2.2. Job demands - resources model (JD-R model)

The Job demand - resource model (JD-R model) first appeared in the early twentieth-first century and has since been in development (Demerouti et al., 2001; Schaufeli & Bakker, 2004; Bakker & Demerouti, 2007, Bakker & Demerouti, 2017). The JD-R model was originally meant to explain the antecedents of burnout (Demerouti et al., 2001), but it was later developed to focus on the relationship between job demands and job resources, and how the interaction between them has different work-related outcomes (Schaufeli & Taris, 2014). According to the JD-R model, different aspects of work can be classified as either job demands or job resources. Job demands refer to *those physical, psychological, social, or organizational aspects of the job that require sustained physical and/or psychological (cognitive and emotional) effort or skills and are therefore associated with certain physiological and/or psychological costs* (Bakker & Demerouti, 2007, p. 312). Job demands are, for example, job insecurity, work overload, emotionally demanding interactions with clients/patients, and role ambiguity (Schaufeli & Taris, 2014). Job resources refer to *those physical, psychological, social, or organizational aspects of the job that are either/or: ... functional in achieving work goals… reduce job demands and the associated physiological and psychological costs... stimulate personal growth, learning, and development* (Bakker & Demerouti, 2007, p. 312). Examples of job resources are social support, autonomy, role clarity, and feedback (Schaufeli & Taris, 2014). Demerouti et al. (2001) found that work environments where job demands are high and important job resources are scarce, can cause employees to experience job strain and even burnout. The JD-R model can be applied to many different occupations. According to the model, job demands are not necessarily negative, but when an employee does not have the resources to deal with the job demands, they can turn into a job stressor (508-509).

2.2.1 Development of the model

The JD-R model focuses on both negative and positive indicators of employee wellbeing and it can be applied to many different occupations. The earlier versions of the JD-R model explain two different processes, the ‘health impairment process’ and the ‘motivational process´. The health impairment process is a result of high and chronic job demands and low job resources, a process that

can exhaust employees' mental and physical resources and lead to health problems. The 'motivational process' is a result of job resources that lead to high work engagement, good performance, and low cynicism. The job resources can lead to either intrinsic or extrinsic motivation (Bakker & Demerouti, 2007). According to the JD-R model, job resources can buffer the effect of job demands in the 'health impairment process. That means that the presence of certain job resources, for example, social support or feedback, can buffer the negative effect of excessive job demands and reduce the chance of health impairment (Bakker et al., 2005).

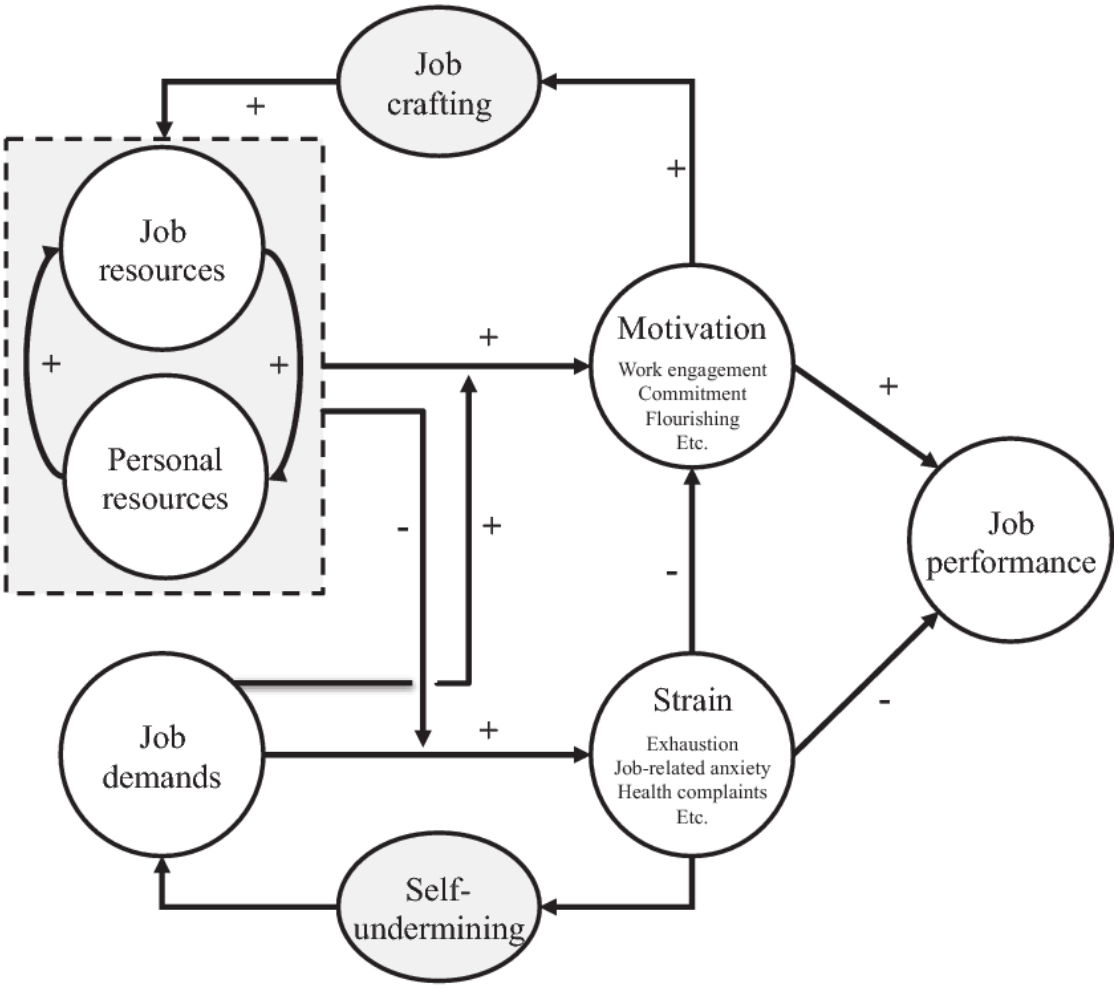

*Figure 2. The latest version of the JD-R model showing how the components of the model influence each other (*Bakker & Demerouti., 2017, p. 275.)

Figure 2 shows the latest version of the JD-R model, which is more detailed than earlier versions and includes personal resources, job crafting, and self-undermining. The model proposes that personal resources, such as optimism and self-efficacy, are related to increased work engagement and that personal resources, as well as job resources, can buffer the negative effect of job demands (Bakker & Demerouti, 2017). In the latest version of the model, Bakker & Demerouti (2017) included *job crafting* as a positive result of high personal and job resources and high motivation. Job crafting refers to the *proactive changes employees make in their job demands and resources* (p. 276). Job crafting behavior is often used by employees who are motivated by their work, and it leads to higher levels of resources, which then leads to even higher levels of motivation, creating a gain spiral. Bakker & Demerouti (2017) have also included *self-undermining* in this revised version of the model, as seen in figure 2. In this context, self-undermining refers to a *behavior that creates obstacles that may undermine performance* (p. 277). Employees who experience work strain are more likely to engage in self-undermining behavior, such as poor communication and work conflicts, which can increase the already high job demands. This creates a loss spiral, where high demands cause high job strain, which causes self-undermining behavior that leads to higher levels of job demands and job strain (Bakker & Demerouti, 2017, p. 277).

2.2.2 Limitations of the JD-R model

One of the limitations of the JD-R model is its inability to explain the underlying physiological processes related to the health impairment and motivational processes. Another one is how flexible the model is. It can sometimes be unclear what serves as a job demand and what serves as a job resource. Responsibility can be a job demand while it can be a job resource in other contexts and for other groups. It is therefore important to look at the context and have a clear idea of what role the different job characteristics play when applying the model (Bakker & Demerouti, 2017, p. 277-278).

2.2.3 Relevance of the JD-R model for this study

The motivational process of the JD-R model can be seen as a salutogenic path, where job resources promote growth and autonomy that lead to positive health. The job strain process of the JD-R model can, on the contrary, be seen as a pathogenic path, where excessive job demands lead to deterioration and exhaustion that have a negative effect on health (Jenny et al., 2017). Vogt et al. (2015) examined, in a longitudinal study, the role of sense of coherence in the motivational process of the JD-R model. The study found a strong link between a sense of coherence and job resources. According to Vogt et al. (2015), job resources help to build an employee's sense of coherence, which

leads to higher personal and job resources, something that promotes greater work engagement (Vogt et al., 2015, p. 204). In the current study, I will focus on what role both personal and job resources play when returning to work after burnout. The motivational process of the JD-R model is particularly relevant for this thesis, by focusing on the salutogenic path and looking at what job resources are important to promote growth and autonomy and to reduce the negative effect of job demands.

3.0 Literature review

In the following chapter, I will present relevant literature on nurses and burnout. First, I will present the search strategy. Thereafter I will present studies on causes and consequences of burnout in the nursing profession, next I will present studies on resources and coping strategies for nurses that experience burnout, and last, I will present studies on returning to work after burnout.

3.1 Search strategy

A literature review was conducted to find relevant literature on nurses' burnout with an emphasis on returning to work. The literature search was carried out in the period August – October 2020 and a new search was conducted in January 2021. The literature search was conducted by first using Google Scholar and Oria, and then by using Web of Science, PubMed, and PsycINFO. Search terms were chosen based on the overall objective of the study; to explore nurses' burnout, with emphasis on how nurses recover from it and how they manage when they return to work. Following search terms were used: *1) burnout, burnout syndrome, professional burnout, 2) nurse*, health care/healthcare professional, health care/healthcare worker, health care/healthcare staff, 3) back to work, return to work, recovery, 4) coping, coping strategy, resource*, challenge*, stressor*, work stressor**

The search terms were combined in different ways using the logical connectors AND/OR. Only peer-reviewed articles were included. The search was mostly limited to studies published in the last 10 years, to ensure the inclusion of updated knowledge. One article from 2007 was included as I considered it relevant, and it was one of few relevant studies conducted in Norway. Only articles in English and Norwegian were included.

When searching for literature, I discovered that numerous studies have been published in recent months about nurse burnout in relation to the COVID-19 pandemic. I decided to exclude studies focusing on COVID-19 because the focus of my thesis is on how nurses return to work after experiencing burnout. As the pandemic is far from over, no studies have been published on how this experience is in the context of the pandemic. The conditions created by this global pandemic are extraordinary and, in my thesis, I have chosen to focus on the connection between nursing and burnout in a general and long-term context.

There are a considerable number of studies that focus on burnout among nurses, most of them focusing on its causes and consequences (Bakhamis et al., 2019; Vinje & Mittelmark, 2007; Lien et al., 2014; Kirchhoff, 2011; Zhang et al., 2018; Manzano-Garcı & Ayala, 2017). There are also studies about resources and coping strategies (Akbar et al., 2016; Kupcewicz & Józwik, 2019; Averlid & Axelsson, 2012; Vargas et al., 2014, Hunter, 2016; Smith, 2014). However, there seems to be little focus on people that have experienced burnout, recovered, and come back to work. The majority of the studies identified on nurses and burnout use quantitative or mixed methods, with only six using qualitative methods.

After a systematic literature search, 17 studies were considered relevant to this project, seven articles on causes and consequences, five articles on coping strategies, and six articles on returning to work.

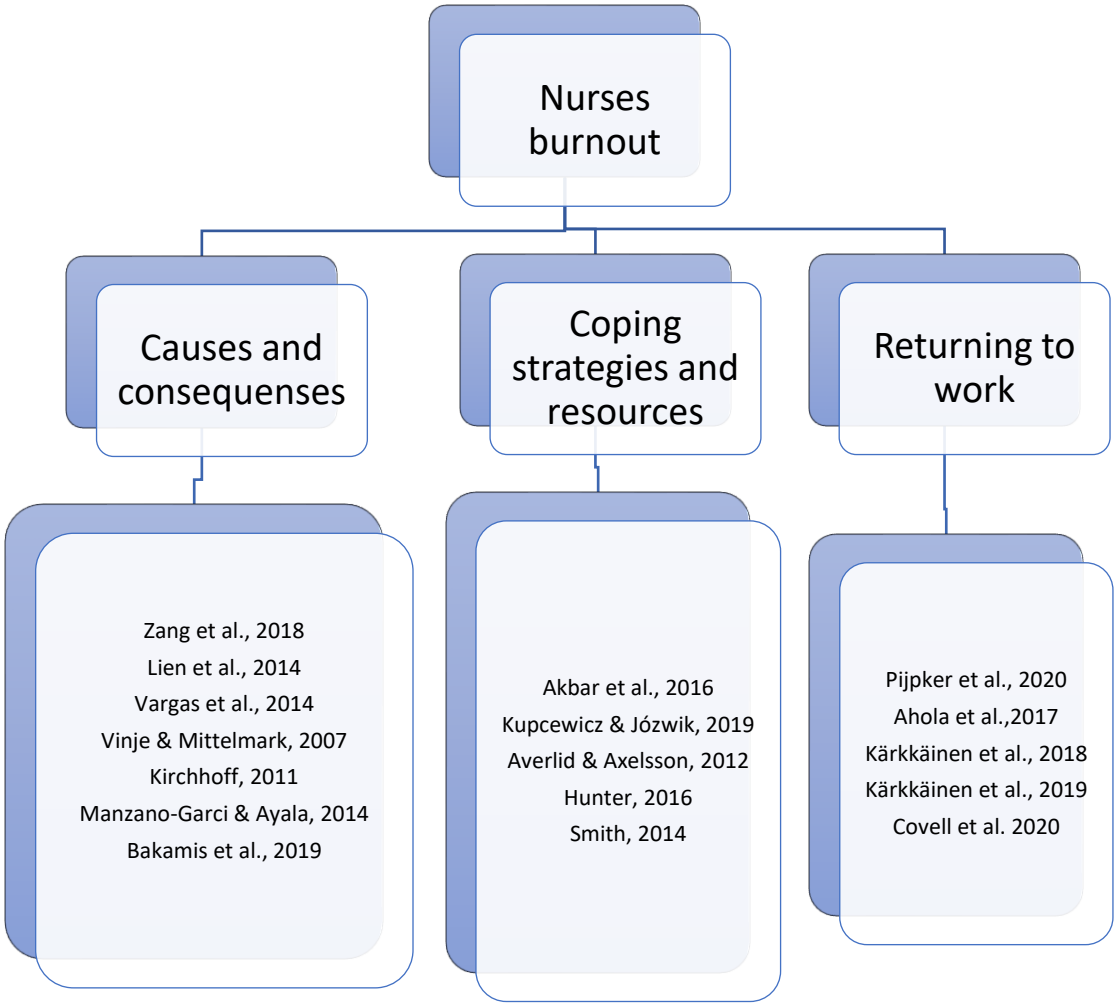

Figure 3. Overview of articles included in the literature review.

3.2 Causes and consequences of burnout in the nursing profession

Research shows that nurses have a higher risk of experiencing burnout than most other professions. To understand the connection between nursing and burnout, and why this profession is particularly prone to experiencing it, one must look at what factors cause burnout among nurses.

Compassion fatigue is a term that often appears in the burnout literature. Zhang et al. (2018) conducted a meta-analysis examining the association between compassion satisfaction, compassion fatigue, and burnout in nurses. Compassion satisfaction refers to a *positive altruistic quality that describes the feeling of self-appreciation while caring for and helping others* (p. 810), while compassion fatigue refers to *psycho-emotional distress that originates because of long-term self-sacrifice coupled with prolonged exposure to difficult situations* (Zhang et al., 2018, p. 810). The meta-analysis, which included 21 studies, found that higher education in nursing is connected to lower levels of compassion fatigue and burnout (Zhang et al., 2018, p. 818). Potter et al. (2010), who conducted a quantitative study on compassion fatigue and burnout among oncology nurses in the USA, claimed that one must analyze and understand the needs of a certain demographic group of nurses to develop an effective intervention to prevent compassion fatigue and burnout (p. 60-61).

Shift work is often mentioned as one of the stress factors in the nursing profession. Lien et al. (2014) conducted a quantitative study on the connection between shift work and self-reported sick leave among nurses in Norway. The study included data from 1464 nurses in the country and found a connection between high levels of sickness-related absence and working three-shift rotation (day, evening, and night). However, these results only applied to female nurses. Short rest and recovery periods between shifts are mentioned as a possible reason for higher levels of sickness absence among female nurses in these conditions (Lien et al., 2014, p. 354).

According to research, there is a link between job satisfaction and burnout. A meta-analysis that focused on the occupational factors related to burnout among nurses found a strong link between burnout and job satisfaction, with low job satisfaction increasing the risk of burnout and high job satisfaction being an important protective factor (Vargas et al., 2014, p.38). Vinje & Mittelmark (2007) examined the relationship between job engagement and nurses' health and functioning in a qualitative study conducted in Norway. They found that although job engagement can be a positive factor and a resource in life, high job engagement can lead to feelings of guilt and perceived failure to live up to own demands among nurses that work under much pressure, often with poor staffing

(p.110-111). A Norwegian study that examined occupational stress and coping strategies among nurses and other healthcare workers in primary health care services found a connection between maintaining patient confidentiality and occupational stress (Kirchhoff, 2011, p.144). The authors claim that maintaining confidentiality can make it hard for nurses and other healthcare workers to work through difficult work-related experiences. Confidentiality, meant to protect the patient's privacy, makes it illegal to discuss individual issues with people outside of work. Although nurses can discuss some aspects of difficult experiences with coworkers, they are not allowed to share details about their work with friends and family. This represents an understudied aspect of nurses' work-related stress (Kirchhoff, 2011, p. 149-150).

Manzano-Garcı & Ayala (2017) conducted a quantitative study aimed to identify insufficiently studied factors that are related to burnout in nursing. In the study, 17 factors were classified as 'little studied' and nine factors were classified as 'very little studied'. Among the factors classified as very little studied were continuous and excessive interruptions, feminine stereotypes, the lack of recognition of part of the tasks that nurses perform (invisible care), and excessive bureaucracy. Factors such as lack of belief in what is being done, too much work and little rest, lack of clarity in processes and procedures, and lack of recognition and praise were classified as 'little studied' (p. 10-11).

Research shows that there is a connection between nurse burnout and lower-quality patient care (Bakhamis et al., 2019). Bakhamis et al. (2019) studied the causes and consequences of nurse burnout in the US and found that nurse burnout can be linked to increased infection rate, higher patient mortality, and increased risk of medical errors. The study also found that many nurses who experience burnout decide to leave their job. Burnout does in that way contribute to high turnover rates in the nursing profession (p. 6-7).

3.3 Nurses coping strategies and resources when faced with work stress

What coping strategies nurses use when faced with work-related stress can both depend on the inner and outer resources. It is important to understand what coping strategies are effective to promote effective coping (Akbar et al., 2016). A qualitative study that explored strategies applied by nurses in Iran to cope with job stress identified six main coping strategies. The strategies were *situational control of conditions* that involve responding immediately to a work-related situation; *preventive monitoring of situation* referring to keeping a close eye on patients and situations at work, to prevent

potentially harmful and stressful situations; *seeking help* refers to seeking social support from either coworkers or family to cope with work-related stress; *self-controlling* which means to take actions to reduce work-related stress and calm yourself down, by for example working out and practicing positive thinking; *avoidance and escape* involves avoid doing certain tasks or dealing with certain situations in order to reduce stress levels and last *spiritual coping* refers to praying and seeking help from a Higher power (Akbar et al, 2016, p. 58-60).

Kupcewicz & Józwik (2019) conducted a quantitative study among Polish nurses focused on how positive orientation and stress coping strategies affected the chances of burnout among nurses. In this study, positive orientation refers to optimism, positive self-esteem, believing in your ability to reach your goals, and high levels of life satisfaction (p. 2). The study concluded that positive orientation is the most important protective factor for burnout among nurses and that a high level of positive orientation is related to active use of coping strategies, which lowers the chance of burnout (p. 12). Averlid & Axelsson (2012) conducted a study in Norway that aimed to identify health promoting factors among nurse anesthetists. They found that collaboration through teamwork played a central role in creating a good working environment. Clarity of roles and good management were also identified as important factors for a healthy and supportive working environment (p. 80).

Hunter (2016) conducted a critical interpretive synthesis to examine whether mindfulness affects the practice of nurses and midwives and if it can be used as a resource to cope with work stress. Mindfulness, a meditation practice focusing on being present in the moment, has been linked to increased resilience and emotional balance as well as more compassion towards other people (p. 918-919). The synthesis, which included five qualitative studies about mindfulness and nursing, found that it can be linked to increased self-efficacy as the nurses and midwives reported increased control over their thoughts and emotions. It was also linked to more agency over actions and work performance, as well as a wider and clearer perspective. According to the study, this is directly linked to better quality care of patients (Hunter, 2016, p. 924-926). Similar findings were identified by Smith (2014) who conducted a critical literature review to find out whether mindfulness-based stress reduction (MBSR) could be used to help nurses cope with stress. Smith (2014) argues that a drastic reduction in nurses' workload and work-related stress is not realistic, and it is more effective to find ways to help nurses cope with work-related stress (p. 119). The literature review, which included eleven quantitative and two qualitative studies, found several positive effects of MBSR. It also found that the use of MBSR among nurses was connected to increased job satisfaction

and decreased levels of burnout and anxiety, self-improvement (self-care, empowerment, and self-reliance), and improved empathy and focus (Smith, 2014, p. 127-129).

3.4 Returning to work after experiencing burnout

As mentioned earlier, burnout is characterized by feelings of energy depletion or exhaustion, increased mental distance from one's job, or feelings of negativism or cynicism related to one's job; and reduced professional efficacy (WHO, 2019). To facilitate a successful return to work (RTW), it is important to understand which individual and occupational interventions are effective (Pijpker et al., 2020, p. 2).

Kärkkäinen et al. (2019) conducted a qualitative study to examine the role of special RTW coordinators in six universities and six hospitals in Finland. The role of the coordinators was to be in contact with the worker during sick leave, plan the RTW and accommodate collaboration between the worker and different stakeholders involved as well as identifying barriers to RTW and clarify roles. The RTW coordinators also provided tools to support recovery, supported the workers' re-engagement with work, and monitored the workers' ability to cope with work after returning. They were also responsible for evaluating staff well-being through staff well-being surveys and monitoring sick leave statistics. Work communities with low levels of staff well-being and high levels of sick leave and burnout were offered special support to reverse the trend (496-498). The coordinators pointed out some challenges that affected the RTW process. Burnout is very complex and the recovery can be unpredictable. It can be affected by for example co-occurring physical or psychological illnesses, conflicts at the workplace, or in some cases lack of motivation to RTW. The results showed that in order to provide good support in the RTW process, it was important that the coordinators understood the causes and consequences of burnout. This study underlines the complexity of burnout and demonstrates the importance of supporting staff well in the RTW process (Kärkkäinen et al., 2019, p.499-500). However, this study focuses only on the experiences and perspectives of RTW coordinators and does not show the experiences of workers who have received help from them after burnout.

Ahola et al. (2017) conducted a systematic review and meta-analysis on the effect of interventions to alleviate burnout symptoms and to support RTW among employees. The study did not find a connection between person-directed interventions and recovery from burnout. Pijpker et al. (2020)

looked at the effect of combined interventions to reduce symptoms and promote RTW. However, combined interventions refer to both person-directed and

organization-directed interventions. The authors conducted a systematic review where 10 quantitative studies from eight counties, focusing on different professions, were included. They found that combined interventions are effective in reducing burnout symptoms and promoting RTW. Employees' involvement in decision-making as well as reinforcing social support and sense of job control were all related to reduced symptoms of burnout. The study suggests that building job resources to reduce workload can reduce burnout symptoms, but the authors point out that further research is needed to clarify what role job resources and stressors play in recovery from burnout and returning to work. Pijpker et al. (2020) also point out that although this review of quantitative studies indicates that combined interventions are effective to reduce burnout symptoms and promote the RTW process, it does not provide information about why it is effective and how. Qualitative research on combined intervention could therefore be useful and provide important information.

Kärkkäinen et al. (2017) conducted a systematic review looking at quantitative studies on RTW after sick leave due to burnout. The study does not focus specifically on nurses, but examines the RTW process in general, regardless of profession. The authors found that people's coping strategies affect the RTW process and that people who show avoidant behavior in conflict situations are less likely to return to work after experiencing burnout. They also found that low work control and long duration (over 6 months) of sick leave are barriers to RTW, while good communication, support from leaders, reduced/modified workload, and recovery from sleep problems are promoting factors in the RTW process (p. 464). Kärkkäinen et al. (2017) emphasize that there is a very limited amount of research and a lack of evidence about what factors promote or hinder the RTW process after burnout. Further research is needed to gain a better understanding of how to support people in returning to work after burnout (p. 467).

Through the systematic literature search, I found that there is a very limited amount of studies that focus specifically on how to accommodate nurses' RTW after experiencing burnout. Covell et al. (2020) conducted a scoping review examining the literature on how to accommodate nurses RTW after sick leaves due to mental health issues and found burnout is classified as a mental health issue together with substance use disorders, anxiety, depression, and post-traumatic stress disorder (p.2), which is different from the WHO classification of burnout as an occupational phenomenon and not a mental health issue (WHO, 2019). However, the results are relevant as they highlight the lack of

research on the topic. Covell et al. (2020) identified six peer-reviewed articles about nurses' RTW after sick leave due to mental health issues and these

articles mostly focus on returning to work after problems with substance abuse (drugs and alcohol). The review does not specifically state whether the substances are used to cope with work-related stress or not. None of the articles focused particularly on returning to work after burnout. The authors conclude that there is a gap in the literature about nurses' RTW after dealing with other mental health issues than substance abuse (p.4-7). The fact that only research that originated in the USA was included is a weakness in the study. Only six studies were included in the review, which is another weakness in the study. Despite these limitations, the review indicates how little research has been done on this topic. The fact that such a recent review has not found any studies specifically on nurses RTW after experiencing burnout underlines that there is a gap in the literature about how to accommodate nurses RTW after sick leave due to burnout.

3.5 Research questions

The nursing job involves multifaceted stress that can, over time and if not managed, lead to burnout. Factors such as compassion fatigue, low job satisfaction, and shift work are negatively associated with burnout. Positive orientation, collaboration through teamwork, and job satisfaction are examples of protective factors. Mindfulness is also suggested as a resource to help manage stress. Nurses' burnout is not only negative for the person experiencing it, it can also be linked to reduced patient safety and high turnover rates. Research shows that to promote a successful return to work after experiencing burnout it is important to work on both personal and organizational factors. After a systematic literature search, I found that there is a limited amount of research on RTW after nurses' burnout. As nurses are more prone to burnout than most other professions, and in the light of both the present and future nursing shortages (WHO, 2020) it is important to find out how to support nurses RTW after burnout.

This study will therefore examine the following research objective and research questions.

Research objective: To explore nurses' burnout, with emphasis on how nurses recover from burnout and how they manage when they return to work.

Research questions:

- How do nurses who have been on sick leave because of burnout, experience the process of returning to work?
- What are the main coping strategies and resources they identify in the process of returning to work?
- What are the main challenges/stressors they identify when they return to work and how do they deal with these challenges?

4.0 Methodology

Methodology is the study of methods, including the philosophical principles that *inform different approaches as well as the technical issues of how to generate and analyze data* (Green & Thorogood, 2018, p. 386). This chapter includes descriptions of the study's research design, epistemological standpoint as well as data collection methods, the data collection process, and data analysis. I also describe how quality has been ensured in the process and what ethical considerations were emphasized.

4.1 Epistemology

At the beginning of a research process, it is important to identify the researcher's philosophical perspectives or *worldview*; a worldview refers to a general philosophical orientation of the world and the nature of research (Creswell, 2014, p. 5).
Creswell's concept of worldview is commonly referred to as 'paradigm', or as 'ontologies and epistemologies', where epistemologies examine how to acquire knowledge while ontologies examine the nature of being and what things exist (Creswell, 2014, p. 6). Various epistemological traditions inform how knowledge is generated. The researcher's epistemological standpoint affects how research is conducted, what questions are being asked, what data are collected and how they are collected (Thagaard, 2018, p. 33).

In this study, I was interested in learning about nurses' experiences with burnout, recovery, and return to work. I was also interested in learning about what factors and resources were important when returning to work and what they found challenging in the process. My study builds on a phenomenological framework as I am interested in the narrative of the lived experience. Phenomenology is based on subjective experiences and the underlying assumption that reality is the way people experience it (Thagaard, 2018, p. 36). Phenomenology explores the meaning people attribute to their experiences of a certain phenomenon. A phenomenon is how things appear to us, or as we acknowledge them (Thomassen, 2006, p. 83). This study uses a phenomenological framework to examine the phenomenon of returning to work after burnout. Studies with phenomenological orientation describe features of a common experience expressed by a particular group of people, that can provide a general understanding of the phenomena studied (Thagaard, 2018, p. 36).

4.2 Research design

Research design is a framework of research methods and refers to the overall strategy chosen to conduct a study. The choice of research design depends on the nature of the research question as well as the researcher's knowledge of, and access to the field to be studied (Creswell, 2014, p.12-14). Based on my research questions and the phenomenological worldview, I chose a qualitative design for my study. Qualitative research design is well suited for this research as it focuses on understanding and describing characteristics of social phenomena as well as highlighting experiences and opinions that cannot be measured by numbers. Qualitative research methods are characterized by closeness to the participants and are well suited for studying personal and sensitive topics (Thaagard, 2018 p.15-16).

4.3 Data collection

There are different ways to collect data in qualitative research, such as interviews, focus groups, observations, and visual and textual analysis. Data collection with interviews is characterized by closeness to participants, which requires both openness and flexibility of the researcher (Thagaard, 2018, p.12). Interviews are a particular form of conversation, guided by the researcher to generate the type of data considered useful to answer a particular research question. Interviews are the most used method to collect qualitative data (Green & Thorogood, 2018, p.116). In qualitative research interviews, the aim is to allow the interviewee to speak at length and give detailed descriptions of a specific topic (Green & Thorogood, 2018, p. 386). Qualitative interviews can provide insight and a deep understanding of a chosen topic. There are several forms of qualitative interviews, they can be conducted individually or in groups, and they can be structured, semi-structured, or unstructured. The type of interview one chooses to collect data depends on the purpose of the study as well as the chosen group of participants (Thagaard, 2018, 90-92). Qualitative interviews aim to obtain rich and detailed descriptions of lived experiences from the perspectives of interviewees (Green & Thorogood, 2018, p.116). For my study, I chose to conduct narrative interviews.

4.3.1 Narrative interview

Narratives are stories where people talk about events or experiences from their perspective (Thagaard, 2018, p. 126-127). Storytelling is one of the oldest human activities and can be found everywhere in the world, regardless of culture, education, or social status. All human experiences can be expressed through storytelling and narrative interviews are based on the common human ability to tell stories (Jovchelovitch & Bauer, 2000, p. 58). Narrative interviews are unstructured, in-depth

interviews that use storytelling (informant) and listening (researcher) to gain an understanding of a certain phenomenon or some significant event (Malterud, 2017, p. 142). They are based on stories, where the participants describe a sequence of events or happenings and put them into context. During narrative interviews, informants can either talk about their experience of a certain phenomenon, or their life story, as they remember it (Thagaard, 2018, p.126).

Jovchelovitch & Bauer (2000) present basic phases of the narrative interview: preparation, initiation, main narration, questioning phase, and concluding talk. I have used these guidelines when conducting my interviews. During the *preparation phase*, the researcher makes themselves familiar with the field of study and identifies the initial topic of the interview. In the first phase of the interview, *the initiation*, the researcher presents the context of the study and briefly explains the procedure of a narrative interview to the informant. During this phase, the researcher presents the initial theme or topic of the interview. The initial topic should be broad to encourage long and rich storytelling by the informant (Jovchelovitch & Bauer, 2000, p. 61-62). During the second phase of the interview, *the main narration*, the interviewee tells the story and should not be interrupted, not until the end of the story. During the storytelling, the researcher should not comment or ask questions, but listen actively and use non-verbal communication to encourage the storytelling. This is done to minimize the researcher's influence on the narrative. During this phase, the researcher can take notes if necessary. When the informant signals that the story is finished, the researcher can ask if there is anything else he/she wants to add to the story, or if it is finished (Jovchelovitch & Bauer, 2000, p. 62). This leads over to the third phase of the interview, *the questioning phase*. During the questioning phase the researcher can ask the interviewee questions such as; "can you tell me more about ...?" and "what happened before / after this ...?". One should not ask directly about opinions, attitudes, or causes, as that leads to rationalizations or justifications. According to the authors, rationalization should occur spontaneously as a part of the narrative and should not be probed. The three first phases of the interview are recorded and later transcribed. The fourth and last phase of the interview is the *concluding talk*. This is a more informal, non-recorded chat, and during this phase, interesting discussions can occur. Important contextual information often emerges when the informant speaks more casually and informally, but such information can be important when interpreting the data. At this stage of the interview, the researcher also has the opportunity to assess the level of trust, or mistrust that exists between the informant and the researcher. After the interview, the researcher can write down thoughts and impressions from the interview and the more informal chat from the concluding talk (Jovchelovitch & Bauer, 2000, p. 63-64).

Narrative interviews use a form of everyday communication, storytelling and listening, to generate qualitative data. The undisturbed narrative and the researcher's limited intervention during the interview, give the potential to obtain and recreate the interviewee's experience of a specific event (Jovchelovitch & Bauer, 2000, p. 60). However, narrative interviews also come with certain challenges. Jovchelovitch & Bauer (2000) note that the rules for narrative interviews are quite strict and may serve as a standard for aspiration. In many cases, it is not possible to follow the rules completely throughout the interview, and then some kind of compromise needs to be made between the narration and questions. The extent to which a long and uninterrupted narrative is achieved depends on the researcher's communication skills, how well or poorly the initial topic is worded, and the interviewee's narrative ability (p. 64 - 65).

4.3.2 Interview Guide

Before I conducted the interviews, I developed an interview guide, (see appendix 3). Narrative interviews are defined as unstructured, in-depth interviews. Although they are largely based on the interviewee's uninterrupted storytelling, it is helpful to prepare some kind of interview guide or framework for the interview. The researcher prepares the initial question or initial central topic, to get the informant started and trigger a self-sustainable narration (Jovchelovitch & Bauer, 2000, p. 58-61). In the interview guide, I prepared a few probing questions which I could use after the informant had finished the storytelling. These questions all covered themes that I wanted to make sure to address during the interviews, such as motivational factors in the process of returning to work as a nurse, how they dealt with challenging situations when they came back to work and what they experienced as helpful in the process of returning to work. The probing questions were used to address specific issues that the informants did not address themselves or to delve deeper into specific issues raised in the interviews.

4.3.3 Sample and sampling strategy

Typically, when data is collected with qualitative interviews, a small sample of people is interviewed about a certain phenomenon. For my research, I used strategic sampling. Strategic sampling means choosing interviewees who have knowledge or qualities that are relevant for answering the research question (Thagaard, 2018, p.54). In phenomenology, the participants must have personal experience of the phenomenon that is being studied. (Thomassen, 2006, p.83). The inclusion criteria for the study were defined based on the research topic: *returning to work after experiencing burnout as a*

nurse. Inclusion criteria for the project were as follows: being a registered nurse in Norway and working in either specialist or municipal health care services. All the participants had to have experienced burnout, taken a leave of absence, and returned to work as a nurse. They did not have to return to the same workplace, just to have returned to work as a nurse. There were no requirements as to where in Norway the participants lived, as I could use teleconferencing software (Zoom) for the interviews. Another inclusion criterion was to speak either Norwegian, English, or Icelandic. No requirements were made regarding age, gender, or length of work experience.

4.3.4 Recruitment and sample size

The recruitment process was based on two different approaches: snowballing and recruitment through social media. In snowballing the existing study subjects are asked to suggest or invite potential participants from their network (Green &Thorogood, 2018, 77). In my study, it was not the existing study participants who recruited future participants, but a few nurses that I know from work that recruited from their network and helped me to establish a connection to potential participants that met the inclusion criteria. I recruited two participants through snowballing.

A part of the recruitment for the project was done through social media, specifically through groups for nurses on Facebook. Social media, such as Facebook, Twitter, and Instagram, have brought new opportunities to approach and recruit research participants (Green & Thorogood, 2018, p.237). Although social media is not an ideal platform to approach vulnerable groups, or groups that are relatively inactive on social media, it can in some cases be a good platform to access potential participants (Green & Thorogood, 2018, p.237-238). To reach out, I posted an introductory text on a few closed Facebook groups for nurses. The text contained a brief description of my project and at the end, I asked potential participants to contact me if they wanted to know more about the project or if they were interested in participating. I recruited six participants through Facebook.

When deciding on the size of the sample, different issues need to be considered. According to Malterud (2017), the *information power,* of the sample determines how many participants are needed. The information power of the study is decided by the research question, the sample's knowledge and experience regarding the research question, choice of theories, and quality of the interviews and analysis. With high information power, data from a low number of participants (under 10 for example) can be sufficient to provide a rich data material (p.63-64). Qualitative research requires a deep and precise analysis of the data material, something that takes both time and effort. It

is therefore important that the sample size is large enough, but not too large, so the researcher has the capacity to make a detailed analysis of the collected data material (Thagaard, 2018, p. 59). For my study, I recruited eight participants in total. In terms of the time I had to collect and process data, eight participants proved to be a suitable sample size. Based on the research question and based on the participants' background and the interaction with them in the interviews as well as the choice of theories and analysis method, I assessed the information power in the sample to be high. I considered eight participants as an appropriate sample size to provide rich data material.

4.3.5 Pilot interview

Before interviewing the study participants, I conducted one pilot interview. In the pilot interview, I spoke to a nurse who had been on sick leave but not because of burnout. The interviewee did not meet all the inclusion criteria for my study, but it was helpful to try out the interview guide and get feedback. The pilot interview was also a good opportunity for me to practice interviewing, as I have no previous experience of conducting research interviews. In the pilot interview, I had the opportunity to try out technical equipment and go over all the technical aspects of the interview, such as testing how it works to conduct interviews on Zoom and testing the sound recorder. Having gone through these things beforehand made me more comfortable when I first started talking to the research participants.

4.3.6 Conducting the interviews

All eight interviews were conducted via Zoom. The reason for this was partly because the Covid-19 situation made it challenging to meet in person, but also because the use of Zoom opened up the possibility to interview nurses from all over the country. This was beneficial as I was able to reach participants that I would have had difficulty meeting in person because of geographical distance. I conducted all of the interviews myself. The informants received both written and verbal information about the objectives and the aim of the study. They also got verbal information about what a narrative interview is. I obtained written consent from the informants before the start of each interview. I asked the participants for permission to record the interviews on an audio recorder and all of the participants consented. As a precaution, two audio recorders were used to record the interviews. The interviews did not have a specific time frame. The length of the interviews was mainly decided by the participants and lasted as long as necessary for the participants to tell their stories and answer questions. The length of the interviews ranged from 37 minutes to 70 minutes.

During the interviews, I aimed to follow the instructions of Jovchelovitch & Bauer (2000) as closely as possible. Before the interview started, I spoke casually to the participants for a little while, before explaining the project's objectives as well as the course of the narrative interview. Thereafter I presented the initial topic to encourage long and rich storytelling. The length and detail of the stories varied between participants. Most of the participants told their story in a long and detailed way where I did not have to intervene until their storytelling was over. After the story, they answered a few probing questions. For some participants, the narration was shorter, and I had to ask several questions to encourage a continued and more detailed storytelling. Those interviews became more like semi-structured interviews, where I asked open-ended questions and the participants answered. This variation might be due to my inexperience with narrative interviewing, as I might not have been able to initiate the storytelling successfully at the beginning of the interviews in all cases. It could also be due to people's different narrative abilities (Jovchelovitch & Bauer, 2000).

Through qualitative interviews, it is important to listen with interest and accuracy to what the participants say and be sure to also capture what contradicts one's preconceived ideas (Malterud, 2017, p. 134). During the interviews, I tried to be aware of listening very carefully and with curiosity to what the participants had to say. All participants knew about my background as a nurse. This might have led them to use professional terms and talk about certain situations without further explanation because they knew would know their meaning. In those situations, I asked participants to elaborate, to ensure rich and detailed storytelling.
The framework of Jovchelovitch & Bauer (2000) focuses on interfering as little as possible during the main narration. I tried to keep verbal interference to a minimum. But given that the interviews were all conducted via Zoom, it was difficult to signal to the interviewees with facial expressions and body language that I was listening with interest. Therefore, it was natural to give occasional verbal feedback in the form of "aha", "ok", "I see", or "mhm " to show the participants that I was listening.

When collecting data through qualitative interviews, the context around the interviews and the interaction between researcher and participant affect the knowledge that emerges in the interview (Malterud, 2017, p. 133). During the interviews, I sat at home and talked to the participants as they sat in their homes. Since the interviews were conducted via video calls on Zoom, I only saw the face and the upper body of the participants. Because of this, I could not fully capture the participants' body language as well as I could have if the interviews were conducted face to face. Therefore, I made an effort to keep a close eye on the participants' facial expressions, tone of voice, and mood. At the beginning of the interviews, I made it clear to the participants that it was up to them how

much they wanted to share about the time before they experienced burnout, what happened at work and what symptoms they experienced. Experiencing burnout can be a painful and difficult process, and the participants were at different stages of the RTW process when I interviewed them. To show the participants consideration I did not ask for information that could cause them great discomfort. However, it turned out that all the participants shared their experience of what happened before the burnout, what they thought caused it, the symptoms they experienced. For all the participants, this was a part of the story they wished to share. Although the focus of the project is on what happens after the burnout and not what causes it, these stories were valuable in understanding the context in which the burnout took place and what effect it had on the RTW process.

4.3.7 Transcribing the interviews

The interviews were transcribed directly after they were conducted. Transcription is a process where data material that has been collected is converted into textual form (Malterud, 2017, p. 77). Transcribing is time-consuming and it took approximately one hour to transcribe 15 minutes of recorded data. I transcribed all the interviews myself and I became well acquainted with the data material through the transcription process. A total of 349 minutes of recorded interviews were transcribed into 89 pages of written text. The interviews were transcribed using Word, and then uploaded to Nvivo, a software program for organizing and analyzing non-numerical data.

Transcriptions are not a direct description of reality, but an interpretation of what material is created in the interaction between the researcher and the interviewees (Malterud, 2017, p. 77). I wrote the interviews down as accurately as I could, and I tried to capture the nuances of the interviewee's speech. Slang, pauses, hesitations, repetitions, and more were included. I also wrote if the interviewees for example laughed, cried paused to think, or shook their head. Since all the interviews were conducted on video call on Zoom, where I only saw in the face of my interviewees, a lot of non-verbal communication passed me by. Therefore, I made a point of taking notes during the conversations when important things came up that I wanted to remember. Later in the process, when I had analyzed the transcribed interviews and chosen which sentences were included in the presentation of the results, these sentences were translated from Norwegian into English. When translating into other languages, it is important to keep the meaning of the sentences as accurate as possible (Malterud, 2017, p. 79). When I translated the sentences into English I often had to change the word order to make the sentences grammatically correct, but I emphasized keeping the meaning and flow of the sentences.

As a part of anonymizing, I chose to give the participants pseudonyms. I chose Norwegian female names starting with the first eight letters of the alphabet (A-H), shown in the table below.

Interviewee number	**Pseudonym**
Interviewee 1	Anna
Interviewee 2	Britt
Interviewee 3	Camilla
Interviewee 4	Dagny
Interviewee 5	Esther
Interviewee 6	Fride
Interviewee 7	Gunhild
Interviewee 8	Hedvig

Table 1 – Pseudonyms for participants

4.3.8 Data storage

The interview transcriptions, written consents, and a list with personally identifiable information (scrambling key) were stored at the University of Bergen server for secure storage. I set up a SAFE account where I stored the data, but SAFE is a solution provided by the University of Bergen for the secure processing of sensitive personal data in research. According to instructions from REC, the list with personally identifiable information should be stored for five years for control purposes.

4.4 Analysis

Data analysis in qualitative research is the process of turning primary data into findings, by systematically going through the data collected and arranging it, reducing it, finding patterns, and drawing meaning from it. Qualitative data analysis is a way of making sense of the often abundant amount of qualitative and can be described as a purposeful journey from research question to results (Green & Thorogood, 2017; Malterud, 2017). Analysis in qualitative and quantitative research are fundamentally different as analysis in quantitative research is based on strict rules and statistics,

while qualitative analysis is more flexible and is based on the researcher's interpretation (Green & Thorogood, 2018, p. 250). Qualitative data analysis should, however, be based on systematic procedures where the researcher follows a set of rules to ensure quality and avoid that the results are based on subjective opinions (Malterud, 2017, p. 91-92).

When analyzing data one can use an inductive or deductive approach to the data material. In inductive analysis, themes, patterns, concepts, and explanations are identified through a detailed reading of the data material. This is a bottom-up approach where new knowledge and theories arise from the data. Deductive analysis, on the other hand, is a top-down approach that aims to test existing theories and knowledge (Creswell, 2014; Green & Thorogood, 2018). In the research process, I have emphasized an inductive approach, but I have still to some degree been influenced by my research question, the existing literature I had read, and the theoretical framework of the study.

There are several different ways to analyze qualitative data. What method one uses to analyze the research data is determined by the research objective (Green & Thorogood, 2017, p. 253). The objective of my study was to explore nurses' burnout, with emphasis on how nurses recover from burnout and how they manage when they return to work. For my study, I chose to conduct a thematic analysis. Thematic analysis is used to identify themes that summarize important points from the data, or as Howitt (20120, p. 164) describes it, thematic analysis "is the analysis of what is said rather than how it is said". When analyzing research data it is important to have a guide to follow to ensure one takes the necessary steps and stays on track in the analytical process. (Malterud, 2017, p. 92). This is especially important for new and inexperienced researchers, like me. In my research, I chose to follow Attride-Stirling's (2001) guidelines for thematic network analysis. Before I started analyzing, I repeatedly read through all the transcriptions to get well acquainted with the data material.

4.4.1 Thematic network analysis

According to Attride-Stirling (2001) *thematic analyses can be usefully aided by and presented as thematic networks: web-like illustrations (networks) that summarize the main themes constituting a piece of text* (p. 386). The author presents a step-by-step guide on how to conduct a thematic network analysis and explains a way of first identifying the most basic or lowest-order themes from the textual data. These themes are called Basic themes and do not say much about the text as a whole. Next, the Basic themes are grouped into clusters of similar ideas forming middle-order themes called Organizing themes. At last, a super-ordinate theme/themes, a Global theme, is identified. The Global theme is formed by grouping different Organizing themes that together

present an argument or a conclusion about the text as a whole. The relationship between those themes is presented graphically in a web-like illustration (p. 388-389). To analyze the textual data and identify different themes, I followed a six-step guide presented by Attride-Stirling (2001).

Step 1 of the process was *coding the material.* Coding is a process of reducing the data by dividing the text into meaningful text segments and label them with descriptive codes (Thagaard, 2018, p. 153). Through this first step, I developed a coding framework and I used the data program Nvivo to code my data. Step 2 was to *identify themes*. This was done by reading thoroughly through the text segments in each code and grouping codes with similar meanings together. The groups of codes with similar meanings formed basic themes. These themes must be specific and descriptive, but at the same time, they have to be broad to accommodate the meaning of several different codes (Attride-Stirling, 2001, p. 392). Figure 4 demonstrates how basic themes were formed out of groups of codes.

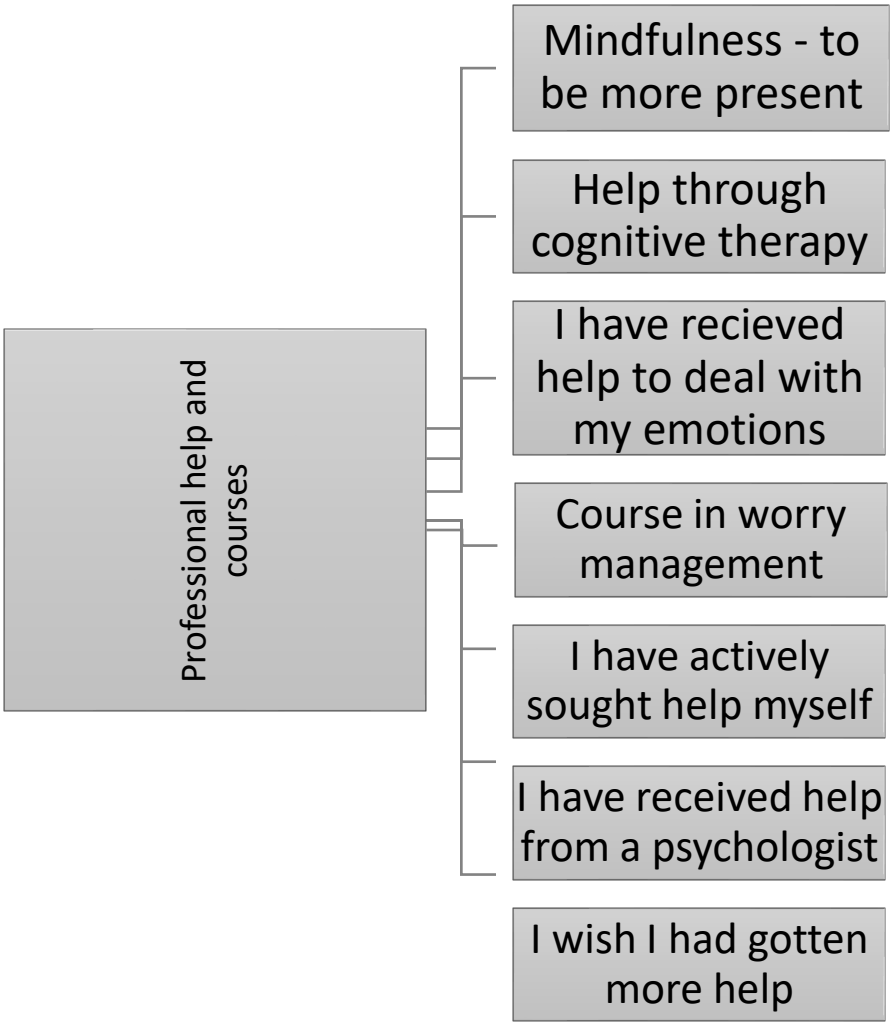

Figure 4 - A diagram illustrating how codes with similar meaning were grouped to form a basic theme

Step 3 was to *construct the network.* After identifying basic themes, I grouped similar themes. These coherent groupings formed the Organizing themes. Next, I summarized the main points in the text, based on Basic themes and Organizing themes, to identify the Global theme. The Global theme can be described as the core of the text or the main claim (Attride-Stirling, 2001, p. 392-393). Figure 5 illustrates the process of forming Basic themes, Organizing themes, and a Global theme.

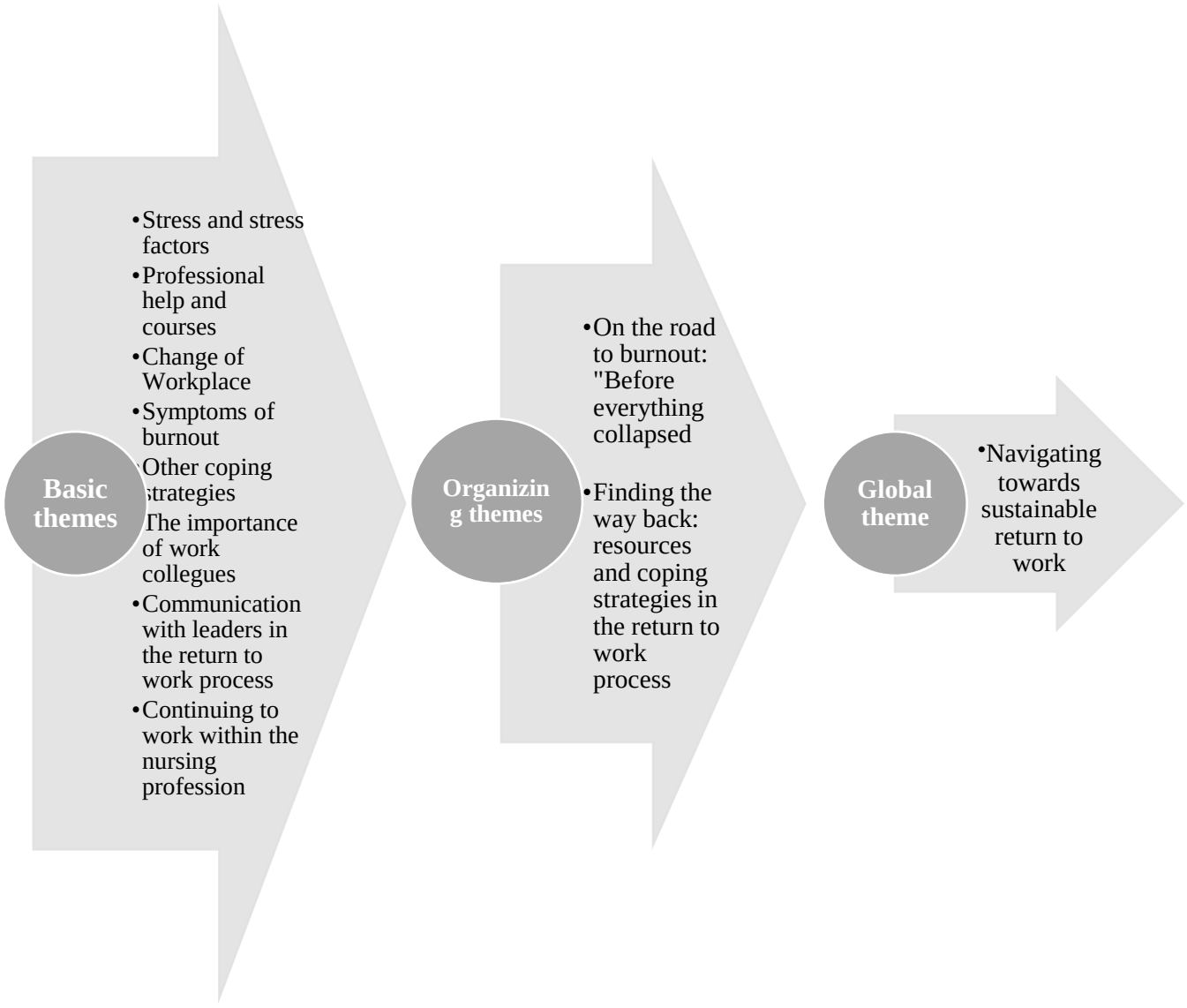

Figure 5 - A diagram illustrating the process of identifying themes

After identifying all of the themes I illustrated the findings, the thematic network, in a web-like representation, see Figure 6 in chapter 5. Step 4 of the process was to *describe and explore the thematic networks.* This step involved going back to the original text, exploring the themes that had emerged, and examining the extent to which these themes represented the text. A part of this step was to describe the contents of the network, supported by text segments. Step 5 was to *summarize the thematic network*. Steps 4 and 5 included writing the results of the study. Step 6 was to *interpret patterns*, which included going back to the research questions and theoretical framework and

addressing them with patterns and structures that arose in the text. The last step included the writing of the discussion chapter (Attride-Stirling, 2001, p. 394).

4.5 Quality assurance

When it comes to describing how quality is guaranteed in research, not everyone agrees on what terms to use. Some researchers use the terms *reliability*, *validity*, and *generalization*, but these terms originally came from quantitative research methods. There are no fully agreed-upon terms to assess quality in qualitative research. However, many converge around using the terms *credibility*, *conformability*, *dependability*, and *transferability* (Shenton, 2004, p.64). In the following section, I will describe the principles that I have followed and the steps that I have taken to assure quality in my study.

4.5.1 Credibility

Credibility refers to the extent to which research results can be perceived as believable and credible, and the extent to which the information is based on reality (Malterud, 2017, p. 192). To ensure credibility in my study I used established methodological approaches and I have made an effort to ensure transparency by giving clear and detailed descriptions of the entire process and substantiating the decisions I have made. Another step to ensure credibility was to have frequent debriefing sessions with my supervisor and group supervision with the supervision group, where we went through each other texts and gave each other feedback.

4.5.2 Confirmability

Confirmability refers to the quality of the interpretation of data, how the researcher arrives at the results. Steps must be taken to ensure that the results are based on the experiences and ideas of the informants, and not on the preferences and ideas of the researcher. This can be done by giving detailed methodological descriptions and describing the research process step by step (Shenton, 2004, p. 72). However, it is important to recognize that the researcher always influences the research process to some extent in qualitative research, as the knowledge is created in the interaction between the researcher and the participants (Malterud, 2017; Shenton, 2004). To ensure confirmability, I have made an effort to give detailed descriptions of the entire research process and all the decisions that have been made. In section 4.4.2, I will discuss my positionality and the strengths and weaknesses of the project, which may have affected the research process and the decisions I made.

4.5.3 Dependability

Dependability looks at whether the same results were obtained if the study was conducted in the same way, in the same context, and with the same participants (Sehnton, 2004, p.71). This is not a realistic goal in qualitative research, as the researcher's participation and the understanding that the researcher develops in contact with the participants always affect the research process to some extent. It is nevertheless important to argue for dependability so the reader has the opportunity to assess the research process (Thagaard, 2018, p. 187). To ensure dependability, I have given descriptions of the research design, detailed descriptions of the data collection process as well as the analysis process, reflected on the context of the study and how my positionality has affected the research process.

4.5.4 Transferability

Transferability refers to if findings from the research apply to other settings and contexts. The researcher must provide a good and detailed description of the particularities of the settings of the case as well as good theoretical analysis so people can assess the extent to which the study is transferable (Green & Thorogood, 2018). Transferability in qualitative research is in some ways similar to generalisability in quantitative research, but there is still a fundamental difference. Generalisability is about how one can generalize findings from a sample to a large population, while transferability is about how one can transfer findings from a small sample in a specific context, to another similar context (Creswell, 2014). It is important to consider and assess the extent to which the results of the project are transferable and of interest to other contexts outside the context in which the project was carried out. Both the context in which the study was conducted and the study sample help to determine the extent to which the results are transferable. (Malterud, 2017, p. 66-67). To be able to assess the transferability of the study, I have made an effort to give detailed descriptions of all the steps that have been taken in the research process, included the sample of the study and the context that the study was conducted in. My research is based on the experience of eight female nurses who have experienced burnout and returned to work. The results of this study cannot be transferred to all female nurses in Norway who experience burnout and return to work. However, the results can provide insight into the experience of this group and help to inform about what both promotes and inhibits the return to work process in this group and groups in similar contexts.

4.5.5 Reflexivity and positionality

I have also emphasized *reflexivity* throughout the whole process. Reflexivity refers to how a researcher reflects on their background, biases, and values and how they may influence and shape the study (Creswell, 2018, p.183). The researcher's background and position will inevitably affect all steps of the research process. In qualitative research, the aim is not to ensure that the researcher is neutral, as that is almost impossible. The aim is rather to ensure that the researcher is aware and open about his/her position, knowledge, and predetermined ideas that influence the research. Subjectivity can occur when the researcher ignores the effects of his position and preconceived notions and does not account for them (Malterud, 2017, p. 44-47). Malterud (2017) claims that reflexivity starts by identifying preconceptions brought into the project by the researcher, or the researcher's positionality (p.44).

Positionality in research can be described as the researcher's backpack, which is all previous knowledge and experiences that have shaped the researcher and that the researcher brings into the process. It can for example be education, work experience, and opinions on the research topic (Malterud, 2017, p. 48). In this process, it has been important for me to be aware of my background, as I have worked as a nurse within specialist healthcare services for several years. I know what role nurses play within the healthcare system and I am familiar with nurses' work environments as well as the pressure and workload nurses face.

I have not experienced burnout myself, but I have experience from working in a similar work environment as the participants in the study. Much of what the participants describe are things I have personally experienced. Since I have the same education, similar work experience, and "speak the same language" as the participants, there is a risk that I will take some of what they say in the interviews "for granted", as a general knowledge that everyone understands. It has been important for me to be aware of that during the interviews and to encourage the informants to describe and explain their stories in detail. Since I have worked as a nurse in the health care system, I have certain ideas about the factors that promote burnout among nurses and how it would be possible to support nurses who return to work after experiencing burnout. Throughout the research process, I have endeavored to put these ideas aside. I have read research articles and listened to my informants with an open mind. To avoid confirmation bias, I have made an effort to listen to what is being said and not just hear what I want to hear. My positionality may also have had its positive sides. The participants may have found it easier to relate to me and tell their stories openly and honestly due to my background and gender. Approaching the material with an open mind and curiosity and at the same time being aware of my position has been highly important in this process.

4.6 Ethical considerations

Research ethics refer to a diverse set of values, norms, and institutional arrangements that contribute to constituting and regulating scientific activity (NESH, 2016, p. 11). Ethical considerations are important throughout the research process and should be considered in every step of the process (Creswell, 2018, p. 95-96). The National Committee for Research Ethics has published guidelines for research ethics to ensure that all research is conducted according to recognized research ethical norms. The guidelines apply to all research conducted in Norway, in both the public and private sectors. They also apply to research projects conducted by students (NESH, 2016). Three main themes are often mentioned in ethical guidelines; informed consent, anonymity, and consequences of participating in research projects (Thagaard, 2018, p. 22).

4.6.1 Informed consent

Informed consent implies that the participants should get enough information to be able to make an informed decision whether they want to participate in the research project or not. Before participants decide to take part in a project, they should be informed about the purpose of the study, who has access to the information collected, how the results will be used, who finances the project, and as well as information about the consequences of participation. The consent should be documented, usually in the form of a signed declaration of consent (NESH, 2016). Before I conducted interviews, I sent all the participants an information sheet with information about the project's objectives and what participation in the project entails. I asked them to read the information sheet carefully and ask questions if anything was unclear. I made sure that the participants understood the given information before the consent was signed and submitted. It was also important to emphasize that participation was voluntary and that participants had the right to withdraw consent. They were also informed that they had the right to access the information registered about them.

4.6.2 Confidentiality

Another key principle for ethical practice is confidentiality. Confidentiality implies that the identities and personal information about the participants are not disclosed. When transcribing interviews one should use pseudonyms or codes to protect participants' identities and when the results of the research are presented, all participants should be anonymized (Green & Thorogood, 2018, p.91-92). After I finished transcribing the interviews, I deleted all the audio recordings. To ensure confidentiality, the researcher must ensure that lists of names and other personally identifiable information are stored securely. All data must be stored responsibly, and the storage time should be

limited (Thagaard, 2018). In my project, I have stored all data on a password-protected computer connected to the University in Bergen server (via VPN). As mentioned before, I set up a SAFE account where I stored personally identifiable information, informed consent, and transcriptions. Personally indetifiable information (scramling key) was separated from other data.

4.6.3 Consequences

The third key ethical principle is consequences; the researcher always has to consider the consequences of participating in a research project. According to the NESH (2016) guidelines, the researcher must ensure that participation in the project does not lead to excessive burdens or damage. It should be a goal to avoid negative consequences and adverse effects for the participants (p.19). It can be both painful and difficult to experience burnout and it has therefore been important to avoid diving too deep into the hard times of burnout. In my project, it has been important to have a health promoting focus throughout the process and focus on what happened after the burnout when the participants returned to work, more than the difficulties of burnout. Using interviews as a data collecting method requires some further ethical considerations. Being involved in research can have emotional consequences for the participants, especially if they are asked to share information about private and/or sensitive issues. It is important that the researcher listens carefully and shows respect and empathy during the interview (Green & Thorogood, 2018, p. 93-94).

At the beginning of the research process, I applied for approval from NSD (Norwegian Centre for Research Data). They directed me to REC (Regional Committees for Medical and Health Research Ethics) where I submitted a remit assessment. REC concluded that I needed to apply to them, rather than NSD, because I planned to interview people who had experienced burnout and had been on sick leave, which involved a chance that I would collect medical information about the participants. The project was approved by REC in December 2020 (see appendix 1).

5.0 Results

In this chapter, I will present the results of the study. First, there is a short introduction about the participants, followed by a diagram of the findings from the thematic network analysis and after that, each theme from the findings will be presented.

5.1 Participants

A total of eight nurses were interviewed for the study. All the nurses interviewed were female and they all worked in Norway, five of them worked in specialist health services and three of them worked in municipal health services. Following is a short presentation of the participants. The length of their sick leave is presented from 0-2 months, 2-6, or 6-12 months. Longer periods than one year are presented as the number of years on sick leave. The length of sick leave is presented in this way because most of the participants were not on one continuous sick leave. Most of them were on and off sick leave for some time, especially at the beginning of the process, when they were finding out that they were experiencing burnout.

Anna has been a nurse for seven years. She was on sick leave for three years due to burnout. Anna worked within the specialist health services before the burnout. She changed jobs before returning to work but continued to work within the specialist health services. She now works 100%.

Britt has worked as a nurse for seven years. She worked within the specialist health services before she experienced burnout. Britt was on sick leave for 6-12 months before returning to the same workplace. She now works 80% but is planning to work full time soon.

Camilla has been a nurse for seven years. She worked within the specialist health services before she experienced burnout. Camilla was on sick leave for one year before returning to work. She changed jobs before returning to work but continued to work within the specialist health services. She now works 75%.

Dagny has worked as a nurse for ten years and works at the municipal health services. Dagny was on sick leave for one year due to burnout. She changed jobs within the municipal health services before returning to work. She now works 100%. Dagny was a ward manager at her former workplace and also has the role of a ward manager at her current workplace.

Esther has worked as a nurse for six years and she works in specialist health services. Esther was on sick leave for 6-12 months. After the sick leave, she returned to the same job and now she works 100%.

Fride has worked as a nurse for over 20 years. She works in the municipal health services. She worked as a ward manager before she experienced burnout. Fride was on sick leave for 0-2 months before returning to work. She changed jobs before returning to work, but still works within the municipal health care services. She does not work as a ward manager at her new workplace.

Gunhild has worked as a nurse for eight years. She works in specialist health services. She was on sick leave for 6-12 months due to burnout. She has now returned 40% to work at the same workplace.

Hedvig has worked as a nurse for ten years. She works in the municipal health services. She was on sick leave for 2-6 months. She returned to the same workplace but got a different position. She now works 80 %.

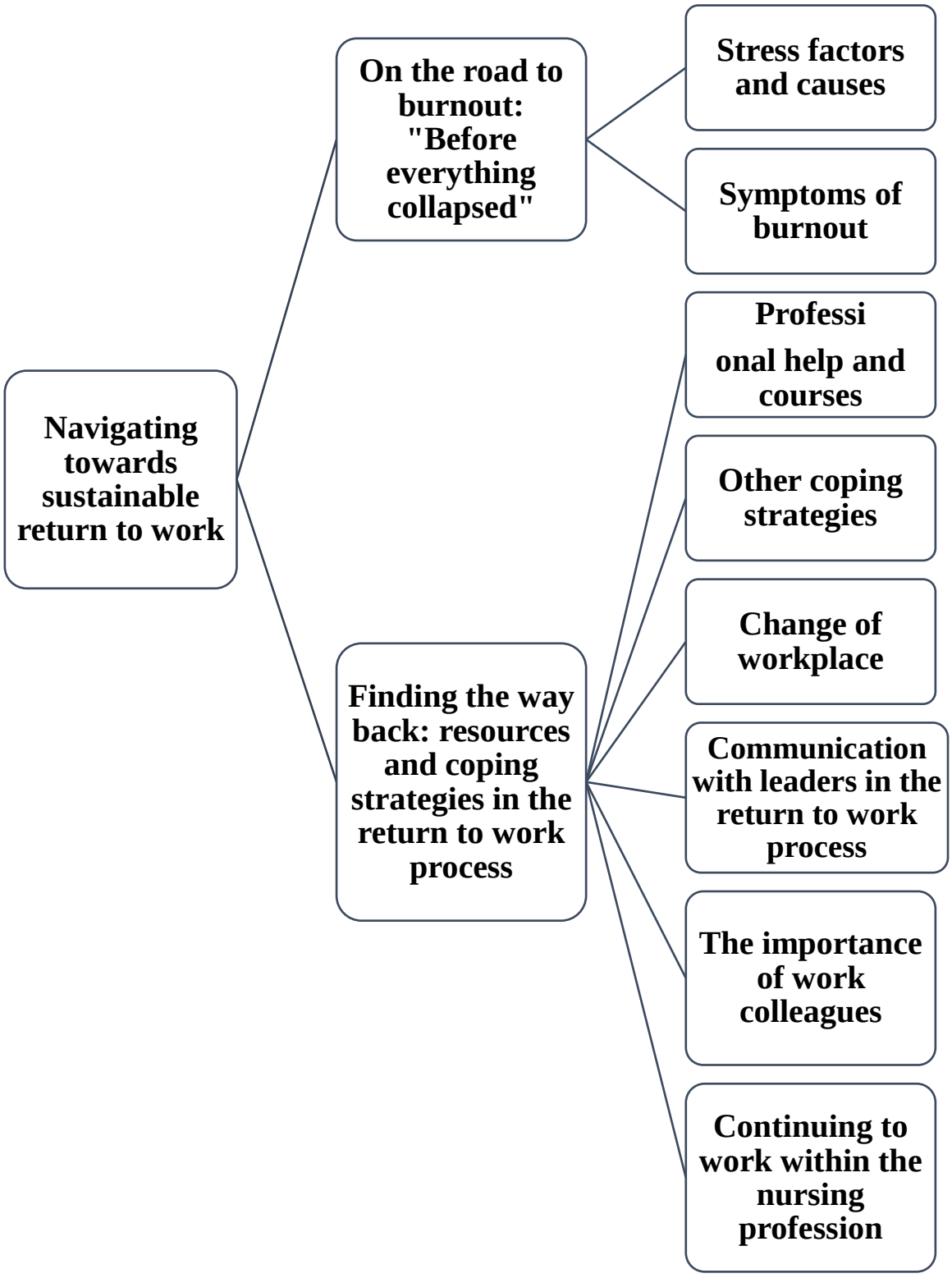

Figure 6 – A diagram illustrating the thematic network

5.2 Navigating towards sustainable return to work

The participants in the study had not all come as far in their journey from burnout to recovery and return to work. A recurring theme throughout all the interviews were the methods used by the participants to support a successful return to work. This was followed by their reflections on whether they had received adequate help in the RTW process and if sufficient changes had taken place, both personally and at the workplace, so they would be able to continue working within the profession long-term. They wondered what changes were necessary, and how it would be possible to support nurses who had experienced burnout in a better way so that they could return to work and continue working within the field. It may be interpreted as such that the underlying theme throughout all the interviews, a global theme, is what can be done and what needs to be help nurses navigate towards a sustainable return to work.

5.2.1 On the road to burnout: “Before everything collapsed”

This theme covers the period before burnout and the focus is on what stress factors the participants experienced and what symptoms appeared. The period before the participants experienced burnout was characterized by high levels of stress in the workplace. They described stressors such as heavy workload, unpredictable workdays, high responsibility for the welfare of critically ill patients, and little time to carry out important tasks resulting in constant worries and feelings of guilt. High sickness rates among nurses were also mentioned as a stress factor, often resulting in poorly staffed shifts that increased the workload on those at work, but it also increased the pressure on people to undertake extra work. Poor management and lack of support from leaders in difficult situations also caused stress among participants. Symptoms of burnout manifested as excessive work-related worries and fear of making serious mistakes at work, increased irritability and little patience, tiredness, and physical pain. Participants also had more difficulty coping with difficult situations than before. Despite experiencing high work-related stress for a long time and experiencing burnout symptoms, most participants were very surprised when they realized that they were experiencing burnout.

5.2.1.1 Stress factors and causes

Most participants talked about heavy workload in the period before they experienced burnout. They described working days where there was a lot to do and little time to carry out important tasks, which was often caused by a mismatch between workload and resources.

> *I did not take any breaks, right, because you have so many tasks that you have not managed to do. But it is simply a lack of resources that makes you not reach your tasks. And then you are working with people that are so sick, they are so vulnerable and they are in such big need of help (Hedvig).*

Many participants also emphasized how heavy workload and too little time to carry out tasks caused much stress when caring for critically ill patients.

> *..and then you had so many patients who were so critically ill and you did not feel that you could give them good enough care… and it was very uncomfortable to have that responsibility, but not enough time to follow up in a good way (Anna).*

Some of the participants mentioned that they had a constant feeling of guilt towards their patients. They felt were unable to provide proper care to their patients because of too many tasks and too little time to carry them out. This also resulted in bad conscience towards their colleagues because a lot of important tasks were passed on to the nurses who came to the next shift, who already had more than enough work to do.

> *You kind of have this feeling that you are not doing enough, that you in a way are not able to do your job, so often when you go home you have this bad feeling, because there has been so much to do that you somehow do not get over your work tasks, you do not have time .. and then get such a bad conscience because you have to give so many tasks over to the people on the next shift and they have enough to do from before (Britt).*

Lack of support from managers or managers that were absent in demanding situations and in tough periods was mentioned as a stress factor by many participants. This meant that staff had to deal with demanding situations themselves and without support, something that caused increased stress and strain.

At my previous workplace, I was left to deal with some extremely difficult patients and relatives by myself. It was at the expense of the other patients (pauses to think) and I was left to deal with them alone because the leaders could not deal with them (Dagny).

Some of the participants experienced poor communication with the leaders and work culture where it was difficult to have an open dialog with the leaders about issues that arose.

I did not feel that I could tell them [the leaders] how I felt because I did not feel welcome, I felt like a burden, and when I was as affected as I was… I did not feel their trust and I did not feel that I could explain how things were, I felt that I did not have the opportunity to do so… I felt like a burden on the ward and that they would probably just like to get rid of me (Camilla).

High sickness absence among nurses was mentioned by many of the participants as stress factors in the period before they experienced burnout. The high sickness absence often resulted in understaffed shifts and also increased pressure on staff to take on extra shifts.

There is a high level of sickness absence in nursing and you notice that a lot, and then it was a little unfortunate that when someone was sick they sent out a text message to everyone. The problem was that the people who were going to work also got the text message. So for example when you woke up on a Saturday morning and dreaded to go work because you knew it was hectic, you woke up to a text saying saying "hey there is a crisis, we need someone to take an extra shift". And you knew that there is probably no one who has the chance to take an extra shift with such short notice on a Saturday morning… and then you just dreaded the workday even more (Anna).

Some participants felt they were under constant pressure to take extra shifts, and felt their leaders did not respect them when they tried to set boundaries.

I felt that I was under a lot of pressure and when I tried to set boundaries and say no…for example when they tried to get me to take an extra shift, and they asked me a lot because I do not have children, I felt that my leader did not listen to me when I said no - and tried to

talk me into getting to work even when I said I could not do it. Sometimes they played on emotions, for example by crying on the phone when I said no (Gunhild).

The high turnover rate, of both nurses and leaders, was mentioned by most of the participants as a stress factor. In many cases, high turnover rates resulted in a loss of valuable skills, especially when employees with long experience found themselves forced to quit due to heavy workload and stress in the workplace.

Everyone I know who was very experienced, the ones that had worked there for a long time and we the less experienced nurses could lean on at work.. and you really need experienced nurses at a ward with critically ill patients because you have to know what to look for and what to be aware of… but most of the experienced nurses quit, they could not do it anymore. But it was never admitted that they quit because they could not take it anymore, it was disguised as people sought further education instead (Anna).

Some of the participants reported that the high sickness rate among staff did not seem to be taken seriously among the leaders. As a result, no significant changes were made to increase employee well-being and reduce the likelihood that more people would have to take sick leave due to stress.

There is this one thing you often hear "yes you are in a hurry, what can you do about it?" or "How can you work more efficiently?" Right, and we are so agile and I feel like… I feel like it is like a rubber band and the threads start to break slowly, one thread at a time (pauses to think) and I know that many people have been on sick leave these past months. But I also know that it is just swept under a rug and then we do not talk about it, we do not make any changes. It is actually quite alarming (Hedvig).

Unpredictable workdays were mentioned as a stress factor by a couple of participants. They described workdays where they were “thrown” between different hospital wards and this caused stress and insecurity.

I became like a ball they threw between four different wards at the hospital. There were so many different people I had to work with and I had four different leaders [...] I did not really belong anywhere, I felt like I was being pulled in different directions, and in the end, it became too much (Camilla).

Two participants talked about shift work as a stress factor that had contributed to them experiencing burnout, where night shifts caused difficulties with sleep and poor sleep caused distress "when I experienced burnout I had no circadian rhythm and I could not sleep" (Britt.)

5.2.1.2 Symptoms of burnout

Most participants said that experiencing burnout had come as a great surprise to them, despite having experienced symptoms of stress for some time. As Anna describes it; "*It came very much like.. like lightning from a clear sky. But for quite a few years I had felt symptoms of stress".* For some of the participants, it was hard to understand that they were experiencing burnout.

> *Before everything crashed, I felt like I was in Matrix [the movie], where all of the numbers fell down, I felt just like that, and I just collapsed and cried. It was just like Matrix, I had thousand thoughts and a total crisis in my head. And that is the thing with burnout, you hardly understand what is happening before everything crashes, and even when it crashes it takes a while (Hedvig).*

For some of the participants, it took a long time to realize that what they were experiencing was work-related.

> *I did not realize that I had hit a wall, but I was very sad and cried a lot. I just started to cry without a reason. And I was very tired, I did not sleep, I just felt really sad and I did not bother to do anything. I did not quite understand why I felt so sad, and so… yes I went to the doctor and got a sick leave for two weeks. It helped a lot, not thinking about work for two weeks, and that is how I realized that maybe all this had something to do with work. But actually, I had to see a psychologist before I realized that the main problem was work (Britt).*

For several participants, one symptom of burnout manifested as a crippling fear of making mistakes at work, mistakes that could have serious consequences.

> *I was so afraid of making mistakes. I was so scared that I would be in charge of a seriously ill patient and I would not know what to do…I was so terrified to go to work that I had to call crying and say "I can not come to work today because I am so scared". So I kind of spent all my energy thinking about what I could have done differently and thinking "what if this or that would have happened"[…] In a way, I was afraid of everything, everything that could go*

wrong. In nursing school, you learn to think about what you could have done differently or better, but I took these thoughts to a completely different level (Britt).

Some participants described physical symptoms that were initially interpreted as signs of physical ailments but then turned out to be the result of burnout.

I got to the point where I slept badly, I started to lose weight, I had to stop the car on the way to work because I became physically unwell and vomited […] so in the course of (pauses to think) 8 months, I lost 15 kg (Dagny).

Few of the participants described great physical tension and muscle pain as one symptom of burnout. This made it difficult for them to rest and relax.

When I got sick I asked the doctor to check my metabolism. But my metabolism was normal, so it was simply all the brooding and overthinking. And yes, I had a huge pain in my neck and back and shoulders, huge pain, I could not relax. I felt like I was lying and hovering over the mattress every night when I was trying to sleep (Hedvig).

Several participants said that in the period before they experienced burnout, they reacted differently to situations at work than they had done before and that they felt different than before.

I did not quite understand what I was feeling, it was as if I did not recognize myself. And this happened at the same time as the coronavirus came, and I did not feel very motivated. It was a bit painful because there were a lot of people who went out in the media like "yes, I am a nurse and we will do this together" and I did not share that same motivation (Esther).

Some participants found that in the period before they experienced burnout they had less mental energy to care for their patients, and they found they had less patience with patients.

I noticed in a way that I did not care about the patients anymore … I thought a bit like "ohh really, do you need help again?" everything felt heavy and it was kind of annoying that the patients asked me about things (Britt).

Some participants also experienced sudden irritability and impatience with their colleagues.

> *It was very busy at work, but for a very long time, I could handle it. Eventually, everything just fell apart. The managers said that several people at work had told them that I had been angry at work. That is probably true, I was desperate and struggling and I have probably been perceived as angry (Fride).*

5.2.2.Finding the way back: resources and coping strategies in the return to work process

This theme reviews what the participants did and what methods they used to recover and eventually return to work, focusing on important resources and coping strategies in that period.

5.2.2.1 Professional help and courses

All of the participants went to their general practitioner (GP) because of symptoms and to obtain a sick leave. All of the participants obtained a sick leave, but the GPs could to varying degrees help them further along the way. Some of the participants were referred to a psychologist or a District Psychiatric Center (DPS) while others received little or no help from their GP with finding professional help to work on their problems.

> *I called the doctor and got an appointment and just cried and cried, I did not understand what was happening, I just could not stop. He said "yes you are probably burnt out" and he said I had to take a sick leave from work […] Yes, then the weeks went by, and the sick leave was prolonged and I asked the doctor "is there anything I can do?" because somehow I did not feel that I could get on my feet again, I kind of felt that I needed some tools or something I could do. I felt that it was not enough to just be at home and go for walks. And then my doctor said that he did not quite know what the trick was (Esther).*

It seemed somewhat random what help the participants received through their GPs, depending on how well the GPs knew about the offers and options available to people who have experienced burnout. Most of the participants said that they had, to a large extent, to seek help themselves.

> *I have to a large extent, perhaps 70% of the time had to actively seek help myself. The doctors have been good at referring me to gastroscopy and colonoscopy and all sorts of examinations, so I have experienced that too (laughs), and I have even received a new*

diagnosis and treatment and I am finished with that now… but that is not what caused the burnout, just something they found by a chance (Dagny).

Out of eight participants, six of them receive professional help in the form of conversational therapy with a psychologist or courses such as stress management, cognitive therapy, worry management, and mindfulness. Those who received professional help to work on the symptoms of burnout agreed that it was an important factor in achieving recovery. Through conversational therapy or workshops, the participants were given important tools to deal with stressful thoughts, worries, and challenging situations at work.

I went to a course in worry management because…what should I say, it had changed from me crying and being sad all of the time and over to anxiety for the workplace. At the course, it was in a way to first understand what a concern or a worry is in a way, what a real concern is, and what unnecessary worries are, to learn the difference. The worries I had were completely unnecessary... so we learned active problem solving and to set aside time for the worries you have. Because for me, when I started there, I felt that it was completely unmanageable. I felt that those concerns took control of my everyday life… so it was in a way to learn that they, that it is in a way something I control, they do not control me. The first thing we learned, to somehow get some control over the worries, was to set aside time for them. When the worries came into my head I could say "no now you have to wait until three o'clock, because then I have 15 minutes to go through these thoughts" and then at three o'clock there were usually no worries there. So it was a way of learning to take control. […] I think maybe this course was the rescue for me, to in a way be able to understand what is going on in my head and why and get more tools to be able to control it (Britt).

After receiving professional help it was easier for participants to cope with demanding workdays by actively controlling their thoughts and managing their stress levels.

The physiotherapist at work was also trained in cognitive therapy and she was allowed to use the cognitive therapy on the staff who needed it. So I got a lot of help from her to deal with catastrophic thoughts and be able to find… (thinks for a moment) .. techniques for my brain to work its way back so that I could start working again. [...] I had a period where I became scared when the phone rang because it was so loud, then I had to think like "I know a phone can ring, I know I can get a message, it's okay, I let the thought be and then it's okay, I'm not

going to do anything about it. I just want to know that this is a possibility and that I handle this" this is one of the techniques I use from cognitive therapy.[...] I use cognitive therapy actively every day when things get a little difficult and when I feel that now… now I am getting tired...I use a lot of those techniques (Dagny).

Some of the participants mentioned that mindfulness, yoga, and meditation helped them to control their thoughts, be present in the current moment, and better cope in different situations. This also helped them to control their breath and learn to pay attention to how their body was feeling.

I have simply tried to readjust as a person, some patterns must be broken and what I have used a lot is mindfulness, of all things…I never thought, I have always talked about mindfulness as it is just nonsense, but it is not true. So I have dived deep into the world of mindfulness and learned about being present here and now and being able to let go of thoughts. Now I can let the thoughts come, and then in a way use the words „I notice" that I have thoughts about such and such. Because when I say that „I notice", I already distance myself a little from the thought and look at it a little from the outside and get a different perspective instead of just being completely engrossed in that thought inside my head. I put it a little away from me so I get a different perspective so that I am in a way aware of what happens in my body when something uncomfortable happens, or maybe when I am happy, then I notice that now I am very happy. Just being present through mindfulness and then I started with a little yoga, in a way to get some help with breathing and learning different breathing exercises to use when you in a way feel that .. when one must focus on the inner again when one must focus on being present (Hedvig).

Two of the participants did not receive any professional help when recovering from burnout. The reasons why they did not receive help were different, one of them did not want any help at the time while the other sought help but did not receive it.

I was so deep in it at the time that I did not know what was best to do. The shop steward at work was not available, the management was not available…my GP actually tried to get me some help but I rejected it. Someone should have put it on me, someone should have said that I should receive some help… but no one did that and I have not done it myself. In hindsight, it would probably have been good to talk to a psychiatric nurse or a psychologist or even the occupational health service, it would probably have helped, but that is in hindsight (Fride).

The two participants who did not receive any professional help agree that they would have liked to get more help, and believe that they would have progressed more in the recovery process if they had received some kind of professional help.

> *I feel in a way that I am not completely back mentally, it is going ok, but I do not feel that I am completely healthy if you say so […] I feel like I am not quite where I wish I was. I am back, but it's not the same as before I was burnt out and went on sick leave (Esther).*

Both of them said that although they had recovered from burnout to some extent and had returned to work, they still lacked important tools to deal with challenging and stressful situations at work.

> *I still notice that if things get stressed or if I have a challenging situation with a patient or a relative and it goes overtime ... then I think about that this situation must not last too long because then it will become scary for me […]What I do at the new workplace to cope is to keep to current affairs, keep a little more distance and involve myself a little less (Fride).*

5.2.2.2 Other coping strategies

After experiencing burnout, most of the participants were more aware of what can lead to burnout and what the symptoms are. They wanted to be one step ahead and arrange things so that they would not experience burnout again. One step in that direction was being aware of how they used their time and energy.

> *... I have learned to think about energy as an economy, thinking that you get a month's salary with energy, and then you have to make sure to budget it out well. If you spend more than you have, then someone knocks on the door and wants it back with interest (Anna).*

Most participants mentioned that they had, after experiencing burnout, learned the importance of setting clear boundaries. This meant not saying yes to everything and not taking on more than they could handle, but rather being honest with themselves and others about their capacity.

> *I have learned a lot about setting boundaries, at work I have always been a bit like "yes, yes I do this, I can help, no problem" even if I have ten thousand other things I have to do*

(laughs). So setting boundaries has helped me a lot, now I am like "you know what, I do not have time to do this now, but if I get time I can do it afterward" (Britt).

For some participants, setting clear boundaries meant daring to speak up and express their opinions.

There is also one thing I have had to learn, I have had to learn to give clear messages and speak out when things do not work… I always formulate myself in such a way that new tasks are not assigned to me when I do not have the capacity and if they are assigned to me, I let them known that I do not actually have the capacity for this. I have become very good at speaking out and this whole process has made me more like…what do you have to lose? Now I speak up, and it works (Dagny).

It was important for some of the participants to realize that they were not responsible for resolving all the issues that arose in the workplace alone; *" I've always been the one to get things done. Now I remind myself that I do not have to solve everything (Hedvig)."* To reduce stress, it was important for some participants to learn to take time to resolve issues that arose, instead of feeling that everything had to happen right away.

I let things sink in longer, instead of reacting directly, I try to wait a bit. If I see something that may not be completely good, I will look at it within a few days. I let it sink in a bit ... that is, as long as it is safe for the patients. But I try to take it easy, I try a little less to solve all problems alone and immediately (Fride).

5.2.2.3 Change of workplace

Four of the interviewees returned to the same workplace after the sick leave, but four participants felt it was necessary to change workplaces to recover from burnout, as Dagny expressed; *„I discovered my workplace was not good for me and I realized that I would not recover and feel better until I had changed workplace*". The reasons why they had to change jobs varied to some degree, but the common denominator was the lack of facilitation in the workplace, as in Anna's case*; „I found that I do not tolerate night shifts well, so the three-part shifts were too demanding, and I was told that I could not return there and get an exemption for night shifts"* and/or experience of poor management and poor communication with leaders.

There was a relatively flat hierarchy, we were three ward managers and then there was the management. The three of us were all interested in dogs and I have had many dogs. So we always had something outside of work to talk about and we were a bit like friends in addition to having a leading function. Then suddenly they were much higher in the hierarchy than me and I was the ward nurse who did not manage, who did not succeed, and they were the two who had to decide a lot. Suddenly that friendship was gone. So, instead of being three women who had a leading function, it was the two of them and I was the one who did not succeed. It was very painful. [...] I also informed the management and they were absent [...] I did not get in touch with them. I felt like I just had to get away (Fride).

One of the participants returned to the same workplace but only because she had the opportunity to get a new position within the same workplace.

I had the opportunity to start in a new position and that was probably the salvation for in a way, the reason why I managed to get back to work because I do not know how ... I still have a little anxiety about returning to the regular service (Hedvig).

5.2.2.4 Communication with leaders in the return to work process

Most participants said that good communication and cooperation with the leaders were very important in the process of returning to work. It was important for them to feel supported by their leaders and that their work capacity was taken into account.

It was all about a good dialogue with the leader, during sick leave and that was not less important when returning to work. It is important that you have the opportunity to let them know what works and does not work and then it is very important to feel that you are being heard. […] And… yes, adapting workload in that phase is important and then I think it is beneficial that colleagues or at least some of the colleagues are informed a little, they do not need to know exactly what has been going on, but they need to be aware not to pile too many tasks on the employee that is returning to work (Gunhild).

The return to work process was in most cases not a linear process. It was important for the participants to test out their work capacity and adjust how much they would work according to their capacity. Most of the participants did not start working full time when they returned but started

working a few hours a week. It was important for them to have the workload adapted, and to slowly increase their workload.

> *I was not allowed to start in more than 20% of work in the beginning, but then the doctor saw that it was too much so it was reduced again. So I worked 10% and then it was increased by 10% every 3. weeks. (Dagny).*

A suitable workload, especially at the beginning of the return to work process, was crucial in order to experience a sense of mastery.

> *The workload must be adjusted so that you feel a sense of mastery from being at work, and not the opposite. I think that is one of the most important things in the phase I am in now (Gunhild).*

Several participants mentioned that although they had they had received an adjusted workload right after the sick leave period, they would have wanted more follow-up from the managers after they returned to work, not only at the beginning of the return to work process.

> *We talked on the phone while I was on sick leave and she [the leader] called to hear how it was going. […] So we have in a way talked a lot along the way. But what I have missed a bit is that since I started to work 100% again, we have not talked so much about it, a bit like "now you're back again so now everything must be okay", but then I have felt that I am not quite where I wish I was (Esther).*

5.2.2.5 The importance of work colleagues

All of the participants mentioned good colleagues and a good working environment as one of the key factors in succeeding in returning to work. Many participants said that meeting their colleagues has been a motivation to get to work; „after a weekend I can think *"ohh I'm going to work on Monday"* but then I think *"ok, I'm going to meet good colleagues"* and it helps a lot" (Camilla). Some also mention that good co-workers make busy workdays easier to handle: *"Yes, sometimes you come to work and think "ok I will work with these people today, it will be nice" and then you know that the shift will be fine"* (Fride). Many participants also mention that support from co-workers has been very important in the returning to work process.

My colleagues have meant everything ... we have a very good working environment, we support each other and I feel that I can be open with them and tell them how I feel, and it is not a big deal if I start crying at work, because everyone has been there in a way. So there is a lot of understanding, we can talk to each other about everything and they have helped me a lot (Britt).

Solidarity and support between co-workers were often mentioned as important factors that helped in the return to work process and contributed to well-being at work.

The best thing is the solidarity between us… I notice that it is very healthy for me to go to work and to meet my colleagues, that is really what has kept me there you know, good colleagues. Yes, and of course I like the patients (Gunhild).

5.2.2.6 Continuing to work within the nursing profession

All the participants agreed that although working as a nurse was challenging, there were several factors with the nursing profession that motivated them to return and continue working as nurses. These motivating factors were that the job was varied and interesting, that they liked helping other people, and that working as a nurse was exciting and rewarding.

What I needed was time to recover. Because I really wanted to go back to work as a nurse, but I did not realize at first, I think the brain experienced the burnout as traumatic… but all this is the education I chose, and I can say that working at my previous workplace [refers to the hospital ward she worked at] it was my dream job! I have never had such a fun job, so challenging and so exciting (Anna).

Most participants mentioned their desire to help people in need and having a positive impact on the lives of others as a strong incentive to return to work as a nurse.

Just being allowed to help […] I like being allowed to be present in other people's lives and be able to contribute, it gives me a lot. So that has been the motivation, to get back and contribute (Camilla).

I'm not at work for my boss or the management or whatever, I'm at work for the patients. I do this work for the patients because I know I am happy when I have the time and peace to make a difference. Being able to help someone who needs it, that's what I fall back on. That's why I still do it. But I have considered doing other things (Hedvig).

Most of the participants had at some point considered leaving the nursing profession and turn to something else, preferably a job with less stress and less responsibility *"…yes after all it is a great profession and I am very much "a nurse", but of course I have sometimes wondered if I should work with something different"* (Fride). Some of the participants were still considering changing professions due to the fear that conditions in the nursing profession, such as heavy workload, little time to carry out important tasks, and too little staff, will never change.

I have come to the stage now where I wonder if it is not quite…I have no words. But if I simply have to try and change directions for a while. I am afraid there will not be enough changes [at the workplace] […] I think it is very sad because I think being a nurse has almost become part of my identity, I have worked as a nurse for so long and I am working with the patient group I have always wanted to work with. But I talked to my psychologist yesterday and he was like "you can work as much as you want on your symptoms, but if you do not get to the triggering factor then you will never fully recover" (Gunnhild).

Many participants expressed their desire for a certain systemic change within nursing where more time and resources would be given to carry out important tasks, with sufficient time to give patients responsible care, and for shifts with adequate staffing.

So I hope in the future that it will be possible to staff up so there are not always just exactly enough people at work to make things go around, with no margins. That is the dream. It would be nice to just staff up so that you can be comfortable and so you can do a proper job, and in a way think a step further instead of just putting out fires all the time. Being able to plan what we can do to, or how we can get the patients a notch further, to be able to think one step further (Anna).

They also talked about their desire to be able to do the job safely, without having to constantly put out fires.

> *In a way, one must be given respite to practice one's profession and trust that we know what the patients need. Because if we fail to give them the help they need, it leads to chaos and insecurity.. and that is not safe. And it just requires more resources ... it would be nice if we could spend less time on frustration and firefighting as I call it, putting out fires all the time, and instead be able to deal with the problems, or taking the challenges right away…doing what you should be doing (Hedvig).*

6.0 Discussion

The objective of this study was to explore nurses' burnout, with emphasis on how they recover from burnout and how they manage when they return to work. In this chapter, the findings of the study will be discussed in relation to previous research, and possible explanations of findings will be discussed in light of the theory of salutegensis and the Job Demands-Resources Model. Finally, the methodological limitations of the study are debated.

6.1 Causes of burnout

The findings in this study indicated that not being able to care for patients adequately and failing to complete work tasks due to time pressure caused stress as well as remorse towards patients and coworkers. According to previous research, high job engagement can lead to feelings of guilt and perceived failure to live up to own demands among nurses, especially when working under much pressure and often understaffed (Vinje & Mittelmark, 2014). The participants in the present study expressed their high job engagement when they described their motivation and desire to return to work after experiencing burnout. The participants described workdays where they experienced an imbalance between job demands and job resources, as there were insufficient resources to meet the high demands. High job demands were described as caring for many seriously ill patients, great responsibility for the well-being of patients, many urgent tasks at the same time, communication with patients and relatives as well as pressure to take on extra work. Lack of job resources manifested in too little support from leaders in difficult situations and too few employees to carry out tasks, which caused time pressure. These results are consistent with the health impairment process of the JD-R model, where chronic high job demands and low job resources exhaust employees' mental and physical resources and negatively affect health (Bakker & Demerouti, 2007). This can according to Jenny et al (2017) be seen as a pathogenic path where excessive workload causes loss, deterioration, resulting in negative health.

The current study shows that many participants experienced less interest, motivation, and energy to care for patients in the period leading up to burnout. They also experienced more irritability and negative thoughts towards patients. This is consistent with the concept of compassion fatigue which is widely used in the burnout literature (Zhang et al., 2018; Potter et al., 2010), and is characterized by psycho-emotional distress that originates because of long-term self-sacrifice, coupled with

prolonged exposure to difficult situations (Zhang et al., 2018). For most people, work is a big part of life and significant time is spent in the workplace. Working conditions are therefore an important determinant of people's sense of coherence (SOC) and thus affect where they are on the health-ease/dis-ease continuum (Jenny et al., 2017). Vogt et al. (2013) have examined Work-SoC, which a context-specific SOC based on perceived comprehensibility, manageability, and meaningfulness of an individual's current work situation. They found that high scores in job demands are related to low scores in Work-SoC, while high scores in job resources are related to high in Work-SoC.
The participants in the present study described workdays that were sometimes chaotic, with inadequate resources to cope with the job demands, which might have caused them to be less interested in committing and getting involved in various situations at work. The participants' description of working conditions before the burnout suggests that they experienced them to a small extent as comprehensible, manageable, and meaningful. Considering the research by Jenny et al. and Vogt et al., such experiences may have resulted in low Work-SoC.

In the narrative accounts in this present study, only two out of eight participants mentioned shift work as an important cause of burnout. However, in a quantitative study conducted by Lien et al. (2014) that examined the effect of shift work on sickness rate, researchers found a connection between working three-shift rotation and high sickness rate. It should be noted that these two studies used different research approaches, and the present study did notspecifically address the relationship between shift work and sick leave, which might explain why shift work did not appear as an important cause of burnout.

6.2 On the importance of getting help and strengthening coping skills

Getting the appropriate help was an important part of returning to work and being able to deal with demands and challenges at work again for participants in this study. Many had been dealing with symptoms such as fear of making serious mistakes, fear of not being able to handle demanding work situations, and anxiety about going to work. Symptoms improved as participants received help in the form of conversational therapy or various courses in stress management, mindfulness etc. This provided them with techniques to calm the mind, control their thoughts and use active problem-solving. Hunter (2016) examined if mindfulness could be a resource for nurses to cope with work-related stress. The author found that through mindfulness training, nurses and midwives could gain some control over their thoughts and stress levels and increase their ability to prepare for and handle

difficult situations at work. Evidence also indicates that burnout rehabilitation through cognitively oriented behavioral rehabilitation (CBR) and Qigong (a Chinese mind-body exercise to reduce stress, anxiety, and depression and to improve physical activity and balance) are related to significantly reduced sick leave among employees who have experienced burnout (Kärkkäinen et al., 2017). Similar findings were made by Smith (2014) who explored if mindfulness-based stress reduction (MBSR) improved nurses' ability to actively cope with stress. The author found that MBSR was linked to decreased stress, decreased anxiety, decreased burnout, improved focus by decreasing distracting thoughts, increased empathy, improved mood, and self-improvement. These studies suggest that mindfulness, and other tools for controlling thoughts and help with active problem solving, can be valuable for nurses who work under pressure. In addition to increased well-being at work, using mindfulness or MBSR has also been linked to improved patient care and safety, as it can reduce stress and increase nurses' ability to focus on patients' needs (Smith, 2014; Hunter; 2016).

Bakker et al. (2005) point out that sufficient job resources can buffer the negative effects of high job demands in the health impairment process of the JD-R model. The help that the participants in the present study received, as well as the methods they learned to cope with challenging situations and tackle difficult thoughts, were experienced as important job resources. Such job resources can, as pointed out by Bakker et al.(2005), contribute to buffer the negative effects of high job demands. Smith (2014) emphasizes that in order to promote the work-related health of nurses, it is important to focus on increasing job resources by helping nurses learn to cope more effectively with stress. The author claims that it is unrealistic to reduce nurses‘ work-related stress significantly and therefore it is more effective to focus on increasing job resources than reducing job demands.

According to Jenny et al. (2017), being able to actively use coping strategies and successfully cope affects where individuals find themselves on the health-ease/dis-ease continuum. Increased manageability, meaningfulness, and experiences of successful coping can help build an individual's sense of coherence. Some of the participants noted that receiving professional help enabled them to learn and utilize methods that helped them experience the workday as more manageable, as they had more resources to cope with the work demands. They also described their workdays as more meaningful, when they found ways to increasingly commit and involve themselves in different situations at work. A systematic review that examined what factors influence nurses' SOC found that nurses with high burnout levels had poor stress coping abilities, something that can be related to the emotional exhaustion of burnout. Strong SOC was linked to strong coping abilities, thriving, and active use of general resistant resources (GRRs), and was also found to be a protective factor

regarding work-related stress. The study also found that strong coping abilities were linked to high scores in personal accomplishment and low levels of emotional exhaustion and depersonalization (Masanotti et al., 2020).

Most participants in the present study received some form of professional help when they were recovering from burnout. However, two participants did not receive any help. They both expressed a sense of not having recovered as well as they had hoped and did not yet feel well prepared to deal with difficult situations at work. One of them described being frightened when she found herself in a difficult and demanding work situation. To protect herself, she therefore distanced herself when difficult issues arose. This might indicate an experience of a low sense of coherence as she describes low manageability and meaningfulness in a work context. Avoidant behavior and escaping have been linked to unsuccessful coping that is negatively linked to burnout (Kärkkäinen et al., 2017). This supports that getting adequate help is an important part of recovering from burnout and a successful RTW process.

After experiencing burnout, most participants were aware of what leads to burnout and took active steps to prevent experiencing it again. Based on this, some of the participants found new ways, or coping strategies, to deal with work and work-related stressors. These strategies included setting clear boundaries at work, not taking on more than they could handle, speaking up at work and expressing their opinions and giving clear messages about what works and what does not work. They also involved asking for help if needed, being aware of how they manage their energy and making sure to have a balance between work and rest. These strategies can be understood through the concept of job crafting. In a position study by Demerouti (2015) that focused on strategies used by individuals to minimize or prevent burnout, the author identified job crafting as one of the strategies to make work less hindering and more motivating. In the JD-R model, job crafting is defined as *the proactive changes employees make in their job demands and resources* (Bakker & Demerouti, 2017, p. 276). These proactive changes can include asking for help or feedback (increasing resources), learning a new skill (challenge job demands), and reducing their workload (decrease hindrance job demands). Job crafting is a self-initiated employee behavior aiming at balancing job demands and job resources to optimize their working environment and help them to stay motivated (Bakker & Demerouti, 2017; Demerouti, 2015).

6.3 Supportive work environment

A supportive work environment was an aspect of the RTW process highlighted by the participants in this study. Good communication and cooperation with the leader throughout the RTW process, together with support and willingness to facilitate as needed, were experienced as important prerequisites for a successful RTW. Facilitation consisted mainly of adjusting the workload and taking into account the work capacity of the employee in the RTW process. Adjusting demands and resources in this process were important for participants to experience a sense of mastery in a work context.

Similar findings were made by Pijpker et al. (2020) and Kärkkäinen et al. (2017) who identified social support, such as support and positive feedback from managers, as an important job resource in the RTW process for employees who have experienced burnout. Contrary to what Smith (2014) argued, that it is unrealistic to eliminate work-related stress for nurses in the fast-paced environment of the health care system, both Pijpker et al. and Kärkkäinen et al. claim that in addition to increasing the job resources, it is also important to reduce job demands to achieve a better balance, making employees more likely to return to work successfully after burnout.

The findings of the present study point to support from colleagues playing a vital role in the RTW process. This finding differs somewhat from the literature on RTW where social support has been identified as an important job resource, however, with emphasis on support from leaders and not as much on coworkers (Kärkkäinen et al., 2017; Kärkkäinen et al., 2019; Pijpker, 2020). In the current study, the support from leaders consisted of facilitating manageable working conditions, adapting workload, and having a constructive dialogue, whereas the support from colleagues was characterized by solidarity, good conversations, and cooperation through demanding working days, as well as sharing rewarding work experiences.

Some of the participants stated that they felt compelled to change workplaces to recover and be able to return to work. This was attributed to a lack of support from managers, and/or co-workers as well as managers' inability to facilitate and adapt the workload for staff returning to work after burnout. Starting in a new workplace with good and supportive work environment as well as having a constructive dialogue with managers, was according to these participants crucial for successful RTW.

Supportive work environment and social support, both from leaders and colleagues, were viewed as important job resources in the RTW process. Increased job resources can, according to the JD-R model, promote a salutogenic path that leads to growth and development, and thus positive health (Vogt et al., 2015). According to the JD-R model, increased job resources can also buffer the negative effect of job demands. Bakker & Demerouti (2006) list different reasons why social support as an important job resource can buffer the negative consequences of high job demands. Support and appreciation from leaders can put demands in another perspective, help employees to better cope with the demands, and get work done more efficiently. Support from colleagues can buffer job demands through collaboration and help to get work done in time.

This study found that support and facilitation from managers in the RTW made the workdays more comprehensible as they became more structured and consistent, and also more manageable, as the participants had more resources to cope with demands. Participants described how the support from colleagues was encouraging for them, made the working days easier to cope with, and often made coming to work feel worthwhile. This can be interpreted as increased manageability and meaningfulness, thus positively affecting SOC, as pointed to by Jenny et al. (2017). Masanotti et al. (2020) found that a strong SOC works as a protective factor for burnout, job dissatisfaction, and depressive state among female nurses, and proposed that nursing management should focus on building a healthy working environment that fosters nurses SOC.

6.4 Challenges in the RTW process

It is noteworthy that the participants in this study experienced varying degrees of help available to them. The type of help they received seemed to depend on how much their GP knew about burnout and possible help available, how well the participants were able to seek help themselves, and on what resources were available in their municipality. As mentioned above, many studies have shown the importance of getting help to strengthen coping abilities to make it easier to return to work after burnout, and to cope with the high demands of the nursing job (Kärkkäinen et al., 2017; Masanotti et al., 2020; Smith, 2014; Hunter, 2016 Pijpker et al., 2020). Considering the narrative accounts of nurses in this study, there seemed to be a lack of coordinated response, or some kind of process that starts when an employee, in this case, a nurse, experiences burnout.

As previously mentioned, most participants received support from their leaders in the RTW process. However, participants experienced this support as temporary. The leaders stopped asking how things were going and in some cases, they began to put pressure on participants to take on more work than participants felt comfortable with. Some job resources, such as good support, facilitation, and follow-up decreased as demands once again increased.

Kärkkäinen et al., (2019) examined the role of RTW coordinators for hospital and university staff in Finland who had experienced burnout. The coordinators followed up and supported employees both during their sick leave, but also after returning to work. Their role involved everything from monitoring staff well-being, initiating the RTW process, planning RTW, and providing tools to support recovery, to monitoring the progress of the RTW process, supporting re-engagement with work, and monitoring coping with work. Their role was also to support managers in planning and implementing necessary work modifications. This is an example of a more holistic approach to the RTW process than what participants in my study experienced, as the RTW process followed a certain path where both employees and leaders received support. As Kärkkäinen et al. point out, burnout and RTW are complex and often unpredictable processes that are influenced by many factors. They emphasize the importance of understanding the causes and consequences of burnout and of providing adequate support, assistance, and follow-up to employees so that there is a greater chance of a successful return to work.

Some participants in the present study expressed doubts about being able to continue working as nurses for a long time, even though they had managed to return to work and despite their continued interest in work within the profession. Some of them regularly wondered if they needed to change careers. This was due to fears that the work environment will not change and the workload will never decrease sufficiently. Some of them stated that although it is possible to modify the workload in the short term it is not possible in the long term. As one participant said "I talked to my psychologist yesterday and he was like "you can work as much as you want on your symptoms, but if you do not get to the triggering factor then you will never fully recover". One may interpret this statement as a questioning of the sustainability of the workload the nursing profession entails for this participant. In the following, I will discuss the findings from my study in the larger context of sustainability in RTW for nurses who have experienced burnout.

6.5 Sustainable RTW

The participants in this study stated that they had a strong motivation to return to work and saw many positive aspects of continuing to work as nurses. A certain tension could be distinguished between wanting to work as a nurse, wanting to make a difference for other people on the one hand, and on the other hand concerns of not being able to continue working in the profession due to heavy workload, and fears of working conditions not changing long term. Finding ways to promote nurses' RTW after burnout, as well as strategies that enable nurses to continue working in the profession is important for their health and well-being. In a larger context, it is also important for the healthcare system and society, given the looming shortage of nurses in Norway and other countries and the great need for nurses now and in the future (SSB, 2019; WHO, 2020).

Heinen et al. (2013) examined nurses' intention to leave their profession in 10 European countries in a cross-sectional observational study. They found burnout to be consistently associated with nurses‘ intentions to leave the profession across European countries. Other factors identified, such as leadership, nurse-physician relationship, and participation in hospital affairs were less consistently related to intentions to leave. Hayes et al. (2011) conducted a literature review on nurses' turnover. They emphasized that nurse turnover is a complex problem, however, they identified a few turnover determinants. Some of those determinants are consistent with the findings indicated in this present study. Hayes et al. (2011) found that high job demands combined with lack of support, low job control, or lack of other resources are associated with high turnover intentions. High job demands resulting in lower quality of care, delayed tasks, and involuntary overtime was also related to increased intentions to leave. Turnover was found to be less likely in workplaces with a good organizational climate, empowering environment, and positive psychosocial work environment, where management was characterized by good leadership, support, and constructive communication.

Aiming for sustainable RTW has been pointed out as a way to support RTW for employees that have been on sick leave. Sustainable RTW can be referred *to as a stable full-time or part-time RTW to either original or modified job for a period of at least 3 months without relapse or sickness absence re-occurrence* (Etuknwa et al., 2019, p.679). I could not locate any studies on sustainable RTW after burnout, but studies on RTW after sick leave due to other conditions can provide valuable information on what factors contribute to a sustainable RTW. Etuknwa et al. (2019) conducted a systematic review that explored what factors are effective in facilitating sustainable RTW outcomes for employees on sick leave due to musculoskeletal disorders and common mental disorders. The

study found that successful and sustainable RTW involves an interplay of many factors, both personal and social, such as support from leaders and co-workers, positive attitude, and high self-efficacy. Younger age and higher education levels were also found to promote sustainable RTW.

Sustainable employment involves the extent to which workers are able and willing to remain working now and in the future. Sustainability in work context involves that work should be organized such that human resources *are fostered rather than exploited, in order to allow these resources to be deployed in the future* (Van Dam et al, 2017, p. 2451). No studies were found on sustainable employment among nurses, or sustainable employment after burnout, but studies on sustainable employment in other contexts can point to relevant factors. Van Dam et al. (2017) conducted a quantitative study on the importance of an intrinsically motivating job and an age-supportive climate for sustainable employment. Findings suggested that sustainable employment can be fostered through job design as well as through a work environment that is supportive, developmental, and rewarding. Studies on sustainable employment in other contexts give an idea of how nurses' issues could be approached holistically. By studying what promotes sustainable employment among nurses, one could identify factors that promote nurses' work-related health and well-being.

6.6 Limitations

In the recruitment process of this study, I used strategic sampling and recruited participants who had knowledge or experience relevant for answering my research question. However, I only managed to recruit female nurses as participants for this study. Although nursing is a female-dominated profession, recruiting both female and male participants could have given added value, as other perspectives and issues might have emerged if male participants were included. Due to the time frame of the study, eight participants were considered to be a suitable sample size. Although I assessed the information power in the sample as high, it is possible that a larger sample would have provided more relevant information.

My inexperience as a researcher may have affected different parts of the study, such as the quality of the data collected, seeing as I have not conducted narrative interviews before. The way I presented the topic and initiated the narration in the interviews might have influenced the participants' narratives to some extent. To minimize the weaknesses connected to my inexperience as a researcher, and to ensure the quality of the study, I have relied on

recognized research methods throughout the process and received guidance from experienced supervisors. I also conducted a pilot interview to test the interview guide and to practice my interview skills.

As mentioned before, all the interviews were conducted through Zoom. This was done both because the Covid-19 situation limited the possibility of meeting face-to-face, but also because it opened up the possibility of talking to nurses all over Norway. Conducting the interviews via Zoom can have affected the interaction between me and the participants I might have been hindered from noticing much of the non-verbal communication like body language, gestures, and posture that I otherwise could have noticed if we had been in the same room.

Data triangulation, which is utilizing diverse sources of data to enhance the credibility of the study (Green & Thorogood, 2018, p. 320), was not used in this study. The findings are therefore solely based on the narratives of nurses who have experienced burnout and returned to work. It is possible that data triangulation, for example in the form of focus group interviews in addition to in-depth individual interviews, would have enhanced the credibility of my findings.

7.0 Conclusion

This study aimed to explore nurses' burnout, focusing on how they manage when they return to work. The following three research questions were identified based on the study's aim: *how do nurses who have been on sick leave because of burnout experience the process of returning to work? what are the main coping strategies and resources they identify in the process of returning to work?* and, *what are the main challenges/stressors they identify when they return to work, and how do they deal with these challenges?* I have systematically sought answers to these questions throughout the research process. In this chapter, I will summarize how the findings have provided answers to the research questions. Lastly, suggestions for further research and implication for the field of health promotion are addressed.

7.1 Summary of findings and conclusion

According to WHO, health is created within the settings of everyday life, making workplaces an important setting for health (WHO, 2010). Furthermore, WHO (2019) has defined burnout as an occupational phenomenon, resulting from chronic workplace stress that has not been successfully managed. Nurses are, through their work, exposed to specific occupational stressors, often combined with a lack of resources to deal with these stressors (Zang et al., 2018). Nurses have a high sickness rate compared to other occupational groups (SSB, 2018), and burnout symptoms in nurses are high (Woo et al., 2020). Existing studies on nurses and burnout focus largely on the causes and consequences of burnout, with little emphasis on how to promote and support recovery and successful return to work.

The findings in the current study indicate several resources and coping strategies to be important in the recovery and RTW process. These factors include getting appropriate help in the form of various courses or conversational therapy, acquiring coping strategies, such as setting clear boundaries at the workplace, and being aware of how they manage their energy. Having a supportive work environment with good collaboration and positive communication with managers and good working colleagues who offer solidarity and support was also highlighted. An inner motivation to work as a nurse, to help people in need, and to have a positive impact on others was further identified as a resource in the RTW process. These factors can be seen as increased job resources. According to the JD-R model increased job resources can promote growth and autonomy, leading to positive health, as well as buffering the negative effects of job demands and thereby reducing health impairment

(Bakker et al., 2005). Increased job resources can thus be considered as salutary factors, factors that actively promote health (Antonovsky, 1996).

The findings also indicated several challenges in the RTW process. There was a variation in the type of help the participants received after experiencing burnout. Most participants had to work hard to find help and some did not receive any help at all. Another challenge was that the support from managers, facilitation, and adjustment of job demands and job resources turned out to be temporary in many cases. As a result, some of the participants soon found themselves in the same situation as before they experienced burnout with an overload of job demands and a deficit of job resources. This caused them to wonder whether they could work in the nursing profession long-term. The study suggests that by approaching the RTW process more holistically, by for example focusing on sustainable RTW and sustainable employment, it would be possible to promote nurses' work-related health and well-being after experiencing burnout.

7.2 Suggestions for further research

As pointed out earlier, studies on how to promote nurses' RTW after experiencing burnout are sparse. Most studies on nurses and burnout deal with causes, symptoms, and consequences. There are, however, some studies on different coping strategies for nurses that have experienced burnout.

One of the issues that emerged in the work of this study was the importance of approaching the RTW process in a holistic way. Conducting research on sustainable RTW and sustainable employment for nurses who have experienced burnout could be of value. Such research could increase understanding of what work-related factors can promote work-related health and thus potentially support the RTW process and increasing the likelihood of nurses remaining in the profession long term. Considering the previously mentioned study by Kärkkäinen et al. (2019), regarding enhanced support for employees, staff, and managers by coordinators throughout the RTW process, it could be useful to conduct intervention studies examining whether RTW coordinators could be valuable for nurses' RTW processes and the promotion of successful RTW.

The majority of the research I found on the subject was quantitative. Conducting more qualitative research on the topic of burnout and RTW among nurses might uncover complementary, qualitative aspects of the process. Such research can give those who have experienced a burnout voice and elicit experiences that may be instructive for future practice.

7.3 Implications for the field of health promotion

Findings in this study are based on interviews with a small sample of nurses in a specific context and can not be generalized for all nurses who experience burnout and return to work. However, the participants in this study have contributed to highlighting factors that they considered important for successful recovery and RTW after burnout, based on their experience. Thus, this research may indicate factors for consideration in supporting nurses who have experienced burnout and it has contributed to the knowledge about a subject which is presently understudied.

Considering the WHO definition of people's health being created *within the settings of their everyday life; where they learn, work, play and love* (WHO, 1986), work is an important determinant for health. Knowledge of what conditions promote and maintain work-related health and well-being is therefore highly warranted in the field of health promotion.

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Appendix 1 – Approval from REC

REK
REGIONALE KOMITEER FOR MEDISINSK OG HELSEFAGLIG FORSKNINGSETIKK

Region:	Saksbehandler:	Telefon:	Vår dato:	Vår referanse:
REK vest	Ingvild Haaland		11.11.2020	185573
			Deres referanse:	

Fungisai Puleng Gwanzura Ottemöller

185573 Etter utbrenthet.

Forskningsansvarlig: Universitetet i Bergen

Søker: Fungisai Puleng Gwanzura Ottemöller

Søkers beskrivelse av formål:

Det overordnede formålet med denne studien er å undersøke sammenhengen mellom utbrenthet og sykepleie.Jeg vil fokusere på sykepleiere som jobber innen spesialisthelsetjenesten samt sykepleiere som jobber innen primærhelsetjenesten/kommunehelsetjenesten.Dette betyr at jeg vil inkludere sykepleiere som jobber på sykehus, sykehjem, hjemmesykepleien og andre sykepleiere som arbeider innen spesialist- eller primærhelsetjenesten. Dette er sykepleiere som jobber i forskjellige situasjoner, men møter mange av de samme utfordringene gjennom sitt arbeid.

Overordnet mål med studien: Å utforske sykepleieres utbrenthet, med vekt på hvordan sykepleiere kommer seg etter å ha opplevd utbrenthet og hvordan det går når de kommer tilbake til jobb.

Forskningsspørsmål:
• Hvordan opplever sykepleiere som har vært sykemeldt på grunn av utbrenthet, å komme tilbake til jobb?
• Hva er de viktigste mestringsstrategiene og ressursene når de kommer tilbake til jobb?
• Hva er hovedutfordringene / stressfaktorene på arbeidsplassen når de kommer tilbake til jobb og hvordan takler de disse utfordringene?

Denne studien er en kvalitativ studie og datasamlingsmetode er narrative intervjuer med sykepleiere som har opplevd utbrenthet og er kommet tilbake til jobb.

Forskning viser at sykepleiere har høy sannsynlighet for å oppleve utbrenthet og er blant de yrkene med høyest sykefravær. Forklaringer på dette er blant annet at jobben er fysisk

og psykisk krevende samt faktorer som turnusarbeid, tett kommunikasjon med pasienter, høyt tempo, innstramming, komplekse pasienter, økte krav til effektivitet og underbemanning. Sykepleiere er en viktig gruppe innen helsesektoren. Ifølge tall fra SSB kommer Norge til å mangle 28.000 sykepleiere om 15. år. Tall fra SSB viser også at 1 av 5 sykepleiere har folatt yrket 10 år etter endt utdanning.

Det finnes relativt mye forskning som fokuserer på sykepleiere og utbrenthet, men det finnes svært lite forskning på hvordan det er å komme tilbake til jobb etter å ha opplevd utbrenthet og hvilken tiltak som er viktig for å fremme deres helse.

Det høyte sykefraværet blant sykepleiere, høyt antall sykpleiere som forlater yrket samt den store sykepleiermangelen som er spådd de næste årene understreker viktigheten av å forstå hvordan sykepleiere kan komme seg på jobb og opprettholde arbeidsevne etter å ha opplevd utbrenthet.

REK vest

Besøksadresse: Armauer Hansens Hus, nordre fløy, 2. etasje, Haukelandsveien 28, Bergen

| **E-post**: rek-vest@uib.no
Web: https://rekportalen.no

REKs vurdering

Vi viser til søknad om forhåndsgodkjenning av ovennevnte forskningsprosjekt. Søknaden ble behandlet av Regional komité for medisinsk og helsefaglig forskningsetikk (REK vest) i møtet 21.10.2020. Vurderingen er gjort med hjemmel i helseforskningsloven § 10.

Om prosjektet

Søker skriver om forsvarlighet: «Som nevnt i punkt 6.4. har vi fokus på det som skjer når deltakerne kommer tilbake til jobb etter å ha opplevd utbrenthet, fremfor fokusere på den vanskelige erfaringen som utbrenthet kan være. Med dette er deltakerne ikke nødt til å tenke og snakke om alt det vanskelige de opplevde da de var utbrent, noe som også skal minimere deres ubehag. Men med sin deltakelse bidrar med verdifull informasjon om hvordan en kan støtte sykepleiere som kommer tilbake til jobb etter å ha vært utbrent og hvilken ressurser og mestringsstrategier er viktige for å kunne opprettholde arbeidsevnen. Det blir samlet minimalt av personopplysninger og ingen personopplysninger blir samlet som kan direkte identifisere deltakerne. Data som samles oppbevares i passordbeskyttet datamaskin som er koblet til UiB-serveren (via VPN), og alle intervjuene blir slettet etter at oppgaven er levert. Det er derfor minimal risiko for at personopplysninger kommer på avveie.»

Komiteen vurderer det som forsvarlig at masterstudenten utføre intervjuer, forutsatt at det knyttes en psykolog til prosjektet som kan kontaktes ved behov for oppfølging av deltakerne.

Data/materiale

Kvalitative analysemetoder.

Annen helseforskning (Kvalitativ forskning, narrative intervjuer).

Søker skriver: «Jeg planlegger å bruke kvalitativ metode for å gjennomføre studien min. Kvalitative metoder fokuserer på å forstå og beskrive kjennetegn ved sosiale fenomener samt fremheve erfaringer og meninger som ikke kan måles med tall. I kvalitative studier samler forskeren vanligvis mye informasjon på noen få enheter, og forskeren er nær feltet. Studien vil være en kvalitativ fenomenologisk studie. Fenomenologiske studier "beskriver betydningen for flere individer av deres levde opplevelser av et konsept eller fenomen".

Denne metoden passer derfor godt for min studie, hvor målet er å forstå og lære av erfaringer til sykepleiere som har opplevd utbrenthet.

Jeg planlegger å samle inn data ved hjelp av kvalitative intervjuer. Jeg valgte denne datainnsamlingsmetoden fordi intervjuer er nyttige når målet er å forstå deltakernes erfaringer og perspektiv.

Jeg vil bruke narrative intervjuer, der "forskerens mål er å gjøre det lettere for intervjuobjektet å fortelle historien sin".

Intervjuguide og informasjonsskriv er vedlagt, men disse er på engelsk. Komiteen ber om at disse oversettes til norsk og sendes til REK vest.

Deltakere

Andre personer enn pasienter (Sykepleiere som har opplevd utbrenthet og vært sykemeldt i forbindelse med det. Inklusjonskriteriet er at de er tilbake i jobb som sykepleiere.)

10 deltakere.

Søker skriver: «Jeg har planlagt kvalitative intervjuer, narrative dybdeintervju. Derfor er slike intervjuer også som regel begrenset til små utvalg. Jeg skal intervjue ca 10 personer (10-12) og jeg tror at jeg får gjennom disse 10 intervjuene nok datamateriale til prosjektet mitt.»

Rekruttering

Søker skriver: ”Dette er et masterprosjekt og det er studenten (medforsker), Vigdis Gudmundsdottir, som kommer til å ha ansvar for rekrutteringsprosessen.

Planen er å komme i kontakt med noen få viktige informanter på Haukeland, og deretter bruke "snowball sampling" for å rekruttere flere deltakere. Jeg planlegger også å rekruttere deltakere fra facebook grupper for sykepleiere, som for eksempel Sykepleierforumet. De som ønsker å delta i prosjektet blir bedt om å ta kontakt via epost.”

Forespørsel/informasjon/samtykkeerklæring

Alle deltakere i prosjektet blir bedt om å lese gjennom og signere informert samtykke.

Før intervjuet starter må deltakeren ha lest gjennom og signert informert samtykke.

Komiteen bemerker som nevnt over at informasjonsskrivet må oversettes til norsk. I tillegg må det oppdateres etter mal fra REK. Videre etterspør komiteen bedre informasjon om beredskap, også i informasjonsskrivet. Kontaktinformasjon til psykolog som deltakerne kan kontakte ved behov må føres opp i informasjonsskrivet. Revidert informasjonsskriv bes sendes REK vest.

Oppbevaring av data

Det er oppgitt at ”Data lagres på en passordbeskyttet datamaskin som er koblet til UiB-serveren (via VPN), og alle intervjuene blir slettet etter at oppgaven er levert.

Deltakerne har rett til å trekke samtykke hvis de ikke lenger ønsker å delta i prosjektet. Deltakerne informeres om at de har rett på innsyn i de opplysningene som er registrert om de. Hvis feil informasjon er registrert blir det rettet og om deltakerne finner informasjon som de ikke har gitt samtykke til skal den slettes.”

Komiteen bemerker at det er feil oppgitt at det ikke skal oppbevares indirekte identifiserende data. Koblingsnøkkel og data må lagres på sikker server, med koblingsnøkkel adskilt fra andre data.

Når et forskningsprosjekt er avsluttet (senest ved godkjent sluttdato) skal en eventuell koblingsnøkkel oppbevares i fem år (15 år ved legemiddelstudier), men kun for kontrollhensyn. Deretter skal en eventuell kodenøkkel slettes og data makuleres eller anonymiseres.

REK vest godkjenner prosjektet med følgende vilkår:

Intervjuguide og informasjonsskriv oversatt til norsk må sendes REK vest.

Informasjonsskrivet må revideres etter ovennevnte merknader.

Bedre beskrivelse av beredskap, inkludert kontaktinformasjon til psykolog i informasjonsskrivet må inkluderes.

Vedtak

Godkjent med vilkår

REK vest har gjort en helhetlig forskningsetisk vurdering av alle prosjektets sider. Prosjektet godkjennes med hjemmel i helseforskningsloven § 10 på betingelse av at nevntevilkår tas til følge.

Med vennlig hilsen,

Marit Grønning
Prof., Dr.med
Komiteleder

Ingvild Haaland
Rådgiver

Sluttmelding

Søker skal sende sluttmelding til REK vest på eget skjema senest seks måneder etter godkjenningsperioden er utløpt, jf. hfl. § 12. Dersom prosjektet ikke igangsettes eller gjennomføres skal prosjektleder også sende melding om dette via sluttmeldingsskjemaet.

Søknad om å foreta vesentlige endringer

Dersom man ønsker å foreta vesentlige endringer i forhold til formål, metode, tidsløp eller organisering, skal søknad sendes til den regionale komiteen for medisinsk og helsefaglig forskningsetikk som har gitt forhåndsgodkjenning. Søknaden skal beskrive hvilke endringer som ønskes foretatt og begrunnelsen for disse, jf. hfl. § 11.

Klageadgang

Du kan klage på komiteens vedtak, jf. forvaltningsloven § 28 flg. Klagen sendes til REK vest. Klagefristen er tre uker fra du mottar dette brevet. Dersom vedtaket opprettholdes av REK vest, sendes klagen videre til Den nasjonale forskningsetiske komité for medisin og helsefag (NEM) for endelig vurdering.

Til Fungisai Puleng Gwansura Ottemöller.

Ang. prosjekt 185573 Etter utbrenthet

Det vises til innsendt revidert informasjonsskriv mottatt 05.01.21. I tillegg opplyser prosjektleder at "We have updated the informasjonskriv accordingly. As requested, we have also identified a psychologist who is linked to my research group at the department for health promotion and development, UiB - Stine Lehmann - who will support us in the project if there is need."

Komiteen tar dette til orientering.

Med vennlig hilsen

Ingvild Haaland
Rådgiver, REK vest

Appendix 2 – Information letter to participants

VIL DU DELTA I FORSKNINGSPROSJEKTET *ETTER UTBRENTHET?*

Formålet med prosjektet og hvorfor du blir spurt

Dette er et spørsmål til deg om å delta i et forskningsprosjekt for å utforske hvordan det er for sykepleiere å komme tilbake til jobb etter å ha opplevd utbrenthet.
Gjennom prosjektet ønsker jeg å undersøke hvordan det er for sykepleiere å komme tilbake til jobb etter å ha opplevd å bli utbrent. Formålet med prosjektet er å identifisere viktige ressurser og mestringsstrategier som sykepleiere bruker når de kommer tilbake til jobb.

Norge, i likhet med mange andre land, står overfor stor sykepleiermangel. Ifølge tall fra SSB kommer Norge til å mangle 28.000 sykepleiere om 15 år. Tall fra SSB viser også at 1 av 5 sykepleiere forlater yrket innen 10 år etter endt utdanning.

Forskning viser at sykepleiere har relativt høy forekomst av utbrenthet og det finnes relativt mye forskning om sykepleiere og utbrenthet. Det er derimot gjort lite forskning på hvordan det er for sykepleiere å komme tilbake til jobb etter å ha opplevd utbrenthet, noe som er viktig for å finne ut hvilke mestringsstrategier og tiltak kan fremme arbeidsevne og trivsel på arbeidsplassen.

Som nevnt tidligere er målet med prosjektet å identifisere viktige ressurser og mestringsstrategier, noe som kan gi økt forståelse av hvordan en kan støtte og fremme arbeidsevnen til sykepleiere som har opplevd utbrenthet og skal tilbake til jobb.
Datainnsamlingen for prosjektet bygger på intervjuer med sykepleiere som er tilbake i jobb etter å ha opplevd utbrenthet.

Hva innebærer prosjektet for deg?

Hvis du velger å delta i dette prosjektet blir du intervjuet om din erfaring med å komme tilbake til jobb etter å ha opplevd utbrenthet. Intervjuet vil ta ca 40-60 min. Intervjuet blir tatt opp på en lydopptaker, men opptakene blir slettet så snart intervjuet er transkribert.
I prosjektet vil vi innhente og registrere opplysninger om deg, som for eksempel kjønn, alder, yrke og beskrivelse av dine erfaringer. All informasjon blir avidentifisert.

Mulige fordeler og ulemper

Det er vårt mål at deltakerne opplever minst mulig ubehag i forbindelse med deltakelse i prosjektet. Intervjuer som dette kan imidlertid vekke sterke følelser. Hvis du føler deg dårlig etter intervjuet har for eksempel tanker som er vanskelig å bli kvitt eller at du kjenner på uro og

har behov for å snakke med noen, skal prosjekt ansvarlige være behjelpelig med å etablere kontakt med en fagperson som kan hjelpe, for eksempel fastlege.

Frivillig deltakelse og mulighet for å trekke ditt samtykke

Det er frivillig å delta i prosjektet. Dersom du ønsker å delta, undertegner du samtykkeerklæringen på siste side. Du kan når som helst og uten å oppgi noen grunn trekke ditt samtykke. Det vil ikke ha noen negative konsekvenser for deg hvis du ikke vil delta eller senere velger å trekke deg. Dersom du trekker tilbake samtykket, vil det ikke forskes videre på dine helseopplysninger. Du kan også kreve at dine helseopplysninger i prosjektet slettes eller utleveres innen 30 dager. Adgangen til å kreve destruksjon, sletting eller utlevering gjelder ikke dersom materialet eller opplysningene er anonymisert eller publisert.
Dersom du senere ønsker å trekke deg eller har spørsmål til prosjektet, kan du kontakte prosjektleder (se kontaktinformasjon på siste side).

Hva skjer med opplysningene om deg?

Opplysningene som registreres om deg skal kun brukes slik som beskrevet under formålet med prosjektet, og planlegges brukt til 2021. Eventuelle utvidelser i bruk og oppbevaringstid kan kun skje etter godkjenning fra REK og andre relevante myndigheter. Du har rett til innsyn i hvilke opplysninger som er registrert om deg og rett til å få korrigert eventuelle feil i de opplysningene som er registrert. Du har også rett til å få innsyn i sikkerhetstiltakene ved behandling av opplysningene. Du kan klage på behandlingen av dine opplysninger til Datatilsynet og institusjonen sitt personvernombud.
Alle opplysningene vil bli behandlet uten navn og fødselsnummer eller andre direkte gjenkjennende opplysninger (=kodede opplysninger). En kode knytter deg til dine opplysninger gjennom en navneliste. Det er kun Vigdis Gudmundsdottir og Fungisai Gwanzura Ottemöller som har tilgang til denne listen.
Opplysningene om deg vil bli oppbevart i fem år etter prosjektslutt av kontrollhensyn.

Godkjenninger

Regional komité for medisinsk og helsefaglig forskningsetikk har gjort en forskningsetisk vurdering og godkjent prosjektet **185573 Etter utbrenthet.**
Universitetet i Bergen og prosjektleder Fungisai Gwanzura Ottemöller er ansvarlig for personvernet i prosjektet.

Kontaktopplysninger

Dersom du har spørsmål til prosjektet eller ønsker å trekke deg fra deltakelse, kan du kontakte Vigdis Gudmundsdottir, tlf 947 88 359, email: vigdiseg@gmail.com eller University of Bergen via Fungisai Gwanzura Ottemöller, Fungi.Ottemoller@uib.no .
Dersom du har spørsmål om personvernet i prosjektet, kan du kontakte personvernombudet ved institusjonen: Janecke.Veim@uib.no
Datatilsynets e-postadresse er postkasse@datatilsynet.no

JEG SAMTYKKER TIL Å DELTA I PROSJEKTET OG TIL AT MINE PERSONOPPLYSNINGER BRUKES SLIK DET ER BESKREVET

Sted og dato	Deltakers signatur
	Deltakers navn med trykte bokstaver

Appendix 3 – Interview guide

Introduksjon:

Målet med denne studien er å utforske hvordan sykepleiere det er for sykepleiere å komme tilbake til jobb etter å ha opplevd utbrenthet. Kan du fortelle meg litt om deg selv, og kan du fortelle meg om din opplevelse av å komme tilbake til jobb etter å ha opplevd utbrenthet?

Oppfølginsspørsmål:

Intervjuet vil være et narrativt intervju. Det er visse temaer jeg vil sørge for å dekke under intervjuet. Jeg har derfor utarbeidet noen oppfølgingssprøsmål spørsmål for å stille deltakerne, for å hjelpe historiefortellingen, hvis de ikke de tar opp følgende temaer selv.

- Hvordan opplevde du prosessen med å komme tilbake i jobb?
- Kan du beskrive hvilke faktorer (generlet) som har vært nyttige for deg etter at du kom tilbake til jobb?
- Er det noe på arbeidsplassen din som du syntes har vært nyttig etter at du kom tilbake til jobb? For eksempel; Kollegaer? Lederen din? Ledelse? Arbeidsmengde? Arbeidsrutiner?
- Har du møtt noen utfordringer etter at kom tilbake til jobb? Hvis ja, kan du beskrive hva som har vært utfordrende og på hvilke måter?
- Hvordan har du taklet utfordrende situasjoner på jobben?
- Hva var det som motiverte deg til å komme tilbake til jobb som sykepleier?