JYU DISSERTATIONS 366

Stela Salminen

“Back on the Right Track”

Rehabilitees’ and their Spouses’ Experiences of Burnout and Recovery

UNIVERSITY OF JYVÄSKYLÄ
FACULTY OF EDUCATION AND
PSYCHOLOGY

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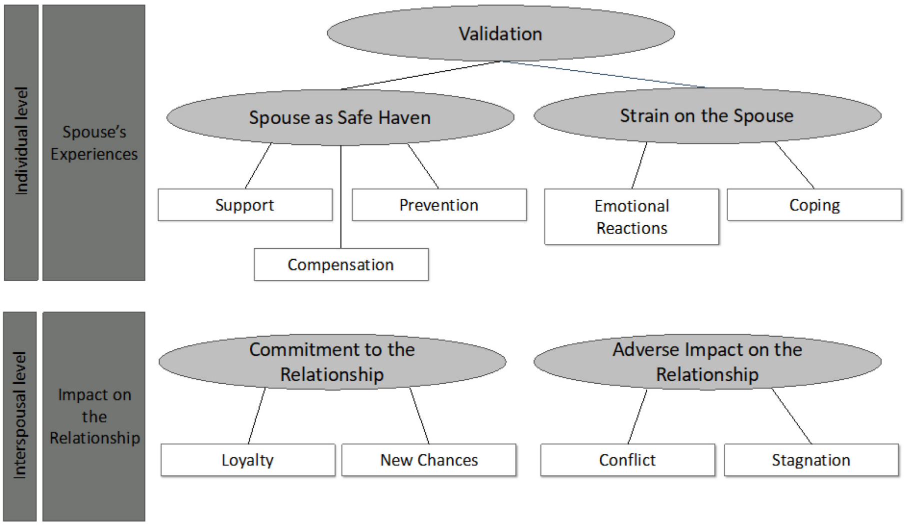
ERRATA

- **Page 20, 1.3. Interventions for burnout, second chapter:**
  "different various" **should be:** "various"

- **Page 37, 2.1. Study design and participants, first chapter:**
  "two rehabilitation periods of 12 and five days each"
  should be: "two rehabilitation periods of 10 and five days each"

- **Page 51, 3.3 Study III, Figure 7:**



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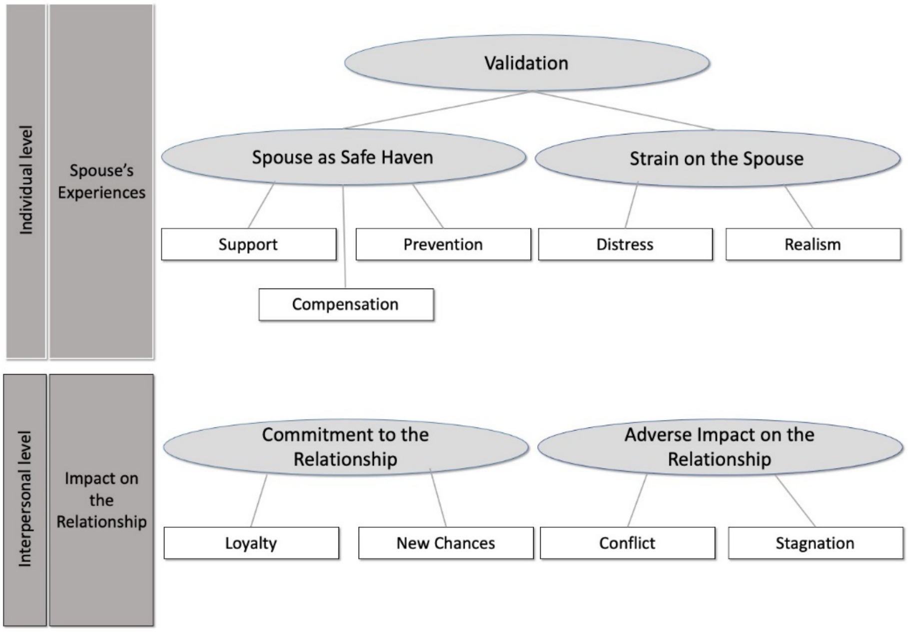

- **Page 55, 4.1.2 The importance of support, sixth chapter**
  "Swedish*" **should be:** "Swedish"

ABSTRACT

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The aim of this dissertation was to explore rehabilitation participants’ subjective experiences of recovery from burnout from a short- and long-term perspective. A further aim was to investigate spouses’ experiences of rehabilitees’ burnout and recovery. The participants in the research were recruited in a rehabilitation centre in Central Finland. Burnout was defined as a stress-related syndrome characterized by exhaustion, depersonalization and reduced professional efficacy. Study I studied rehabilitation participants’ ($n = 12$) experiences of recovery during a rehabilitation course. The results of the content analysis showed that recovery was a cumulative process in which rehabilitation participants gained support, achieved increased awareness of the burnout symptoms, self-approval and self-mercy, and culminated in regained joy. The revelation that they were in charge of their own well-being found expression in the main theme, My Well-Being in My Hands. Study II utilized a longitudinal design and analysed the narratives of four rehabilitation participants two years after rehabilitation. Personal agency, supervisor support and personal factors were found to be common elements in the narratives of recovery. A change of job was not decisive to maintaining recovery; instead, favourable changes in the workplace were of greater importance. Study III investigated spouses’ ($n = 10$) experiences of rehabilitees’ burnout and recovery. The results of thematic analysis demonstrated that burnout had a significant impact on the spouses and on the interspousal relationship. The spouses played a crucial role in supporting the burnt-out spouse both emotionally and in practical terms, but experienced considerable distress in the process. Regarding the interspousal relationship, stagnation was seen as the most deleterious consequence of burnout. However, the spouses stressed their commitment to the relationship and shared positive outcomes as a result of the hardship overcome. All in all, rehabilitation was an important factor that initiated recovery. Agency and support from the supervisor were essential for the recovery to stay on course. Burnout had an impact on people connected to the burnt-out individuals. Spouses and other family members should hence be taken into consideration when planning burnout interventions as their well-being is also affected. In the future, focus can be placed on those outside the realm of an intervention as they seem to be in the most vulnerable position.

Keywords: burnout, recovery, rehabilitation, spouses, qualitative research, content analysis, narrative analysis, thematic analysis

TIIVISTELMÄ (FINNISH ABSTRACT)

Salminen, Stela
”Takaisin oikeille raiteille”: Kuntoutujien ja puolisoiden kokemukset työuupumuksesta ja siitä toipumisesta
Jyväskylä: University of Jyväskylä, 2021, 103 s.
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Tämän väitöskirjan tavoitteena oli tutkia kuntoutusasiakkaiden subjektiivisia kokemuksia työuupumuksesta toipumisesta lyhyellä ja pitkällä aikavälillä. Lisäksi tavoitteena oli tutkia puolisoiden kokemuksia kuntoutettujen uupumisesta ja toipumisesta. Tutkimuksen osallistujat rekrytoitiin Keski-Suomessa sijaitsevasta kuntoutuskeskuksesta. Työuupumus määriteltiin stressiin liittyväksi oireyhtymäksi, jolle on ominaista uupumus, kyynisyys ja heikentynyt ammatillinen itsetunto. Osatutkimuksessa I tutkittiin kuntoutusasiakkaiden (n = 12) kokemuksia toipumisesta kuntoutuskurssin aikana. Tulokset sisällönanalyysista osoittivat, että toipuminen oli kumulatiivinen prosessi, jonka aikana kuntoutusasiakkaat saivat tukea, saavuttivat paremman tietoisuuden työuupumuksen oireista, ja oppivat hyväksymään itsensä. Toipumisprosessi huipentui palautuneeseen iloon. Sisällönanalyysin pääteemaksi nousi *Hyvinvointi omissa käsissäni*, joka kuvasti kuntoutujien oivallusta siitä, että he olivat vastuussa omasta hyvinvoinnistaan. Osatutkimuksessa II käytettiin pitkittäisasetelmaa ja analysoitiin neljän kuntoutusasiakkaan narratiiveja työuupumuksesta ja siitä toipumisesta kaksi vuotta kuntoutuksen päättymisen jälkeen. Henkilökohtainen toimijuus, esimiehen tuki ja kuntoutuskurssi nostettiin tärkeiksi tekijöiksi osallistujien narratiiveissa. Työpaikan vaihto ei ollut ratkaiseva tekijä toipumisen ylläpitämisessä. Sen sijaan suotuisat muutokset työpaikoilla, kuten tehtävien uudelleenorganisointi, työajan vähentäminen ja esimiehen tuki, olivat tärkeämpiä. Osatutkimuksessa III tutkittiin puolisoiden (n = 10) kokemuksia kuntoutujien uupumisesta ja siitä toipumisesta. Tulokset osoittivat, että kuntoutujien työuupumus- ja toipumisprosesseilla oli merkittävä vaikutus puolisoihin ja puolisoiden välisiin suhteisiin. Puolisoilla oli ratkaiseva rooli työuupuneen puolison tukemisessa sekä emotionaalisesti että käytännössä, mutta toipumisprosessi tuotti heille itselleen myös huomattavaa kuormitusta. Parisuhteen kohdalla puolisot pitivät suhteen pysähtyneisyyttä uupumisen vahingollisimpana seurauksena. Puolisot kuitenkin korostivat sitoutumistaan suhteeseen ja pystyivät löytämään positiivisia puolia yhdessä koetuista vaikeuksista. Johtopäätöksenä voidaan todeta, että kuntoutus oli tärkeä tekijä, joka käynnisti toipumisprosessin. Toimijuus ja esimiehen tuki olivat välttämättömiä toipumisen jatkamiselle ja hyvinvoinnin ylläpitämiselle. Työuupumus vaikutti myös uupuneiden läheisiin. Puolisot ja muut perheenjäsenet olisi otettava huomioon suunniteltaessa interventioita, sillä työuupumus vaikuttaa myös heidän hyvinvointiinsa.

Avainsanat: työuupumus, kuntoutus, toipuminen, puolisot, laadullinen tutkimus sisällönanalyysi, narratiivinen analyysi, temaattinen analyysi

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This dissertation is dedicated to my family.

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LIST OF ORIGINAL PUBLICATIONS

I Salminen, S., Mäkikangas, A., Hätinen, M., Kinnunen, U., & Pekkonen, M. (2015). My well-being in my own hands: Experiences of beneficial recovery during burnout rehabilitation. *Journal of Occupational Rehabilitation. 25*(4), 733-41. DOI: 10.1007/s10926-015-9581-6

II Salminen, S., Andreou, E., Holma, J., Pekkonen, M., & Mäkikangas, A. (2017). Narratives of burnout and recovery from an agency perspective: A two-year longitudinal study. *Burnout Research, 7*, 1-9. DOI: 10.1016/j.burn.2017.08.001

III Salminen, S., Mäkikangas, A., Kykyri, V-L., Saari, E-L., & Pekkonen, M. (2021). Spouses' experiences of rehabilitees' burnout and recovery. Submitted manuscript

Taking into consideration the supervisor and co-authors' comments, the author of this dissertation prepared the research plan, planned the data collection for the third article, analysed the data and was the main author of all the original articles.

FIGURES

FIGURE 1 Data collection points. 41

FIGURE 2 Categories, sub-categories and the overarching theme My Well-Being in My Own Hands. 45

FIGURE 3 Sara's narrative 47

FIGURE 4 Diana's narrative 47

FIGURE 5 Paula's narrative 48

FIGURE 6 Astrid's narrative 48

FIGURE 7 Main themes and subthemes, Study III. 51

TABLES

TABLE 1 Summary of Systematic Reviews and Meta-Analyses on Burnout Interventions 22

TABLE 2 Contents of burnout rehabilitation 38

TABLE 3 Overview of the studies 43

TABLE 4 Summary of narratives and spheres of meaning 49

CONTENTS

ABSTRACT
TIIVISTELMÄ (FINNISH ABSTRACT)
ACKNOWLEDGEMENTS
LIST OF ORIGINAL PUBLICATIONS
FIGURES AND TABLES
CONTENTS

1 INTRODUCTION 13
  1.1 Burnout: Definition, prevalence and measures 14
  1.2 Antecedents and outcomes of burnout 16
  1.3 Interventions for burnout 20
  1.4 Rehabilitation in Finland 25
  1.5 Recovery from burnout 27
  1.6 Agency 30
  1.7 Studies on the effect of burnout on family members 32
    1.7.1 Crossover 33
    1.7.2 Theories of family burden 33
  1.8 Aims of the study 35

2 METHOD 37
  2.1 Study design and participants 37
  2.2 Data collection 40
  2.3 Data analyses 41

3 OVERVIEW OF THE ORIGINAL STUDIES 44
  3.1 Study I 44
  3.2 Study II 46
  3.3 Study III 50

4 DISCUSSION 52
  4.1 Short-term recovery from burnout: a cumulative process 52
    4.1.1 Assuming control of one's own well-being 53
    4.1.2 The importance of support 53
  4.2 Long-term development of recovery from burnout 55
    4.2.1 Heterogeneous paths 56
    4.2.2 Stability of recovery depends on several factors 56
  4.3 Restoration of agency and the presence of nonagency 57
  4.4 Spouses' experiences of burnout and recovery 59
    4.4.1 The multiple roles of the spouse in the process 59
    4.4.2 Experienced distress and boundary setting 60
  4.5 Impact on the interspousal relationship 60
  4.6 Methodological considerations and evaluation of the research 62

4.6.1 Research methodology 62
4.6.2 Credibility 63
4.6.3 Ethical considerations 63
4.6.4 Limitations 64
4.7 Avenues for further research 65
4.8 Conclusions and recommendations for practice 67

YHTEENVETO (SUMMARY) 70

REFERENCES 74

APPENDICES

ORIGINAL PAPERS

1 INTRODUCTION

Ever since the term *burnout* was introduced in the domain of occupational health psychology by Herbert Freudenberger (1974) and Christina Maslach (1976) in the 1970s the corpus of scientific research has focused on investigating the causes, symptoms and outcomes of this syndrome. The question of recovery from burnout has also been addressed to some extent, but the majority of studies have explored these topics quantitatively, by evaluating the effectiveness of various interventions and treatment modalities, thus giving no voice to the individual suffering from burnout. The qualitative investigation of recovery from burnout has attracted less attention and thus the specific mechanisms of short- and long-term recovery have remained largely unaddressed. Furthermore, burnout has traditionally been explored from the perspective of burnt-out individuals, thus ignoring the effect of this syndrome on family members.

The present study was prompted by an obvious need to learn more about the mechanisms of recovery from burnout by applying a qualitative approach to a field dominated almost exclusively by quantitative research. It aims to complement the large body of research already accumulated on the topic by directing its attention to the individual behind the numerical data. The study adopts an experiential perspective and turns the spotlight onto the subjective accounts of recovery of participants on a national rehabilitation course. It aims to elucidate the individual experiences of both short- and long-term recovery by looking into the stories of participants, first, during their participation in a structured rehabilitation intervention in Finland, and later, by tracking their paths of continued or discontinued recovery after rehabilitation over a two-year period. Additionally, the study addresses the subjective experiences of spouses of burnt-out individuals, of their role in the processes of burnout and recovery, of the effects of these processes on their own well-being and of the impact on the interspousal relationship.

In order to grasp the complexity of burnout and recovery, the introduction section draws upon the large body of literature accumulated throughout the history of scientific investigation of the syndrome. It goes beyond the immediate scope of the articles constituting this dissertation as it aims to paint a more comprehensive picture of the phenomena of interest and provide sufficient information to understand the participants' individual accounts.

1.1 Burnout: Definition, prevalence and measures

Numerous definitions of the burnout syndrome have been presented since the introduction of the term, but in the occupational health psychology literature it has typically been defined as a state of ill-being resulting from prolonged job-related stress characterized by exhaustion, depersonalization (or cynicism) and reduced professional accomplishment (Maslach, Jackson, & Leiter, 1996). Exhaustion refers to extreme fatigue resulting from long-lasting and intense work stressors. Depersonalization designates distancing from work and implies a cynical attitude. Reduced professional accomplishment refers to a concept very similar to self-efficacy. Many studies consider exhaustion and depersonalization to be the core dimensions of burnout, whereas reduced professional accomplishment plays a less central role (Bakker, Demerouti, & Verbeke, 2004; Maslach, Schaufeli, & Leiter, 2001; Shirom, 2002).

The term burnout was first introduced in the occupational health literature in 1974 by a German-American psychiatrist, Herbert Freudenberger (Freudenberger, 1974), who observed volunteers working with drug addicts. He described the state of utter exhaustion and lack of functional capacity, which he referred to as burnout. Before long, the term spread to cover the outcomes of stress in other occupations, too. At approximately the same time, Christina Maslach, an American social psychologist, observed the same phenomenon among health care workers (Maslach, 1976). Although Freudenberger observed the phenomenon of burnout in a clinical context, and Maslach detected it in human professions, it has subsequently been determined that burnout may occur in any context (Maslach et al., 1996). Since the 1970s a substantial body of research has studied this phenomenon, its causes and consequences. Despite that, there persists some ambiguity as to the exact definition of burnout and its delineation from other stress-related conditions (Heinemann & Heinemann, 2017), which leads to considerable heterogeneity in study parameters in research and inhibits the drawing of conclusions (Ahola, Toppinen-Tanner, & Seppänen, 2017; Doulugeri, Georganta, & Montgomery, 2016).

According to a survey conducted in 2011, 3% of women and 2% of men in Finland suffered severe burnout, whereas the percentage of those exhibiting moderate or mild burnout was much higher – 22% and 23% for men and women respectively (Suvisaari et al., 2012). In the Finnish survey (Suvisaari et al., 2012) burnout symptoms were measured by the Maslach Burnout Inventory (Maslach et al., 1996), and the severity of burnout was based on the frequency of occurrence of the symptoms. Reports on the prevalence of burnout in the European Union member states include widely varying figures, possibly because only a very small number of countries base their reports on major representative surveys across sectors, because the surveys employ various measurement instruments, and the study of the phenomenon has been conducted among different occupational groups (Eurofound 2018). No official data are available on the prevalence of burnout worldwide, but is has been estimated that burnout prevalence may be very high among specific occupational groups: for instance, as high as 50% among physicians in the USA (Rothenberger, 2017), and even above 60% for mental health workers (Morse, Salyers, Rollins, Monroe-DeVitta, & Pfahler, 2012).

Burnout is not an officially diagnosable condition in most countries. Italy and Latvia are the only EU member states to have recognized burnout as an occupational disease (Eurofound, 2018). Eight other countries (Denmark, Estonia, France, Hungary, Netherlands, Portugal, Slovakia and Sweden) may also acknowledge burnout syndrome as an occupational disease (Lastovkova et al., 2018). Sweden is the only EU country to apply an ICD-10 diagnostic code, exhaustion/fatigue syndrome (*uttmattningssyndrom*), designated by diagnostic code F43.8A (ICD-10-SE, Socialstyrelsen, 2010), but it covers both occupational and non-occupational stressors. In Finland, as in other EU member states, burnout is not recognized as a disease and patients are not entitled to sick leave (Lastovkova et al., 2018). A commonly used diagnostic code is Z73.0, which denotes a state of vital exhaustion and is classified under the larger category or problems related to life management difficulty. Based solely on this diagnosis, a physician may prescribe a short-term sick leave, but such a diagnosis does not obligate the employer to provide sick pay for the duration of the leave. Therefore, a commonly used diagnosis that envisages a sick leave exceeding one week and compensation, is either depression, anxiety or adjustment disorder (F43.22), provided that the diagnostic criteria for these are fulfilled, and an additional code Z73.0 is marked to indicate the presence of burnout (Tuunainen, Akila, & Räisänen, 2011). The latest revision of the International Classification of Diseases, ICD-11, envisages the inclusion of a burnout diagnosis denoted by the code QD85 and located under the broader category of *Problems associated with employment and unemployment*. Despite including a diagnostic code, the ICD-11 explicitly states that burnout is not considered a medical condition; instead, it is classified as an occupational one. Therefore, in Finland it will not have any significant consequences for diagnostic practices and sick leave compensation mechanisms. As a sick leave is not a solution deemed sufficient in burnout treatment, many employers have early support programmes in place, in which warning signs of burnout are specified and action plans are deployed in case burnout is imminent (Duodecim, 2018).

Numerous psychometrically sound scales have been designed to measure burnout in quantitative studies. The *Maslach Burnout Inventory* (MBI) (Maslach et al., 1996) has long been the gold standard to measure burnout. Schaufeli and Enzmann (1998) estimated that the majority of scientific studies on burnout – as many as 91% - utilized the MBI. Other validated scales include the *Bergen Burnout Indicator* (Salmela-Aro, Rantanen, Hyvönen, Tilleman, & Feldt, 2011) which has two versions: BBI-15 (Näätänen, Aro, Matthiesen, & Salmela-Aro, 2003), which is commonly used in Finnish occupational healthcare, and its shortened version BBI-9 (Feldt et al., 2014), which has been used in quantitative studies on burnout; *the Burnout Measure* (BM; Enzmann, Schaufeli, Janssen, & Rozeman, 1998); *the Copenhagen Burnout Inventory* (CBI; Kristensen, Borritz, Villadsen, & Christensen, 2005), *the Oldenburg Burnout Inventory* (OLBI; Demerouti, Bakker, Vardakou, & Kantas, 2002; Halbesleben & Demerouti, 2005), which includes only two dimensions - exhaustion and disengagement from work; *the Shirom-Melamed*

Burnout Questionnaire (SMBQ; Lundgren-Nilsson, Jonsdottir, Pallant, & Ahlborg, 2012; Melamed, Kushnir, & Shirom, 1992), and its later developed version, the *Shirom-Melamed Burnout Measure* (SMBM; Shirom, 2002), used mainly in studies on connection between burnout and health (Eurofound 2018); the *Spanish Burnout Inventory* (Gil-Monte & Faúndez, 2011); and the *Granada Burnout Questionnaire* (GBQ, De la Fuente et al., 2013). The most recent addition to the plethora of measurement tools is the Burnout Assessment Tool (BAT; Schaufeli, De Witte, & Desart, 2019), which proposes four scales of burnout: exhaustion, mental distance, emotional impairment and cognitive impairment.

Researchers in different countries typically use inventories that have been validated for the country in question, and this guided the choice of a measurement tool in the present research, too. In Finland, the BBI-15 has been found to have a good validity and reliability among Finnish employees (Näätänen et al., 2003) and has therefore been chosen as the measure used in this study. The development of the BBI-15 was preceded by a long and rigorous process of research collaboration in the Nordic countries, and it was designed for use particularly in occupational health care. Theoretically, the inventory is based on the same definition of burnout as the Maslach Burnout Inventory and its most widely used version, the MBI-General Survey (MBI-GS) (Maslach et al., 1996). As in the MBI-GS and other scales for measuring burnout, the BBI-15 comprises three dimensions (Salmela-Aro et al., 2011): exhaustion, cynicism and sense of inadequacy at work. The main difference between the BBI-15 and the MBI-GS is the wording of the professional efficacy items: The BBI-15 measures low professional efficacy at work (i.e., negative item wordings), whereas the MBI-GS measures the frequency of positive experiences of professional efficacy (reversed items in the burnout score) (Mäkikangas, Feldt, Kinnunen, & Tolvanen, 2012). The first two dimensions – exhaustion and cynicism - have been found to correlate strongly with the corresponding dimensions in the MBI-GS (.87 for exhaustion and .88 for cynicism), whereas the third dimension, sense of inadequacy at work, correlates more weakly with reduced professional efficacy (Näätänen et al., 2003). Despite the fact that the present study is qualitative in design, the BBI-15 was used to determine eligibility for participation in Studies I and III.

1.2 Antecedents and outcomes of burnout

The original articles which constitute the present dissertation focused primarily on the process of recovery, which commenced on a rehabilitation course for employees suffering from burnout, and on the participants' spouses' subjective experiences of these processes. Even though no specific emphasis was placed on analysing the individual paths to becoming burnt-out, including the causes underlying the participants' deteriorating occupational health and the direct consequences of suffering burnout, it is crucial to present an overview of the typical antecedents, symptoms and outcomes of burnout. Such an overview serves to better understand the accounts of the subjective experiences shared by the participants, which contain references to concrete events, risk factors and continuous evaluations of the effects of these in the process of becoming burnt-out. Furthermore, it facilitates the understanding and interpretation of the spouses' stories as it elucidates the circumstances under which burnout develops and the symptoms that can be detected by an external observer.

Burnout has been approached from different theoretical perspectives, but the most popular theoretical explanatory models are the Conservation of Resources theory (Hobfoll, 1989; Hobfoll, 2012) and the Job Demands-Resources theory (Bakker & Demerouti, 2014; Demerouti, Bakker, Nachreiner, & Schaufeli, 2001), which share certain tenets. According to the Conservation of Resources (COR) theory (Hobfoll, 1989) individuals aspire to preserve their physical, psychological and social resources and perceive the loss of these resources as a threat. Resources in this theory are defined more broadly than in the Job Demands-Resources model (Demerouti et al., 2001), and encompass characteristics, objects, conditions or energies instrumental to achieving desirable goals, e.g., mastery, self-esteem, socioeconomic status, time, knowledge. Suffering a loss of resources, especially when this is severe and sudden, triggers a traumatic reaction. On the other hand, individuals have the ability to replace lost resources. What is characteristic of these resources is that they have a tendency to aggregate and form 'resource caravans' (Hobfoll, 2002; Hobfoll, 2012). The presence of resources can generate new resources, but the opposite also tends to be true: a loss or depletion of resources leads to a subsequent loss, and resource loss has been found to have greater significance than resource gain. Prolonged exposure to low resources and excessive demands leads to a downward spiral of loss of other resources, with each consecutive loss exacerbating its predecessor, and can be construed as the process of burnout (Hobfoll, Freedy, Lane, & Geller, 1990). In this process, exhaustion sets in first, followed by depersonalization (cynicism), which is a maladaptive coping strategy, leading eventually to a loss of personal accomplishment (Alarcon, 2011). A recent longitudinal study by Mäkikangas and her colleagues (Mäkikangas, Leiter, Kinnunen, & Feldt, 2020) shows that this is indeed one of the possible developmental trajectories for burnout, but not the only one. In the study the authors identified a second profile of burnout development, in which cynicism and reduced personal accomplishment were on elevated levels at the beginning of the process, whereas exhaustion remained low throughout the 8-year time span investigated.

More recent and comprehensive, the Job Demands-Resources theory (Bakker & Demerouti, 2014; Bakker & Demerouti, 2017) is an extension of the JD-R model (Demerouti et al., 2001). Job demands designate those aspects of the job which are associated with physical and/or psychological costs (Demerouti et al., 2011), whereas job resources encompass those facets of the job that are instrumental in achieving work-related goals, which nourish personal growth, and are associated with reducing the costs entailed in job demands (Bakker & Demerouti, 2007; Demerouti et al., 2001). The JD-R theory suggests that burnout results from two processes: a health impairment and a motivational process. In the first process, job demands lead to overburdening and, in turn, to exhaustion. In fact, job demands have been found to be the major cause of exhaustion (Bakker et al., 2004). In the second process, job resources are insufficient, thus impeding the meeting of job demands, which leads to withdrawal behaviours and eventually to disengagement. In simple terms, it has been suggested that burnout results from a combination of high job demands and insufficient resources (Schaufeli & Taris, 2014). In accordance with the JD-R model, employees can prevent the development of burnout through two processes: top-down and bottom-up (Bakker, 2017; Hakanen & Bakker, 2017). The former refers to HRM and HRD practices intended to improve work conditions, whereas the latter process implies that employees engage actively in modifying their work environment, an activity referred to as job crafting (Bakker, 2010; Wrzesniewski & Dutton, 2001). By engaging in job crafting employees can enhance their job resources and reduce the job demands, thus improving their well-being, nourishing work engagement and preventing burnout (Plomp et al., 2016; Tims, Bakker, & Derks, 2013; Tims, Derks, & Bakker, 2016).

Although burnout research has largely been seen to be influenced by organizational factors, individual personality differences have also been found to affect burnout emergence (Adriaenssens, de Gucht, & Maes, 2014; Alarcon, Eschleman, & Bowling, 2009; Bakker, van der Zee, Lewig, & Dollard, 2006; Zellars, Perrewé, & Hochwarter, 2000). Findings tend to differ slightly in terms of the extent to which a particular characteristic predicts a dimension of burnout. The Big Five factor personality traits have often been selected as independent variables in studies on correlation or causality. In a meta-analytical study, Swider and Zimmerman (2010) found all Big Five personality traits to correlate with all burnout dimensions. Other studies have found only partial associations. For example, neuroticism has been found to predict emotional exhaustion, but not depersonalization and reduced professional accomplishment (Zellars et al., 2000), whereas later studies have reported that this personality factor correlated with all burnout dimensions (Bakker et al., 2006). Extraversion seems to offset disengagement (depersonalization) (Bakker et al., 2006) and enhance perceived personal accomplishments (Zellars et al., 2000). Openness is also associated with increased personal accomplishment (Zellars et al., 2000), whereas autonomy is negatively associated with depersonalization (Bakker et al., 2006). Furthermore, higher order psychological constructs such as self-esteem, self-efficacy and optimism have been found to yield relationships with burnout (Alarcon et al., 2009). Perfectionism, in particular perfectionist concerns, which include fear of negative evaluation, of making mistakes and of negative reaction, has likewise been found to correlate with burnout (Hill & Curran, 2016). Gender has been explored as an influential demographic antecedent of burnout, and it was found that women tend more often to experience emotional exhaustion, while men experience depersonalization (Purvanova & Muros, 2010).

Burnout has been found to have considerable short- and long-term outcomes. Especially in its more severe forms, it has been seen to be associated with various organizational and health-related consequences. Burnout has been found to correlate with absenteeism (Salvagioni et al., 2017; Swider & Zimmerman, 2010; Ybema, Smulder, & Bonders, 2010), high turnover and low work satisfaction

(Westermann, Kozak, Harling, & Nienhaus, 2014; Ybema et al., 2010), impaired job performance (Bakker & Sanz-Vergel, 2017; Swider & Zimmerman, 2010; Taris, 2006), including lower patient safety (Hall, Johnson, Watt, Tsipa, & O'Connor, 2016). On the individual level, burnout is associated with health impairment and physical illness (Honkonen et al., 2006), increased risk of going on work disability pension (Toppinen-Tanner, 2011), increased cardiovascular mortality risk (Kivimäki et al., 2002; Salvagioni et al., 2017) and cardiovascular diseases among men (Ahola, 2007; Honkonen et al., 2006), diabetes type II, musculoskeletal diseases, especially among women (Ahola, 2007; Honkonen et al., 2006), gastrointestinal problems and respiratory issues (Salvagioni et al., 2017). Furthermore, it affects executive cognitive functioning, attention and memory (Deligkaris, Panagopoulou, Montgomery, & Masoura, 2014) and has psychological consequences such as depression (Ahola, 2007), anxiety and insomnia (Salvagioni et al., 2017).

Since the introduction of the burnout term, a prominent line of burnout research has applied a variable-centred approach (for a systematic review, see Mäkikangas & Kinnunen, 2016). This approach is interested in statistical relations between variables (Magnusson, 1998) and makes the assumption that correlations between variables are the same across the entire population. Despite its undeniable contribution to the field, this approach does not take into account individual profiles of burnout, namely how the burnout symptoms correlate with each other within the individual over time. This is achieved by applying a person-centred approach. It is more holistic and integrative, as it puts the individual at the centre of investigation (Bergman & Trost, 2006). This approach has gained more popularity in recent studies and has thus enriched the burnout research literature (Ahola, Hakanen, Perhoniemi, & Mutanen, 2014; Hultell, Melin, & Gustaffson, 2013; Mäkikangas & Kinnunen, 2016; Mäkikangas et al., 2020; Rudman & Gustavsson, 2011). The person-centred approach has been essential in finding identifying individual profiles of people who share particular characteristics or relations between attributes (Bergman & Trost, 2006; Laursen & Hoff, 2006). It is particularly useful when applied to longitudinal data as it reveals the heterogeneity of developmental paths (Muthén & Muthén, 2000).

Applied to the field of burnout research it has contributed to a more comprehensive understanding of the development of burnout and the variety of developmental trajectories that burnout can take over time. Furthermore, Mäkikangas and Kinnunen (2016) have concluded that burnout demonstrated differing trajectories both in the general and the intervention context. For example, Hätinen and her colleagues (Hätinen et al., 2009), identified three burnout profiles – "low burnout", "high burnout-benefited", and "high burnout-not benefited" in a rehabilitation intervention context. In a recent intervention study, Kinnunen et al. (Kinnunen, Puolakanaho, Tolvanen, Mäkikangas, & Lappalainen, 2019) found six burnout and mindfulness skills profiles which presented different combinations of reduction of burnout and/or increase in mindfulness skills. It is worth noting that due to the differences in the approaches, the application of these two approaches can, in fact, lead to different interpretations of the same data (Ahola et al., 2014; Hultell et al., 2013). In light of person-centred research, it is clear that the developmental trajectories of burnout as well as the paths of recovery vary for different individuals. Therefore, it is essential to complement the findings of quantitative research with insights obtained in qualitative studies which capture these various subjective experiences even better than the person-centred approach.

1.3 Interventions for burnout

Recovery from burnout has been investigated primarily in studies of interventions and their effectiveness in reducing symptoms of burnout; quantitative research methods have predominated. Although the present study adopts a qualitative approach and its aim is not an evaluation of the effectiveness of a specific intervention, it is deemed relevant to present the body of knowledge accumulated in quantitative research by summarizing the main findings of meta-analyses on interventions. Such an overview will shed light on the types of interventions, their main content and on the evidence of their effectiveness. As the present study explores the experiences of participants in an established rehabilitation intervention, it is crucial to understand how the content and focus of an intervention are linked to recovery.

In line with the categorization of causes of burnout, interventions have been guided by the same parameters and have been classified as individual, organization and a hybrid mode, namely individual-organizational (Schaufeli & Enzmann, 1998). Individual interventions aim at increasing individuals' coping mechanisms through different various relaxation techniques and providing overall knowledge of salutogenic factors whereas organizational interventions focus on the work environment and aim at reducing job stressors and increasing job control. The third, hybrid, type of interventions combines these two perspectives and attempts to influence both the individuals' psychological resources and the organizational context.

In addition, depending on the time dimension of their implementation interventions can be classified as primary, secondary and tertiary (Schaufeli & Enzmann, 1998). Primary interventions aim at preventing the development of burnout symptoms by reducing risk factors among all employees. Secondary interventions are targeted at a selected group of people deemed to be at elevated risk of developing burnout and thus prevent a fully-fledged burnout. Tertiary interventions are directed towards people who have already developed burnout and aim at minimizing the negative consequences, e.g., loss of work ability. They may be offered at the individual or organizational level. Typically, individual-level interventions aim at personal re-assessment of the situation and involve elements of cognitive behavioural therapy (CBT), relaxation training, meditation or physical activity, whereas organization-based interventions usually focus on organizational re-structuring and leadership training (Maslach & Goldberg, 1998)

The last two decades have witnessed an upsurge of systematic reviews and meta-analyses of burnout interventions (Ahola et al., 2017; Awa, Plaumann, & Walter, 2010; Dreison et al., 2018; Iancu, Rusu, Măroiu, Păcurar, & Maricuțoiu, 2018;

Jaworska-Burzyńska, Kanaffa-Kilijańska, Przysiężna, & Szczepańska-Gieracha, 2016; Johnson et al., 2018; Maricuțoiu, Sava, & Butta, 2016; Luken & Sammons, 2016; Panagioti et al., 2017; Perski, Grossi, Perski, & Niemi, 2017; Regehr, Glancy, Pitts, & LeBlanc, 2014; Richardson & Rothstein, 2008; van der Klink, Blonk, Schene, & van Dijk, 2001; van Wyk & Pillay-van Wyk, 2010; Wallensten, Åsberg, Wiklander, & Nager, 2019; Walsh et al., 2019; West, Dyrbye, Erwin, & Shanafelt, 2016; Westermann et al., 2014), but the findings of these are not conclusive. The main findings and conclusions of the systematic reviews and meta-analyses are summarized in Table 1. In general, the overall effects reported in the reviews and meta-analyses are small, but statistically significant. Some meta-analyses demonstrate that especially cognitive, behavioural and mindfulness-based interventions appear to be effective in reducing stress (Dreison et al., 2016; Iancu et al., 2018; Regehr et al., 2014), with cognitive-behavioural intervention being more effective than other modalities, including organization-based types (Richardson & Rothstein, 2008; van der Klink et al., 2001), but that they may be effective only for the dimension of emotional exhaustion (Maricuțoiu et al., 2016). More precisely, cognitive-behavioural interventions tend to be more effective when the work environment provides sufficient job control (van der Klink et al., 2001). Surprisingly, when considered in isolation, organizational interventions were not effective for overall burnout reduction (Dreison et al., 2016).

This finding contrasts with recent meta-analyses of burnout interventions for doctors working in a range of settings, which found comparable results between these types of interventions (West et al., 2016) or that organizational interventions were more effective (Awa et al., 2010; Westermann et al., 2014). In a similar vein, a Finnish research team (Ahola et al., 2017) found that individual-based interventions had no effect on burnout alleviation. A recent systematic review revealed that most rehabilitation interventions for burnout have marginal effects (Wallensten et al., 2019). Earlier reviews seem to support this view by concluding that there is, at best, limited (Marine, Ruotsalainen, Serra, & Verbeek, 2006) or insufficient evidence of the effectiveness (van Wyk & Pillay-van Wyk, 2010) of both person-based and organization-based preventive interventions in reducing stress and burnout. Positive effects seem to decrease over time (Awa et al., 2010), but it is likely that a follow-up period or booster session may succeed in sustaining the acquired benefits (Awa et al., 2010; van Wyk & Pillay-van Wyk, 2010).

Following the latest revision of the JD-R theory (Bakker & Demerouti, 2017), Hakanen and Bakker (2017) conclude that the impact of burnout interventions seems to be at its highest when employees are presented with challenging job demands, only few hindrance job demands, and have at their disposal sufficient job and personal resources. In addition, greater burnout reductions tend to be observed in studies where participants reported higher baseline burnout (Dreison et al., 2016).

The voluminous corpus of literature accumulated on the topic justifies the conclusion that there is a recognized need for longitudinal studies using representative samples and long investigation periods (Westermann et al., 2014). All three approaches to treating burnout – person-directed, organization-directed and a combination of these - may be useful, but their validation requires further exploration in a variety of settings. It is worth noting that the focus, content and target of the intervention may also impact different dimensions of burnout, e.g., person-based interventions may be more beneficial for tackling emotional exhaustion, whereas organization-based ones hold promise for increasing personal accomplishment and reducing overall burnout, as Johnson et al. (2018) suggest. It appears that effective interventions should ideally combine individual and organizational approaches (Awa et al., 2010; Morse et al., 2012; Westermann et al., 2014) and have follow-up periods that reinforce the results achieved (Awa et al., 2010; van Wyk & Pillay-Wyk, 2010).

The summary of meta-analyses, however, reveals the outcomes of studies conducted strictly in the quantitative research tradition. Differences in the design of the studies, the baseline levels of burnout and the measures used within the studies make comparison between studies difficult and the drawing of far-reaching conclusions unwarranted. The studies included in such meta-analyses are typically focused on the alleviation of symptoms of burnout, but the very process of how this takes place over time remains unexplained. Therefore, the present study adopts an experiential perspective and attempts to address the process of change as expressed and articulated in the stories of burnt-out individuals in the process of recovery. Exploration of the effects of interventions using a qualitative approach is necessary as there is evidence that the subjective experience of recovery from burnout tends to be more positive than what is otherwise concluded by measuring the change quantitatively (Siltala, Mäkikangas, Hätinen, Kinnunen, & Pekkonen, 2016). The qualitative design of the study provides the participants with sufficient space and freedom to bring up any factors, events and phenomena they consider relevant in describing the process of recovery and invites them to voice their interpretations of the significance of these factors to their convalescence.

TABLE 1 Summary of Systematic Reviews and Meta-Analyses on Burnout Interventions

Study	*Type*	*Included studies (year)*	*Main results*
Ahola, Toppinen-Tanner, & Seppänen (2017)	Meta-analysis of interventions.	14 included studies; Four in meta-analysis.	Mixed effects. The 4 studies in the meta-analysis did not alleviate BO. Individual-based interventions did not alleviate BO symptoms.
Awa, Plaumann, & Walter (2010)	Systematic review.	25 primary interventions, of which 17 individual-based, 2 organization-based, 6 combined.	Individual interventions effective in the short term; combined -long term. Positive effects diminished over time.

TABLE 1
(continued)

Dreison et al. (2018)	Meta-analysis of burnout interventions for mental health workers.	Interventions studies between 1980 and 2015.	Overall effects small but positive. Individual-based interventions more effective than organization-based for emotional exhaustion. Higher effect if baseline burnout level was high.
Iancu, Rusu, Măroiu, Păcurar, & Maricuţoiu (2018)	Meta-analysis of individual-based burnout interventions for teachers.	Assessed the impact of type of intervention (CBT; mindfulness and relaxation; social-emotional skills; psychoeducational approach; social support; professional development), teacher level, time lag and duration of the interventions in 19 journal articles and 4 dissertations.	Overall effects small but statistically significant. Exhaustion and personal accomplishment were impacted. Mindfulness interventions effective, whereas short-term (< 1 month) interventions least effective.
Jaworska-Burzyńska, Kanaffa-Kilijańska, Przysiężna, & Szczepańska-Gieracha (2016)	Systematic literature review of studies between 2000 and 2015 on the role of therapy in burnout reduction.	Review of 22 studies.	Reduction of burnout achieved in most studies. Support groups enhanced the therapy effects. A small percentage of studies (14%) used physical exercise, which proved effective. Mixed effects of mindfulness-based interventions.
Johnson et al., (2018)	Narrative review with a focus on mental healthcare staff well-being.	Reviewed trends, causes, implications consequences of burnout in peer-reviewed journals. Reviewed three meta-analyses (Dreison et al., 2018; Panagioti et al., 2016 & West et al., 2016).	Effect sizes are small. Both intervention types hold promise, but target different dimensions.
Luken & Sammons (2016)	Systematic review.	8 articles; participants were health care professionals and teachers.	6/8 studies showed decrease in burnout after mindfulness training.

TABLE 1
(continued)

Mariçitoiu, Sava, & Butta (2016)	Meta-analysis of intervention studies.	47 studies, including mostly individual-based interventions.	Small effects on overall burnout and exhaustion, with effects on exhaustion found 6 months after the intervention. Did not find that CBT interventions were most effective.
Perski, Grossi, Perski, & Niemi (2017)	Systematic review and meta-analysis.	Eight studies of tertiary interventions.	No significant effects on RTW (return-to-work); exhaustion, depression or anxiety.
Regehr, Glancy, Pitts, & LeBlanc (2014)	Review and meta-analysis of 12 studies.	Aimed to explore interventions for stress, anxiety, and burnout in physicians.	Cognitive, behavioural and mindfulness interventions reduced anxiety.
Richardson & Rothstein (2008)	Meta-analysis (builds upon van der Klink et al.'s meta-analysis).	36 experimental studies and 55 interventions for stress management between 1977 and 2006.	CBT produced larger effects on stress management than other types of intervention.
van der Klink, Blonk, Schene, & van Dijk (2001)	Meta-analysis of studies on occupational stress management between 1977 and 1996.	48 experimental studies; four intervention types: cognitive-behavioural, relaxation techniques, multimodal and organization-based.	Cognitive-behavioural and multimodal interventions had a moderate effect. Small effect for relaxation techniques. No significant effect of organization-based interventions.
van Wyk & Pillay-van Wyk (2010)	Review of RCT studies of stress management interventions.	Ten studies of interventions in healthcare workers.	Insufficient evidence of effectiveness of stress management interventions. Only one study showed sustainable effect over the medium-term. Refresher sessions may help sustain the effect.
Wallensten, Åsberg, Wiklander, & Nager (2019)	Narrative review.	Reviewed literature on interventions for stress-induced exhaustion disorder.	CBT and multimodal interventions reduce BO symptoms. Workplace interventions facilitate RTW.

TABLE 1
(continued)

Walsh et al. (2019)	Systematic review.	14 studies on interventions for burnout among undergraduate and graduate medical residents, but none targeted specifically for burnout.	6/14 studies reported reduction of BO. Absence of any study with a focus on BO prevention only.
West, Dyrbye, Erwin, & Shanafelt (2016)	Systematic review and meta-analysis.	15 RCT studies and 37 cohort observational studies of interventions for burnout among physicians.	Both individual-based and organization-based interventions may be effective.
Westermann et al. (2014)	Systematic literature review.	16 studies of interventions for burnout among elderly care nursing staff.	Individual-based interventions have short-term effects. Organization-based and combined have longer-term effects.

1.4 Rehabilitation in Finland

As participants in the present study were recruited from national rehabilitation courses in a rehabilitation centre in Central Finland, the purpose of this subsection is to present the rehabilitation system in Finland in order to describe its specific features and contents.

Rehabilitation plays a key role in addressing the full spectrum of health needs by employees in the 21st century (WHO, 2017). The ageing population of Europe and the surge of epidemiological diseases impose a substantive demand and pressure on national health systems and call for an adequate response in their prevention and treatment (Stucki, Bickenbach, Gutenbrunner, & Melvin, 2018). It has been estimated that effective rehabilitation can result in savings in the health care sector and it should be made an integral part of national health plans and policies (WHO, 2017).

Rehabilitation in Finland has a long history and deep roots. The efforts in rehabilitation have traditionally been directed towards reducing defects and deficiencies in employees (Järvikoski & Härkäpää, 2004). More recent forms of rehabilitation courses have been targeted at specific occupational groups and taken into consideration characteristics of particular diseases or disorders. Currently, KIILA rehabilitation is offered to employees or entrepreneurs whose disease or disorder hinders to a significant extent their working capability. These individuals may have received help from occupational health care, but it is deemed insufficient.

According to the Finnish Social Insurance Institution (KELA) register, a total of 134,010 individuals participated in rehabilitation courses in 2019 (Kela, 2020). The vast majority of these, 87,151 individuals, participated due to mental health and behavioural disorders. It has been estimated that in the last two years mental health disorders have become more common and surpassed musculoskeletal diseases in the number of sick leave days (Reiterä, Mattila-Holappa, Miettinen, Rättö, & Vadén, 2020). Such disorders are also the most common reason for early disability pension.

Rehabilitation interventions are designed for various physical conditions and are aimed primarily at employees of working age (Kela, 2020). These interventions are discretionary medical interventions as no subjective right to them so far exists. Rehabilitation is state-financed and the Finnish Social Insurance Institution, KELA, is in charge of both funding these services and providing income for the duration of rehabilitation. The application process may be initiated either by the applicants themselves or by a referral from that individual's occupational health care. The local branch of the Finnish Social Insurance Institution conducts the initial screening and the final selection is made by the chief physician of the rehabilitation centre. The instruments used for screening participants are usually psychological tests or scales. Those most commonly used by the Social Insurance Institution include GAS (Goal Attainment Scale), the Working Ability Index, BDI -21, and the World Health Organization Quality of Life (WHOQOL) -BREF questionnaire.

Rehabilitation interventions use holistic and multidisciplinary approaches. They start with an overall evaluation of an employee's physical, psychological and social state by various rehabilitation professionals including a physician, a psychologist, a physiotherapist and a social worker. Rehabilitation interventions include various individual and group activities such as guidance and counselling, physical exercise, group discussions, tasks completed between the different periods, educational sessions on nutrition, sleep, health and ergonomics, tests and examinations. Typically, the groups consist of 4-10 participants, and last for 15 days in total, starting with a 10-day period and ending with a follow-up period, which takes place within 7 months of the first period.

One of the main goals in rehabilitation is to strengthen coping strategies and enhance a sense of coherence (Antonovsky, 1987). The relationship of the sense of coherence and well-being has been demonstrated in a variety of studies (Eriksson & Lindström, 2006; Feldt, 2000; Grevenstein, Aguilar-Raab, Schweitzer, & Bluemke, 2016; Kivimäki, Feldt, Vahtera, & Nurmi, 2000). In contrast to personality traits, coping strategies and sense of coherence are seen as malleable and subject to change, and are therefore a core topic in rehabilitation (Feldt et al., 2011; Hätinen, 2008; Nilsson, Lepert, Simonsson, & Starrin, 2010). Another key goal in rehabilitation and counselling is the strengthening of agency (Adler, 2012; Järvikoski, Martin, Autti-Rämö, & Härkäpää, 2013), which can also be seen as similar to a sense of coherence. As it is a central concept in this dissertation, it will be presented in more detail in subsection, 1.6.

An evaluation of the benefits of rehabilitation courses reported that the number of rehabilitation clients who perceived their quality of life to be good or very good after a mental health rehabilitation course in 2018 increased by 20%, and a similar increase was observed in respondents' reported satisfaction with their health (Reiterä et al., 2020). Furthermore, the biggest increases in participants' satisfaction with their health were observed on the mental health courses, musculoskeletal disease courses and the professional KIILA courses (Reiterä et al., 2020). This proves that rehabilitation has a positive effect on the measured variables.

1.5 Recovery from burnout

The investigation of recovery from burnout is a recommended line of research (Hakanen & Bakker, 2017). Ironically, research on burnout has focused heavily on the process of burning out, i.e., the antecedents and consequences of burnout rather than on the process of recovering from it and the factors supporting this (Shirom, 2002). Thus, despite the large body of research on antecedents, symptoms and outcomes of burnout, there is still a lack of studies on the actual process of recovery. The insufficiency of knowledge about the process of regaining one's well-being and the attempt to understand the mechanisms driving the recovery have been a central and major motivation for conducting the present study. In addition, the study sought to pursue a more profound understanding of the *short-* and *long-term recovery* from burnout, as different beneficial factors conducive to recovery may be highlighted depending on the timepoint of sharing one's experiences.

Recovery from severe mental disorders, e.g., psychosis, is a much more extensively researched topic than recovery from burnout (see, e.g., Davidson et al., 2005). One reason for the scarcity of research conducted on the topic of recovery may be that burnout is not deemed to be as detrimental and incapacitating as are psychotic disorders and chronic somatic diseases. Another possible reason may be found in the ambiguity still surrounding the concept of burnout (Heinemann & Heinemann, 2017). However, taking into consideration the prevalence of burnout, particularly among certain professional groups, e.g., physicians (Rothenberger, 2017) and mental health workers (Morse et al., 2012), it is imperative to attempt to understand the drivers behind change eventually leading to recovery.

The research literature abounds in definitions, but broadly said, recovery means having no symptoms or deficiencies and presumes the ability to function independently (Davidson et al., 2005). Based on this definition, recovery from burnout can be construed as reduction of the symptoms of burnout (exhaustion, cynicism and reduced professional accomplishment). The quantitative research tradition has explored the decrease of burnout symptoms after application of specific interventions. As the meta-analyses presented in subsection 1.3. demonstrated, individual studies provide evidence of beneficial effects achieved particularly in cognitive-behavioural and mindfulness-based interventions (see Table 1 for details of the meta-analyses). However, even though individual studies report effects, meta-analyses frequently reveal weak or insufficient evidence of effectiveness (e.g., Ahola et al., 2017) and highlight the importance of follow-up periods in interventions (Awa et al., 2010; van Wyk & Pillay-van Wyk, 2010). Regarding long-term recovery, recent longitudinal quantitative studies have found that through the application of mindfulness-, acceptance- and value-based approaches (MAV) burnout symptoms can be alleviated and long-term improvements in well-being achieved, especially by adopting a non-judgemental attitude and learning skills such as observing and describing external stimuli (Kinnunen et al., 2019; Kinnunen, Puolakanaho, Mäkikangas, Tolvanen, & Lappalainen, 2020).

Quantitative studies, however, are not apt to reveal the exact mechanisms of change as perceived by burnt-out individuals. They are indisputably valuable in demonstrating statistically significant correlations and causality between variables, in studying mediator and moderator effect, or in identifying profiles of burnout, but they do not enable the exposition of individual lived experiences and a multitude of interpretations as does qualitative research (Patton, 2015). Largely due to the established tradition of adhering to quantitative research in the field of occupational health psychology, very little evidence has accumulated on the subjective experiences of recovery as reported by individuals with burnout. Ahola et al. (2017) proposed that qualitative analysis would be a useful addition when analysing the benefits of participation in an intervention, but qualitative studies that investigate factors facilitating recovery have been sparse.

Only few qualitative studies on recovery from job burnout have been identified in the literature. One of the earliest qualitative studies exploring recovery from burnout was Diane Bernier's study of 36 professionals of various professional backgrounds (Bernier, 1998). The interviews were conducted retrospectively after the recovery process had taken place. The results demonstrated that successful recovery included two types of change processes – internal, referring to the cognitive and emotional changes and external, indicating changes in the work environment. All in all, six stages were identified: *admitting the problem, distancing oneself from work, restoring health, questioning values, exploring work possibilities and making objective changes*. Bernier concluded that the process is psychosocial in nature and takes in total from one to three years.

A decade later, in her doctoral dissertation, Krista Regedanz (2008) explored the successful job recovery of 21 individuals who had suffered from job burnout and recovered over the last five years. As in Bernier's study (1998), data were collected after recovery had taken place. Regedanz (2008) identified 11 strategy themes and 15 situational themes reported in the participants' accounts. The process of recovery was found to be continuous and made possible with time. The strategies utilized by participants on their journey to recovery included, among others, asserting boundaries, assuming personal accountability, confronting a supervisor and requesting help at work. Among the situational and personal themes revealed in the analysis were *support, increased sense of control, enhanced agency and increased self-care*. Regedanz (2008) concluded that the distress experienced through burnout could lead to personal growth and to significant existential and identity shifts.

Another prominent qualitative study on recovery from burnout was conducted in Sweden (Fjellman-Wiklund, Stenlund, Steinholtz, & Ahlgren, 2010). Two different intervention programmes were compared: a cognitive-behavioural rehabilitation combined with Eastern philosophy methods (Qigong) and another applying Qigong only. Both interventions proved beneficial and six categories and a core category emerged from the analysis. The authors of the study named the category representing the entire process of recovery *Take Charge*, which encompassed various stages, advances and barriers on the way to full healing. Similarly, another study which utilized a dataset of exhaustion disorder patients, a diagnosis used in Sweden that designates a condition very close to burnout, used return to work as a marker of recovery (Norlund, Fjellman-Wiklund, Nordin, Stenlund, & Ahlgren, 2013). The results revealed a core category "*regaining the ability to work*", which was the outcome of both internal and external resources, the former including perceived validation, adaptive coping skills and insights, and the latter referring to practical, structural and emotional support.

Recent years have seen the publication of a couple of qualitative studies on recovery from burnout in specific professional groups. The primary focus in these seems to be burnout among healthcare professionals, mainly physicians (Abedini, Stack, Goodman, & Steinberg 2018) and sports coaches (Lundkvist, Gustafsson, Hjälm, & Hassmén, 2012). Abedini et al. (2018) identified two different types of burnout in medical residents: circumstantial and existential, which necessitated different coping strategies. Circumstantial burnout was the outcome of environmental factors and recovery from it required three distinct steps: *resolving challenging workplace issues, tending to personal lives and taking time off*. Existential burnout, on the other hand, resulted from more profound and permanent issues related to the professional role. Thus, recovery arose from experiencing feelings of validation, re-connecting with colleagues and patients, re-discovering meaning in the profession and redefining one's own role and identity. Similarly, Lundkvist et al. (2012) identified two burnout profiles on the basis of the perceived cause of burnout. The first was linked to the performance culture in itself, whereas the second burnout profile was associated with the overall situation of the coaches and encompassed the aspects of workload, family and health. The recovery process included energy-boosting strategies, such as *seeking support, engaging in activities relieving stress and learning to live with the performance culture*.

On the whole, the study of recovery from burnout has established that it is an ongoing, gradual process (Abedini et al., 2018; Bernier, 1998; Fjellman-Wiklund et al., 2010; Norlund et al., 2013; Regedanz, 2008). The common steps identified in the studies and perceived as crucial to the process are receiving sufficient support and validation, replenishing personal physical, psychological and social resources, and making concrete changes in both the personal and the professional domain. When none of these avail, more radical coping strategies may include resigning from one's job, which was found to be common in Bernier's (1998) and Regedanz's studies (2008). However, these studies focused on interventions designed for research purposes (e.g., Fjellman-Wiklund et al., 2010) or focusing on a particular professional group (e.g., Abedini et al., 2018; Lundqvist et al., 2012). The present study takes a broader approach and differs from these in that it explores the experiences of participants in an established rehabilitation intervention, i.e., one not specifically tailored to serve the needs of scientific research, and includes employees representing different professions and occupations.

Furthermore, despite the undeniable contribution of the above-mentioned studies, they all have in common a cross-sectional design employing retrospective interviews on the development of burnout and subsequent recovery, which fails to monitor the changes over the course of time and the fluctuations in an individual's well-being. Motivated by this obvious need, the present study approached the process of recovery and participants' experiences as they developed, thereby affording a perspective different from the retrospective one in which participants *recall* past events. Furthermore, Study II, in particular, adopted a long-term perspective, aiming to embrace the whole process from commencement of recovery while in rehabilitation to a timepoint two years post rehabilitation. The rationale behind this goal is related to the fact that even if a reduction in symptoms is ascertained during rehabilitation, the recovery is not necessarily permanent and certain individuals relapse to the same or similar levels of burnout. Their recovery after completing the course and returning to work was of particular interest due to the multitude of outcomes that take place once they leave protected and structured environment of the rehabilitation course (Hätinen, Mäkikangas, Kinnunen, & Pekkonen, 2013). By applying a qualitative research design, the study was able to track their trajectories of recovery as they occurred, and simultaneously identify the manifestation of agency in the maintenance of recovery.

1.6 Agency

As mentioned in subsection 1.4, the reinforcement of agency is a central objective in rehabilitation (Järvikoski et al., 2013). Various definitions of agency have been proposed in the literature, depending on the context in which a study is conducted. The present study uses the definition of agency proposed by Albert Bandura (2000) in accordance with social-cognitive theory. Agency describes the belief that one can exercise influence over one's life. It is a concept that bears resemblance to other terms in psychology such as self-efficacy, competence and personal sense of control (Bandura, 1997). Three distinct forms of agency have been distinguished – personal, proxy and collective (Bandura, 2000). Personal agency refers to the control or influence individuals exert over their own functioning and over environmental events. When individuals cannot achieve the desired outcomes by themselves, they exercise proxy agency by influencing others with the necessary resources, knowledge, or means to act on their behalf in the achievement of these goals. These others may, for example, be peers, supervisors, experts possessing the knowledge and influence to help the individual achieve his/her goals. The third form, collective agency, indicates people's shared belief in their common power to achieve the desired outcomes (Bandura, 2000). It is a testimony to the fact that human beings do not live their lives in total individual autonomy, but are often in a relationship of interdependence with other people. Agency has four central characteristics (Bandura, 2001; Bandura, 2006): intentionality or the ability to initiate a certain course of action, to plan and execute the plans; anticipation of the results of the action; self-regulation in order to transform objectives into action; and self-reflection, which includes an assessment of one's thoughts, actions and outcomes.

The exercise of control or influence over one's life has been labelled with different terms in the recovery literature. This phenomenon has been called "take charge" (Fjellman et al., 2010) and "taking control of everyday life" (Eriksson, Karlström, Jonsson, & Tham, 2010). The explicit reference to agency has been far rarer in studies on recovery from burnout. In her doctoral dissertation, Regedanz (2008) identified the sense of agency as one of the situational and personal themes in successful job burnout recovery. This theme implied a sense of empowerment and an enhanced ability to act, consistent with Bandura's definition of agency. The sense of agency was perceived as the counteraction to a "pull toward inaction" (Regedanz, 2008, p. 96), which was a commonly experienced feeling during the burnout stage. An especially important finding was that while burnout is linked to exhaustion, recovery from burnout is strongly associated with the reassertion of the sense of personal efficacy, which is synonymous with agency.

Agency seems to have received more attention in psychotherapy research (Coleman & Neimeyer, 2015) than in the burnout recovery literature. Particularly psychotherapies within the paradigm of depth psychology emphasize the role of clients as agents in the quest for increased competency (Coleman & Neimeyer, 2015). Agency is closely related to a person's sense of meaning and purpose because it implies an ability and autonomy to exert influence on one's life, and is also found to be associated with well-being (Adler, 2012). For example, studies of therapy narratives have revealed that personal agency is a pervasive theme in the narratives of participants with both high levels of well-being and ego development (Adler & McAdams, 2007; Adler, Skalina, & McAdams, 2008). These narratives showed a shift from a big, personified problem towards a state of overcoming the problems and reasserting one's authority. The mechanism by which agency and positive outcomes in therapy are related is not completely clear, but it has been suggested that if therapy clients view themselves as active self-healers, they are more likely to engage in a more effective use of therapy (Coleman & Neimeyer, 2015).

Apart from manifestations of strong agency, the psychotherapy literature has also explored instances of weak agency or nonagency. Lack of agency or nonagency can be construed as passivity or inaction (Ely, MacGibbon, & Hadge,

2000) or lack of mastery (Toivonen, 2019). Manifestations of nonagency have been identified in narratives of drunk driving incidents (Seilonen, Wahlström, & Aaltonen, 2012), in therapy for psychosis (Avdi, Lerou, & Seikkula, 2007), and in individual therapy for various mental health problems such as anxiety, stress, depression and panic attacks (Toivonen, 2019). What is characteristic of the examples of nonagency is an assumed lack of control over the issues at hand, taking a victim position and assuming a stance of helplessness. Studies, however, show that impoverished agency can be reconstructed and reinforced in the context of dialogue and therapy (Avdi et al., 2007; Coleman & Niemeyer, 2012), demonstrating that agency is not a personality trait, but an attitude amenable to change. This conclusion is particularly relevant in the context of rehabilitation and recovery, as the possibility to strengthen agency opens a pathway to improved well-being.

Although rehabilitation is not psychotherapy *per se*, the empowerment paradigm in rehabilitation implies that the activities included therein are targeted at reinforcing an individual's sense of control, self-efficacy and active involvement in the rehabilitation process (Hätinen, 2008). Bearing in mind that burnout is often associated with low levels of self-esteem, self-efficacy and optimism (Alarcon et al., 2009), the objective of strengthening agency in rehabilitation appears logical and fully justified. The rehabilitation context from which the participants in the present study were recruited, the adoption of a qualitative research design and the apparent significance of agency in countering the low levels of self-efficacy associated with burnout made the exploration of agency in the study a valid and worthwhile goal. The presence of agency, the obstructed manifestation or lack of agency discernible in the stories of participants and viewed against the background of perceived recovery or continued ill-being could yield important knowledge about the role of agency in the commencement and maintenance of recovery.

1.7 Studies on the effect of burnout on family members

Burnt-out individuals have been the core focus of burnout research, which has primarily investigated the consequences and developmental paths of burnout. However, the effect of burnout on those closely related to burnt-out individuals has been largely ignored in qualitative research.

The respective impact of burnout on spouses, in particular, remains so far largely unexplored and the lack of knowledge about the phenomenon was a major incentive for the present study. In light of evidence that family support has a demonstrably positive effect on rehabilitees as reported in earlier studies (Fjellman-Wiklund et al., 2010; Hålstam, Stålnacke, Svensen, & Löfgren, 2015), it is somewhat surprising that there is still a paucity of qualitative studies examining partners' experiences of individuals' burnout and recovery.

Two distinct lines of inquiry have engaged in exploring the impact of individuals' mental states on people closely related to them and these will be presented in the paragraphs below. The first one, on crossover, is predominantly quantitative and is presented here for the sole purpose of providing a general background on the concept of crossover and the type of studies conducted within this perspective, whereas the perspective of family burden is more comprehensively considered and utilized in Study III, and is presented in more detail below.

1.7.1 Crossover

This line of research has investigated the phenomenon of transfer (also called contagion) of stress from individuals directly experiencing job stress to those with whom they interact on a regular basis. The phenomenon has been labelled crossover (Westman, 2001) and has been recognized and studied extensively in the literature (see e.g., Bakker, Demerouti, & Schaufeli, 2005; Bakker, Schaufeli, Sixma, & Bosveld, 2001; Westman & Etzion, 1995; Westman, Etzion, & Danon, 2001). Five main variables have been explored: physical health, burnout, depression, work-family conflict, anxiety and dissatisfaction (Westman, 2006). Indicative of the importance of burnout is the fact that it is among the major strains investigated in crossover research (Westman, 2006). A recent study by Nasharudin and colleagues (Nasharudin, Idris, & Young, 2020) reported that husbands' burnout crossed over to wives, but the opposite crossover effect, i.e., from wives to husbands, was not observed. Bakker (2009) also found indirect effects of burnout. He concluded that in occupations where burnout is typically observed, an individual's burnout can affect the partner's physical and psychological health through partner burnout. Furthermore, individuals whose partner was burnt-out were more likely to report higher scores on depression and lower on health, thus indicating indirect effects of burnout.

1.7.2 Theories of family burden

The impact of a mental health condition on caregivers has also been explored from the perspective of family burden. This concept was first introduced by Treudley in the mid-20th century (Treudley, 1946) and later elaborated in 1981 by Platt (Platt, 1981), who used family burden to refer to the hardship and adverse events affecting those closely connected to psychiatric patients. It was Schene (1990) who in 1990 proposed an integrative framework including the objective and subjective dimensions of the burden. Objective refers to the direct tasks of care whereas the subjective dimension refers to the emotional impact of caring for an ailing family member. Objective burden includes the following factors: household tasks, intrafamilial relationships, children, finances, leisure and working life and also changes in social networks. Under subjective burden two categories can be found: health and subjective exhaustion. Some authors, however, dispute this division as objective burden factors are defined on the basis of partners' self-reports (Sales, 2003).

Family burden has traditionally been explored in the context of chronic physical disease (e.g., Alzheimer's disease; see Garity, 1997) or severe mental health disorders, for example schizophrenia or psychosis (Hultsjö, Berterö, & Hjelm, 2009; Stengård, 2005), which impose significant physical and emotional demands on caregivers. Thus, the majority of research on the topic has focused specifically on these patients (see also Kuhlman, 2013; Rautiainen, 2010; Sales, 2003; Stengård, 2005). The experiences of family members of individuals with depression have also been explored, although to a lesser degree. Similarly, anxiety disorders have been studied, but primarily in their more severe forms, e.g., obsessive-compulsive disorder (OCD) and posttraumatic stress disorder (PTSD) (Kalra, Kamath, Trivedi, & Janca, 2008). Van Wijngaarden and colleagues (van Wijngaarden, Schene, & Koeter, 2004) concluded that caregivers experience significant distress and may themselves need therapeutic help. Given the extent of burnout, it is somewhat surprising that the experiences of people closely related to the person with burnout have received very little attention in the scientific literature and knowledge of their own well-being is still scarce. It may be assumed that burnout is not deemed to be as detrimental and burdensome as chronic or psychotic disorders and thus the experiences of the relatives or caregivers have been ignored (Sales, 2003; van Wijngaarden et al., 2004).

At the time of writing the summary of the dissertation, only two qualitative studies exploring spouses' experiences of burnout could be identified. The first is Eija Peiponen's doctoral dissertation (Peiponen, 2015), which utilized Schene's framework of family burden and investigated spouses' experiences of burnt-out individuals from an action research perspective.

In Peiponen's study (2015) couples, in which one of the spouses suffered from burnout, participated in a three-year programme designed with a focus on the families of burnt-out employees. The results of the study supported Schene's (1990) framework and demonstrated that burnout had a far-reaching impact on the families and their life structures, while also exerting an effect on the interspousal relationship and intrafamilial relations. The interviews and diaries of the spouses revealed that these spouses had assumed responsibility for running the household, taking care of children and managing finances, as burnout, with the demands it placed on the spouses, brought about many changes in social relations and family dynamics.

As the spouses' own free time diminished and the workload increased, their personal resources became depleted, which in turn affected their own mental health, caused distress and exacerbated pre-existing mental or physical conditions. The spouses were engaged in a process of rebuilding their own self-confidence and self-knowledge in addition to gaining knowledge about their partners. This was achieved in the course of time and via peer support groups and weekend respite courses. Spouses reported positive outcomes of the lived hardship, and these were expressed as better interpersonal communication, greater self-respect and attention to one's own well-being (Peiponen, 2015).

Secondly, Ericson-Lidman and Strandberg (2010) explored the experiences of people closely connected to health care providers working in psychiatric and geriatric care who were recovering from burnout. The dataset included five participants: three spouses, a best friend and a child of burnt-out individuals. The results showed that being close and providing support burdened the individuals connected to those in recovery. The researchers identified four themes and 14 subthemes describing an experience of "*putting one's life on hold*" to support the other. The authors concluded that the significant others were put into a wearing situation, in which they had to provide encouragement, protect the other person from strain and take over additional responsibilities. This led to their becoming exhausted themselves, and feeling guilt for not being able to provide sufficient help, but eventually they were able to recuperate and gain new self-knowledge.

Despite the obvious contribution of these qualitative studies, they leave certain questions unanswered. First, Peiponen's study (2015) focused on couples participating in an intervention targeted at burnt-out individuals and their families, and the perspective from which the data were analysed was action research. The second study, on the other hand, explored the experiences of various people related to the burnt-out individual, and did not focus exclusively on spouses (Ericson-Lidman & Strandberg, 2010). The interspousal relationship also remained unexplored and demanded further attention. In response to the need for a better understanding of both rehabilitees' and their spouses' experiences, the present study attempts to find answers to the question of what exactly is beneficial to recovery, how recovery is maintained, and how spouses experience the process while remaining outside observers of the process. The rehabilitation context provided the framework for the original studies, but the focus was not on evaluating the effectiveness of the rehabilitation interventions, but rather on the subjective experiences of the participants of the burnout and recovery processes.

1.8 Aims of the study

Given that recovery is a recommended line of research and that experiences of the process have so far been insufficiently explored, the overall aim of this research was to elicit subjective experiences of burnout and recovery from both the rehabilitees' and their spouses' perspectives. The changes perceived in the process of recovery from burnout have been investigated to some extent, but primarily by applying quantitative methods, as is common in the field of work, organizational and occupational health psychology. Qualitative studies have hitherto occupied a marginal niche, even though some movement towards a combination of both approaches or towards purely a qualitative orientation has been observed (Fjellman-Wiklund et al., 2010; Siltala et al., 2016). Therefore, more studies are needed to understand the subjective experiences of burnt-out individuals. Knowledge of these experiences may uncover issues not previously hypothesized, but which may reveal important elements in the whole process that can be tested further by quantitative methods. Furthermore, although the role of caregivers in more severe disorders has received extensive attention in research, very little attention has been paid to the experiences of people closely related to those suffering from burnout, and the effect of this syndrome on interpersonal relationships. Only recently have studies focusing on this topic begun to emerge. Thus, these research gaps were identified and the aim of the original studies was to address them.

Study I aimed to explore the subjective experiences of recovery from burnout of 12 participants on rehabilitation courses whose burnout scores had diminished by one class. The focus was on the particular beneficial factors that initiated and facilitated recovery, and on their role in the overall process as perceived by the participants.

Study II focused on the long-term development of recovery over a two-year period of four participants selected from the dataset in Study I. The aim was to explore the stability of the participants' well-being and identify what factors were conducive or what were unfavourable to continued recovery. A further aim was to investigate the role of different modes of agency (Bandura, 2000) in the maintenance of well-being.

Study III addressed two questions: First, how spouses (n = 10) experienced the process of rehabilitees' burnout and recovery, what they saw as crucial in the process and how they perceived their role with respect to the burnt-out individual. Second, how the rehabilitees' burnout and recovery affected the interspousal relationship as perceived by the spouses, including both negative and positive impacts.

2 METHOD

2.1 Study design and participants

The data for this research were collected from rehabilitation clients (Studies I and II) and their spouses (Study III) participating in courses in a rehabilitation centre in Central Finland. The nature and contents of the rehabilitation courses utilized for the first two studies differed slightly from those used to recruit participants for Study III. The rehabilitation courses, from which the participants in Study I and II were selected, were *Virveli* (in Finnish: *Vireyttä ja Elinvoimaa*, meaning *Vitality and Energy for Working life*) rehabilitation courses specifically tailored to employees whose working ability was jeopardized by burnout. They last approximately one year, and comprise two rehabilitation periods of 12 and five days each, with a period in between not longer than seven months. The main content of this type of burnout rehabilitation is presented in Table 2. The courses used for recruiting participants for Study I and subsequently Study II took place between August and December 2012.

For Study III, the courses from which the participants were selected were called *Silmu* and took place between August and December 2017. They were designed for adults whose working capability was imperilled due to mild or moderate depression and/or anxiety disorder that may have developed as a result of burnout or bipolar disorder in remission (see KELA rehabilitation standards, KELA, 2017). One eligibility criterion is an initiated and continuing patient relationship in occupational or student healthcare and an assessed ability to benefit from a group-based intervention. Ten rehabilitees per rehabilitation course are selected based on their symptoms of burnout, depression, anxiety or bipolar disorder. The course lasts for 15 days, usually divided into three five-day periods (5+5+5), within a timespan of 12 months. One period lasts a minimum of three days.

Several background characteristics were collected in the three original studies: age, gender, education, marital status and number of underaged children living in the same household (Studies I-III), time with the current employer

(Studies I-II), current work position (Studies I-II), duration of the interspousal relationship (Study III) and age, gender and education of the spouse (Study III).

TABLE 2 Contents of burnout rehabilitation

	Psychosocial activities	*Physical activities*	*Other*
Individual level	• Individual guidance and counselling sessions with psychologist	• Interviews, tests and examinations by physician and physiotherapist	• Individual tasks between rehabilitation periods (individual rehabilitation plan)
Group-level	• Participatory group discussions with psychologist* • One group discussion with psychiatrist • One group discussion with physiatrist (e.g., pain, medication) • Goal setting and attainment discussions • Social activation and guidance	• Physical exercise • Relaxation • Group discussions with physiotherapist • Health education (e.g., nutrition, exercise) • Ergonomics	• Various group activities with occupational therapist

* Examples of participative group discussion topics during rehabilitation: 'Stress, burnout, and depression', 'Sleep and relaxation',' Assertiveness', 'The relationship between thoughts and well-being', 'Means for reducing burnout'

Study I (*n* = 12) comprised participants from three different rehabilitation courses conducted during the second half of 2012. The aim of the study was to study rehabilitation clients whose burnout had abated during the intervention. Fifteen out of a total of 23 clients were identified as eligible, and 12 out of the 15 eligible clients agreed to participate in the study. The baseline levels and the subsequent changes were measured using the Bergen Burnout Indication (BBI-15) (Näätänen et al., 2003). All three dimensions of burnout – exhaustion, cynicism and reduced professional efficacy – are measured by the BBI-15, with the responses being rated on a 6-point Likert scale (1= totally disagree, 6= totally agree). Burnout symptoms are classified as severe, moderate, mild or no burnout based on the total score, which varies between 15 and 90.

Eligibility for the study was established if burnout scores had diminished by at least one class, e.g., from severe to moderate, in at least one symptom. The psychologist at the rehabilitation centre informed the eligible clients of their opportunity to participate in the research. The majority of the participants in the study were female (*n* = 11), which aptly reflects the typical gender distribution of rehabilitation clients in Finland. The mean sample age was 51.3 years, varying between 38 and 63 years. Of these, 58% had vocational school education and one third worked in supervisory positions. Duration of employment with the current employer ranged from .5 to 38 years. At the time of the study, most were working, one was on study leave and one had become unemployed. At the start of the rehabilitation course the mean burnout score was 63 (SD=12.09) corresponding to severe burnout. During the follow-up period the mean burnout score had declined to 41 (SD = 12.28), indicating no burnout. This decline was statistically significant, $F(1,11) = 66.57$, $p < .001$.

Study II utilized part of the dataset collected for Study I, complemented by data collected 1.5 years and 2 years post-rehabilitation. The 12 participants in Study I were sent an electronic questionnaire 1.5 years after the end of the rehabilitation course, in spring 2014. The questionnaire measured participants' job burnout with the BBI-15 (Näätänen et al., 2003). It also contained open-ended questions related to any changes that may have occurred in the participants' workplaces, their managers' actions and their overall well-being after the rehabilitation course. In addition, depression was measured with the DEPS-screen in Study II (Salokangas, Poutanen, & Stengård, 1995). The questionnaire is presented in Appendix II. Nine out of 12 participants responded to the questionnaire, and eight gave their consent to be approached later for further inquiry. Four of these eight respondents were selected through purposeful sampling for further in-depth interviews. The two criteria for selection were degree of recovery, i.e. continued recovery or exacerbation of burnout, and whether a job change had occurred. The follow-up interviews were conducted in October 2014. The age of participants at this collection point varied between 41 and 64 years. Two of the participants had a vocational school level of education, one held a professional polytechnic qualification, and one had a university degree. The length of employment with the current employer varied between 3 months and 40 years, and all were currently working, but one was on part-time retirement.

Study III comprised ten couples. First, eligible rehabilitees were selected from eight rehabilitation courses conducted between September and December 2017. As the courses were not specifically tailored to employees with burnout, their eligibility was assessed by the rehabilitation centre psychologist based on their clinical diagnoses, their anamneses, burnout scores and rehabilitation goals. After eligibility was determined, they were informed about the study and their spouses' willingness to participate in the study was ascertained. The invitation to the study is presented in Appendix IV. All couples were heterosexual and included three female and seven male spouses. The spouses' age varied between 32 and 66 years (mean 54.5 years). Rehabilitees' mean age was 50.2 years, with a range between 39 and 60 years. The duration of the relationship was under 7 years in three of the couples; the rest had been in a relationship longer than 7 years.

2.2 Data collection

Semi-structured interviews comprised the main data for the three original studies. This type of interview was selected as it captures accurately the clients' experiences of burnout and recovery.

In *Study I* the topics in the interview covered rehabilitation clients' burnout histories, their subjective experiences of general factors related to recovery and aspects of the rehabilitation course, their current state and future expectations regarding their well-being. The topics and questions of the interview are presented in Appendix I. The interviews were conducted by master's students of psychology who had received interview training and had completed practice interviews prior to the interviews proper. The participants were interviewed in the rehabilitation centre at the end of the 5-day follow-up period. The duration of the interviews varied between 45 and 90 minutes. The total length of the interviews was 288 pages of transcribed data.

In *Study II* the follow-up interviews were conducted by a master's student of psychology in the participants' homes. The interviews lasted between 1 and 1.5 hours, and the total length of the transcribed material was 138 pages. Topics in the interview included participants' experiences of the rehabilitation courses, their current evaluation of their physical, social and emotional well-being and their future expectations (see Appendix III).

For *Study III*, both the rehabilitees and their spouses were interviewed, but the interviews with the rehabilitees were used for contextualization and a more comprehensive understanding of the burnout histories. The topics in the interviews with the rehabilitees covered their burnout histories, the various modes of professional help they sought, and the rehabilitation embarked on. In addition, they were asked to evaluate the amount and quality of support they had received from their spouses and the impact of their burnout on the interspousal relationship. The topics in the interviews with the spouses were similar, but more oriented towards their subjective experiences of the other spouse's burnout and subsequent recovery (see Appendix V). They were asked to share their specific role in the process, the feelings they experienced throughout and their own perceptions of the impact of burnout and recovery on the interspousal relationship. The interviews were conducted by three master's students of psychology who underwent interview training delivered by the author of the dissertation. They conducted and recorded practice interviews prior to the interviews proper. Based on the feedback given by the students, slight modifications, e.g., deletion of redundant questions and further specification of existing questions were made to the interview structure. The interviews were conducted between September 2017 and February 2018. One couple was interviewed on the premises of the rehabilitation centre and the rest were interviewed on the phone, due to the various locations in which the study participants lived. The total length of the transcribed interviews with the spouses was 130 pages.

The data collection points for each of the studies are presented in Figure 1 below.

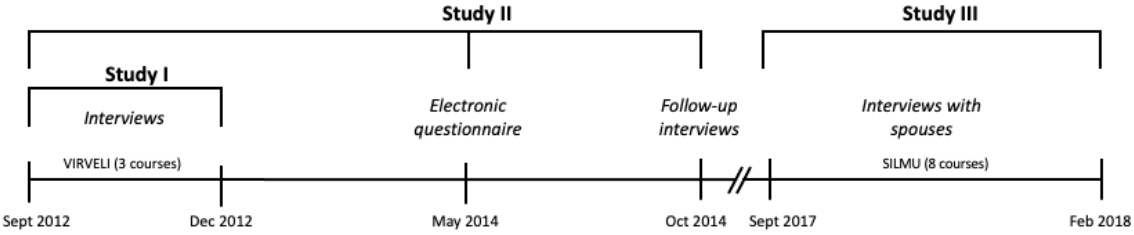


FIGURE 1 Data collection points.

2.3 Data analyses

The three original studies employed qualitative analyses. These were deemed the most appropriate to capture the essence of the respective data sets and to answer the specific research questions posed in each individual study. Three different kinds of qualitative analysis were utilized in this research: content, narrative and thematic analysis.

In *Study I* content analysis (Krippendorff, 2012) was employed to identify the categories reflecting the rehabilitation clients' experiences of beneficial recovery. The interviews were first read to grasp the general meaning. Upon subsequent readings codes were assigned to units of the text considered meaningful and reflective of the experiences of recovery. The codes were compared and analysed for similarities and differences. Codes with similar content were merged to form subcategories. These subcategories were further condensed and grouped into larger categories. Finally, an overarching theme depicting the process of recovery in its entirety was identified. Throughout the process of analysis, the quotations linked to the codes were continuously re-read and discussed between the first three authors of the study.

Study II applied thematic narrative analysis to the dataset collected at three time points. Narrative inquiry tackles questions concerned with what a story can uncover about the person and his/her cultural and social milieu (Patton, 2015; Smith, 2016). Narratives offer a window into human experience while leaving its richness and complexity intact (Bell, 2002). Through narratives the lived experience is acknowledged as a source of knowledge and understanding (Clandinin, 2013). The analysis was conducted in accordance with the description of this method by Catherine Riessman (2008). This type of narrative analysis attempts to answer the *What?* question, i.e. the focus is on the content of the story being told, and it was seen as particularly appropriate to capture aspects of the long-term recovery experienced by each individual study participant. The concept of agency (Bandura, 2000) was adopted as the theoretical lens through which the individual accounts were filtered and analysed. Thus, attention was paid to the instances of different modes of agency or lack thereof underlying the narrative. In line with Riessman's (2004) exposé of the method, common themes present across the participants' accounts were also identified without compromising the integrity of individual narratives. These common themes were recurring elements, factors or events discerned in the narratives, which had a decisive influence on the process of successful or impeded recovery. Furthermore, as the experiences of change and transformation offer an opportunity to explore sense-making processes (Adler 2012; King & Hicks, 2006) the so-called spheres of meaning were discerned in the narratives. Four distinct spheres of meaning can be identified in narratives (Hänninen & Koski-Jännes, 1999): emotional, explanatory, moral and ethical. Emotional spheres of meaning are related to the emotional basis of narratives, whether the story has a happy or sad ending (Gergen, 1988), whereas explanatory spheres refer to the way in which the causes and consequences of events described are linked. Moral spheres of meaning imply possible aspects of accusation or excuse in the narrative and refer broadly to the allocation of responsibility (Baumeister & Newman, 1994). Ethical spheres are very similar to moral spheres, but they articulate more profound aspects of good and bad, right and wrong in life and thus occupy a more abstract level of the sense-making process. In the final stages of the analysis, each narrative was assigned a name that condensed the lived experience and described in a most adequate way the content of the story recounted. The storyline was presented visually in a stylized manner in accordance with Gergen & Gergen's instructions (Gergen & Gergen, 1988).

Study III utilized thematic analysis as presented by Braun and Clarke (2006). The guidelines for conducting the analysis were strictly adhered to in order to ensure a high-quality output. The interviews with both the rehabilitees and the spouses were read to obtain a general idea of the content and the timeline of events. The interviews with the rehabilitees were used for contextualization and to obtain a more comprehensive picture of the events that had occurred prior to the rehabilitees' burnout. Next, the interviews with the spouses were re-read and initial codes generated for meaningful units and these were later reviewed and condensed. By reviewing and analysing the codes the first themes began to emerge and these were subsequently refined. In the final stages of analysis, the names of the themes were generated, and clear and vivid descriptions of the themes and sub-themes were written.

Atlas.ti -software was used for a more systematic qualitative analysis in Studies I and III. The data in Study II were analysed without the support of any software as the aim was to grasp participants' voice and approach the collected interview data from a more holistic point of view. An overview of the studies is presented in Table 3 below.

TABLE 3 Overview of the studies

	Participants	*Aims*	*Data collection*	*Data analyses*
Study I	• n=12 • mean age 51.3 years • mean burnout score 63 at the beginning • mean burnout score 41 at follow-up • clients on three rehabilitation courses	• To explore the beneficial process of recovery among participants whose burnout score had diminished	• Semi-structured interviews	• Content analysis (Krippendorff, 2012)
Study II	• n= 4 • two had continued on the path of recovery • two had changed jobs	• To explore the long-term trajectory of burnout and the stability vs. Instability of recovery	• Semi-structured interviews at T1 • Electronic questionnaire at T2 • Semi-structured interviews at T3	• Thematic Narrative Analysis (Riessman, 2004)
Study III	• n= 10 couples • mean age of rehabilitees 50.2 years • mean age of spouses 54.5 years	• To explore spouses' experiences of rehabilitees' burnout and recovery • To investigate the impact of burnout and recovery on the interspousal relationship as perceived by the spouses	• Semi-structured interviews	• Thematic Analysis (Braun & Clarke, 2006)

3 OVERVIEW OF THE ORIGINAL STUDIES

3.1 Study I

Salminen, S., Mäkikangas, A., Hätinen, M., Kinnunen, U., & Pekkonen, M. (2015). My well-being in my own hands: Experiences of beneficial recovery during burnout rehabilitation. *Journal of Occupational Rehabilitation, 25,* 733-741. DOI: 10.1007/s10926-015-9581-6

Aims: The aim of this study was to investigate the experiences of burnout rehabilitees who were participants on a national rehabilitation course in Finland. The dataset comprised twelve rehabilitees whose burnout scores had diminished by at least one class while participating in the rehabilitation course. They came from three different rehabilitation courses, which presumably reduces groupthink and increases the reliability of the study.

Procedure: The rehabilitees were interviewed at the end of the follow-up period of the rehabilitation course using semi-structured interviews encompassing topics such as rehabilitees' burnout histories, their experiences of different factors related to recovery as well as the contents of the rehabilitation intervention, and their visions and expectations of the future. The transcribed interviews were analysed by content analysis.

Results: The analysis identified an overarching theme, *My Well Being in My Own Hands*, and four themes: *Support*, *Awareness*, *Approval* and *Regained Joy.* The themes and subthemes are presented in Figure 2 below. The main theme depicts the process of recovery in its entirety and shows that rehabilitees hold the key to their own well-being, either by changing their attitudes, habits and coping mechanisms or by demanding changes at the workplace. During the recovery process, the rehabilitees pursued a path of increased self-mercy and self-approval, demonstrated willingness to accept help and support from the peer group and professionals, and ultimately regained their joy in life. They also reassessed the order of priorities in their lives and replaced their pursuit of perfection with a realistic view of their own abilities and limitations. This overarching theme resembles to a large extent Bandura's (2000) concept of agency in that the rehabilitees held the belief that they could re-gain control over their lives and/or influence others with the necessary resources to accomplish beneficial changes.

The other four themes depicted the cumulative steps taken in rehabilitation towards recovery. *Support* described the cognitive, emotional and practical support provided by the professionals involved in rehabilitation, by the peer members of the rehabilitation group and by family members. The rehabilitees described the positive effects of realizing that they were not alone in their ordeal and that their experiences were shared by other people. They also valued the patience and empathy received from the professionals in the rehabilitation centre and benefitted from the concrete actions carried out by these professionals. *Awareness* summarized the process of accumulating knowledge about burnout symptoms as well as one's own needs and limits. It entailed a journey towards understanding one's body and mind better, which led to being more sensitive and responsive to their signals. *Approval* was the next step and referred to accepting oneself as one is, mitigating one's perfectionism and breaking free from the sense of guilt and/or shame that often accompanied the state of exhaustion. This category also included affirmation of one's needs and limits and adopting a realistic view of what one was capable of. The ultimate step, *Regained Joy in Life*, was achieved towards the end of the journey and encompassed renewed interest in social interaction, hobbies and increased experienced joy in different activities.

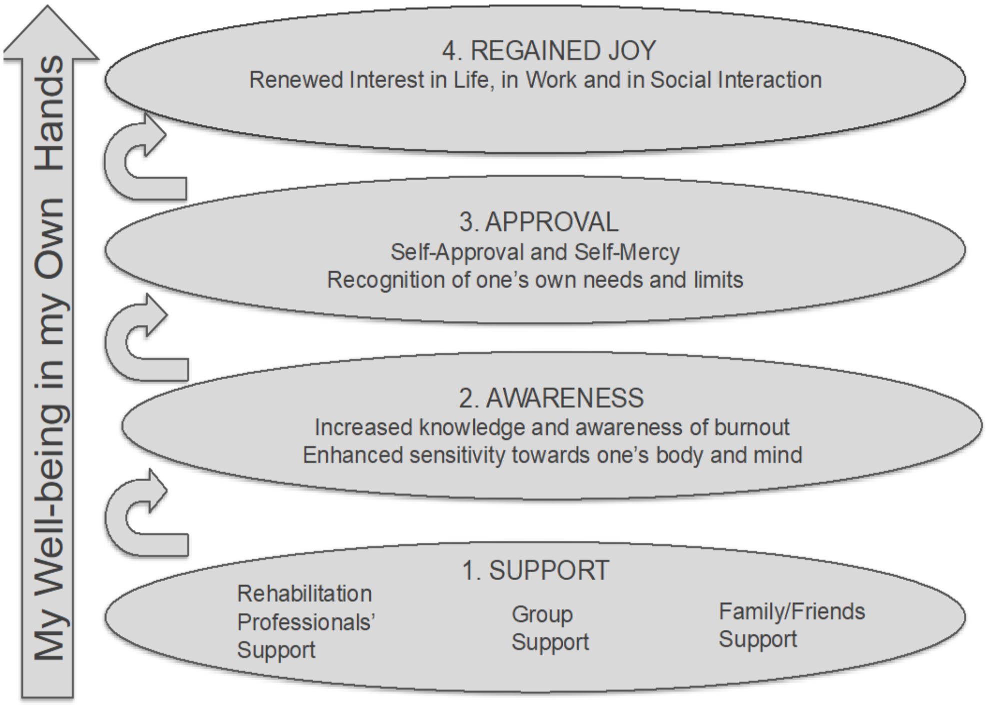


FIGURE 2 Categories, sub-categories and the overarching theme My Well-Being in My Own Hands.

3.2 Study II

Salminen, S., Andreou, E., Holma, J., Pekkonen, M., & Mäkikangas, A. (2017). Narratives of burnout and recovery from an agency perspective: A two-year longitudinal study. ***Burnout Research,*** **7, 1-9. DOI:10.1016/j.burn.2017.08.001**

Aims: Study II focused on the long-term development of recovery and aimed to find out how stable the path of recovery was after a certain period of time. It explored the narratives of four rehabilitation course participants starting from the rehabilitation course, going through their experiences 1.5 years later and by interviewing them two years after the rehabilitation course. More specifically, it studied the role of agency and identified spheres of meaning in the accounts of the participants: emotional, explanatory, moral and ethical.

Procedure: Four participants who participated in Study I were sent an electronic questionnaire 1.5 years after the rehabilitation course and were interviewed using semi-structured interviews two years post rehabilitation. The participants were: 1) Sara, 57 years, a kindergarten teacher, divorced; 2) Diana, 61 years, reception nurse, married; 3) Paula, 41 years, management assistant, married; and 4) Astrid, 64 years, director, married. The interview in the follow-up period of the rehabilitation course, the responses to the electronic questionnaire and the interview two years after rehabilitation constituted the narrative of each of the participant and were treated as three interrelated, but distinct parts of the narrative. The data were analysed by thematic narrative analysis (Riessman, 2008).

Results. The analysis revealed decidedly heterogeneous recovery paths which were contingent upon various factors. Two of the rehabilitees had changed jobs, and two had stayed in their original workplaces. Stability of recovery was observed for two participants and exacerbation of burnout was registered for two of them, but these were not consistent with the job change. Two of the narratives were thus of successful recovery (Paula's and Astrid's), one could be referred to as expectation of retirement (Diana) and one was an open-ended narrative (Sara). The presence of individual or proxy agency, whereby the rehabilitee used the influence of another person to achieve her goals, was predictive of a more stable and continuous maintenance of well-being. The role of the supervisor was also essential as he/she was instrumental in executing changes that, first, facilitated the return to work, and second, were conducive to maintaining a good level of well-being and to preventing burnout. Personal factors were also found to be of significance. The rehabilitee's own or her family member's health exerted an influence on the outcome and either taxed the already depleted resources or freed new ones. Other personal events, such as divorce, also had an influence on subjective well-being. The most beneficial path was identified when personal agency was strong, the supervisor demonstrated understanding and provided support, and the personal factors were conducive to recovery. Fluctuations were also identifiable, but it could be concluded that even when the circumstances did not entirely facilitate full recovery, the lessons learnt in rehabilitation mitigated the negative effects of adverse factors, as seen in the open-ended narrative. The visual depiction of the narratives including the major events mentioned is presented in Figures 3-6, and the main elements of the narratives are summarized in Table 4 below.

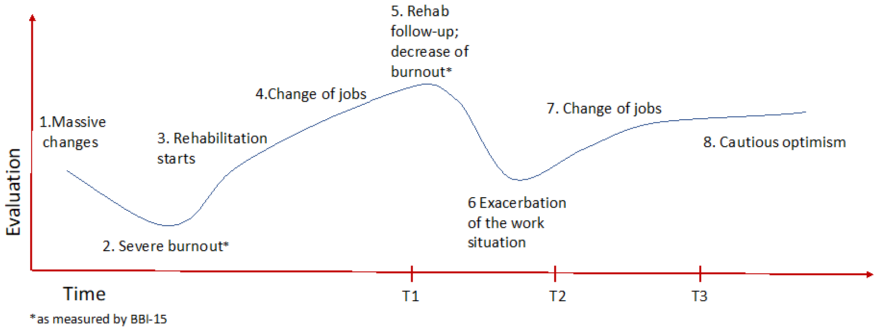


FIGURE 3 Sara’s narrative

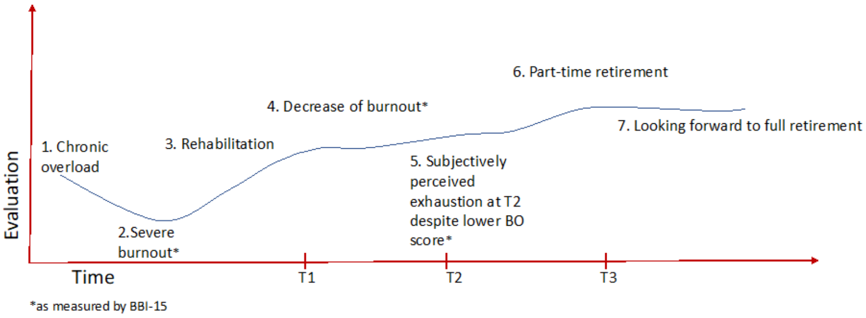
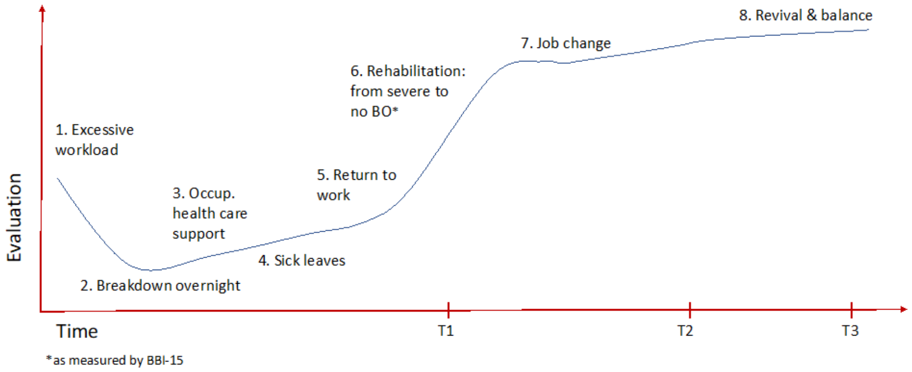


FIGURE 4 Diana’s narrative



*as measured by BBI-15

FIGURE 5 Paula's narrative

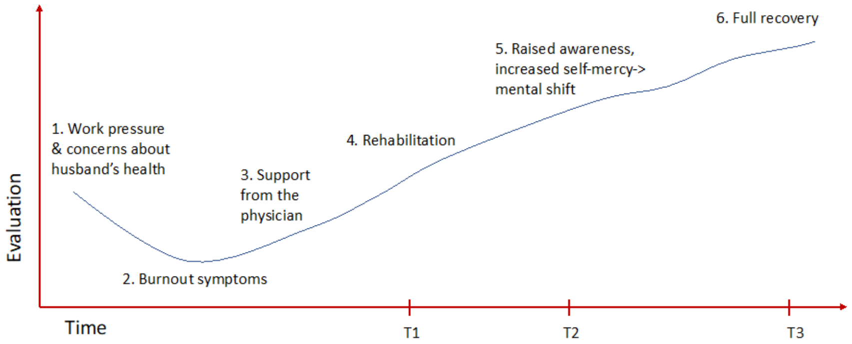


FIGURE 6 Astrid's narrative

TABLE 4 Summary of narratives and spheres of meaning

Participant	*Sara, 57 years*	*Diana, 61 years*	*Paula, 41 years*	*Astrid, 64 years*
Name of the narrative	"Change is the only constant"	"Eyes set on retirement"	"The successful job changer"	"Turning being married to the job into a happy marriage"
Emotional tone	mixture of optimism and disappointment	resignation and fatigue	revival	happy and relieved
Explanatory sphere of meaning	constant changes, no firm ground	work overload and lack of adequate response thereto; physical ailments	excessive workload combined with extreme conscientiousness	own perfectionism
Morally blamed	the lack of stability undermines one's foundations; problems are not taken seriously by management	injustice	work ethic in the childhood family	feeling of insufficiency
Morally praised	daughter and dog	rehabilitation professionals and part-time retirement	rehabilitation	rehabilitation and husband's recovery
Ethically good	presence of support	own work ethic	mental maturation	re-ordering of priorities in life and being reconnected to her family
Ethically bad/evil	being treated without respect; being robbed of professional dignity	perceived injustice	perceived injustice	-

3.3 Study III

Salminen, S., Mäkikangas, A., Kykyri, V-L., Saari, E-L., Pekkonen, M. (2021). Spouses' experiences of rehabilitees' burnout and recovery. Submitted manuscript

Aims. The aims of the study were, first, to investigate the spouses' subjective experiences of the rehabilitees' burnout and recovery, and second, the effect of these two processes on the interspousal relationship, as perceived by the spouses.

Procedure. Study III addressed the experiences of rehabilitees' spouses of burnout and recovery. Ten rehabilitees and their spouses were interviewed in the course of rehabilitation using semi-structured interviews. The interviews covered topics including the spouses' experiences during the burnout phase, their role in the process, the changes they witnessed upon commencement of rehabilitation, their views of the interspousal relationship and their future expectations.

Results. The analysis yielded three themes on the individual level and two on the interspousal level. The individual level comprised Spouse as Safe Haven, Strain on the Spouse and Validation. On the interspousal level the themes identified were: Commitment to the Relationship and Adverse Impact on the Relationship. The themes and the sub-themes are presented in Figure 7 below.

Spouse as Safe Haven was a researchers' construct, i.e., it was not labelled as such by the participants, but was a term ascribed by the authors of the study. It depicts the various roles the spouses played during the burnout phase and refers to their role regarding the future. This theme encompasses three subthemes: Support, Compensation and Prevention. *Support* refers to the various emotional activities the spouses engaged in to be able to comprehend the rehabilitees' suffering. These included listening, comforting and being present for the other one. *Compensation* describes the roles or tasks the spouses performed in order to make up for the absence of the other one. These involved, for example, taking care of under-aged children, cleaning, cooking, attending to the household and paying bills. *Prevention* has a future orientation due to the spouses' unique position of being close to the burnt-out individual, yet still a separate entity. As the spouses were able to gain valuable information and knowledge about burnout, they acquired the skills to monitor changes in the rehabilitees' well-being and signal if burnout symptoms were detectable.

Validation, even if present in one account only, is a particularly significant theme as it summarized the experience of having one's behaviour, position and course of action affirmed. It refers to the opportunity given to spouses to participate in the rehabilitation course on a day designated for them. This opportunity was perceived as particularly beneficial and crucial for the spouses' own mental health.

Strain on the spouse includes *distress* and *realism*. *Distress* describes the reactions caused by the rehabilitees' burnout. These varied from sadness, to helplessness, to frustration and anger. Distress was highest during the most acute phase of burnout and in cases where burnout had led to complications and additional disorders, e.g., depression. *Realism* implies an attempt to protect one's own well-being and possibly dependents' well-being. It includes actions aimed at maintaining healthy habits, distancing oneself from the problem and engaging in hobbies and other free-time activities.

On the interspousal level, *Commitment to the Relationship* contains two sub-themes: Loyalty and New Chances. *Loyalty* is the theme describing the stability of the relationship and the commitment to preserving it despite and in the face of the experienced hardship. *New Chances* is the outcome of cognitive re-evaluation and resorting to meaning-making strategies. It includes finding positive aspects in an adverse event and extracting benefits from an otherwise straining situation.

Adverse Impact on the Relationship comprised the sub-themes Conflict and Stagnation. *Conflict* refers to the tension existing in the relationship and the low threshold for quarrels and fights between the spouses. *Stagnation*, however, is seen as more detrimental as it designated the lack of shared activities and an air of stalemate as a result of burnout. It was most noticeable in the acute phases of burnout and was alleviated when recovery commenced.

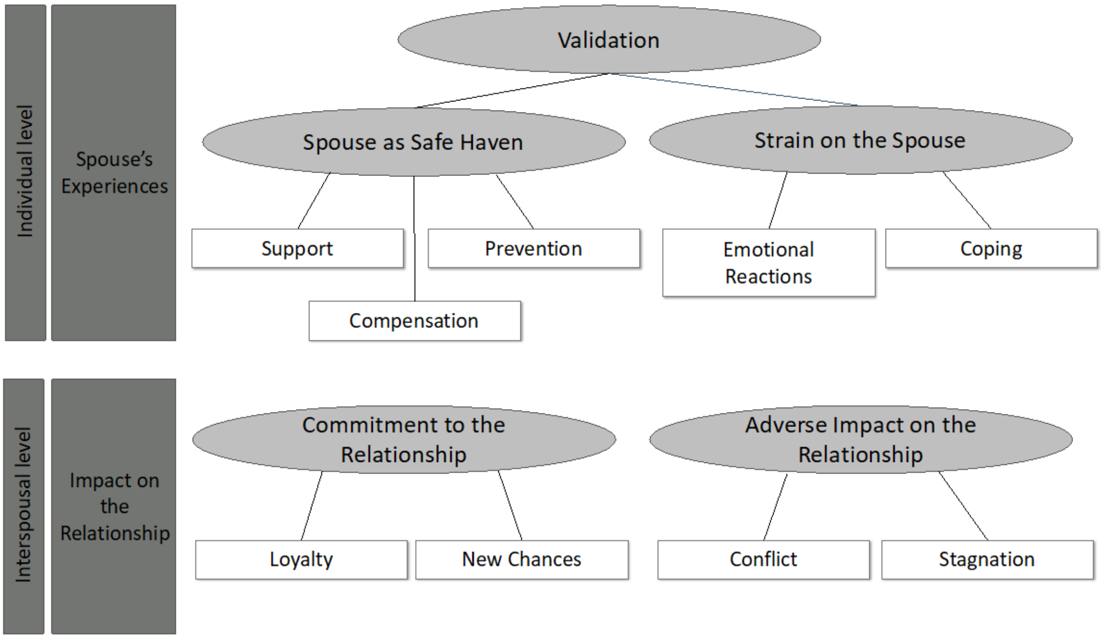


FIGURE 7 Main themes and subthemes, Study III.

4 DISCUSSION

The aim of this dissertation was to explore rehabilitation participants' subjective experiences of recovery from burnout in the short- and long-term. The focus was on the particular factors perceived as facilitating and maintaining recovery during and after the rehabilitation course. A further aim was to investigate spouses' experiences of rehabilitees' burnout and recovery as well as the perceived impact of these processes on the interspousal relationship. The analyses of the datasets yielded the following main results: First, short-term recovery was found to be a cumulative process starting with the acquisition of support and ultimately leading to the realization that an individual holds the key to his/her own well-being. Second, the maintenance of recovery in the long term was not uniform and heterogenous paths were observed, but certain common factors were conducive to the stability of recovery. Third, the restoration of agency was found to be closely linked to recovery whereas discontinued recovery tended to be associated with weak agency. Fourth, burnout affected not only the burnt-out individuals but also their spouses and the set of multiple roles played by the spouses in the process led to an experience of psychological distress. Finally, burnout exerted an effect on the interspousal relationship, but once recovery had started, a re-evaluation of the co-lived hardship resulted in the identification of beneficial outcomes for the relationship.

4.1 Short-term recovery from burnout: a cumulative process

Recovery from burnout is one of the recommended areas of research that warrant further investigation (Hakanen & Bakker, 2017). Given the need to understand recovery more profoundly, it is surprising that there is still a paucity of studies exploring in depth the very process of recovery, its duration, stages and stability. The results of the present research demonstrated that recovery is a cumulative and continuous process involving the accrual of positive factors leading eventually to an experience of commenced recovery. These beneficial factors may be *individual*, including, for example, a mental shift, a more merciful attitude towards oneself, building up psychological resources, e.g., optimism, sense of control and resilience; or *organizational*, e.g. structural changes in the workplace, re-allocation of responsibilities at the workplace, pro-active leadership and taking on additional personnel. In particular, the study showed that recovery commences with the reception of support, continues towards self-awareness and self-approval and culminates in regained joy in life and activities. This process is accompanied by a revelation of being in charge of his/her well-being.

4.1.1 Assuming control of one's own well-being

An important finding in the research was the identification of an overarching theme, *My Well-Being in My Own Hands*, referring, on the one hand, to the realization of being in charge of one's life and well-being, and, on the other hand, to the actions taken to assume control of the various life circumstances affecting health and modifying one's reactions and attitude towards these. This theme is not new *per se*; similar descriptions have been presented in earlier studies in the field. Fjellman-Wiklund et al. (2010) referred to this process as "take charge", while Bremander et al. (2009) described it as "changing one's life plan," and Eriksson et al. (2010) labelled it "taking control of everyday life" to designate the same process. Bullington and her colleagues (Bullington, Nordemar, Nordemar, & Sjöstrom-Flanagan, 2003) used a similar metaphor, "meaning out of chaos" to describe the journey to recovery of chronic pain patients. Likewise, Engebretsen and Bjorkbækmo (2020) found that burnt-out individuals experience an emergence of meaning out of existential chaos. The overarching theme *My Well-Being in My Own Hands* identified in Study I also bears resemblance to the concept of agency (Bandura, 2000), as it implies a belief that individuals, alone or with the help of others or a collective, can influence the environment and achieve their goals. The maintenance of this attitude or strategy for handling stressful situations was instrumental in sustaining the process of beneficial recovery post rehabilitation, as was evidenced in Study II. As reinforcing agency is seen as one of the central goals in rehabilitation, it can be inferred that the rehabilitees were able to achieve this goal while in rehabilitation. The restoration of agency is also viewed in subsection 4.3. below as it is a common characteristic of both short-term and long-term recovery and is a central concept in this study.

4.1.2 The importance of support

In the present dissertation support from family members, rehabilitation professionals and occupational health care was seen as the first key step to recovery, and examples of support were consistently reported by participants. Support provided affirmation of the experiences and reassurance that the burnt-out individuals were not alone in their hardship. The perception of support was achieved by the empathetic attitude and non-judgemental attitude demonstrated by the rehabilitation professionals. The experience of sharing common difficulties and hardship with the peer group strengthened the feeling of not being alone and created an atmosphere of belonging, cohesion and mutual protection. Support from family members served as a source of hope and additional motivation to heal and was thus also viewed as an essential stepping stone on the path to recovery.

The results of the present study are consistent with those of earlier research showing that relationships have a huge potential and lasting influence on the recovery process in severe diseases (Davidson et al., 2005; Topor, Borg, Mezzina, & Davidson, 2006). Social support also reduces the negative effects of stigma and the emergence of depressive symptoms in the caregivers of people with mental health issues (Perlick et al., 2007). Support can originate from different actors and in different communities, and social relationships in particular occupy a central position in recovery (Topor et al., 2006).

Support from rehabilitation professionals and the peer group provided affirmation of the burnout experiences, which in earlier studies has been seen as a starting point of the recovery process (Abedini et al., 2018; Botha, Kaunonen, & Aho, 2014; Bremander et al., 2009; Dyrbye et al., 2010; Eriksson et al., 2010; Fjellman-Wiklund et al., 2010; Topor et al., 2006). Peer support is instrumental in removing shame due to being incapable of taking care of routine everyday tasks (Bremander et al., 2009; Segal, Silverman, & Temkin, 1993). Peer support groups have been found to enhance perceived general health, mitigate the strain by job demands and lead to a higher perceived participation at work (Peterson, Bergström, Samuelsson, Åsberg, & Nygren, 2008). Similarly, Maslach and Goldberg (1998) have found that peer groups provide emotional support and may serve as sources of encouragement.

Earlier studies provide evidence that family support is instrumental in alleviating stress symptoms, mitigating burnout (Galek, Flannelly, Green, & Kudler, 2011) and facilitating successful recovery (Muscroft & Bowl, 2000). Support from family members, along with support received from colleagues, has been found beneficial for recovery among medical students (Dyrbye et al., 2010). Livingston (2014) has also found that emotional support from the spouse reduces burnout to a significant extent, a finding which was especially valid for male burnt-out individuals.

Supervisor support was raised as an essential factor in the post-rehabilitation phase, which was the focus of Study II. Outside the safety of a rehabilitation course, a supportive figure showing understanding for the fragility of recovery and taking concrete actions towards facilitating the return to work was of the utmost importance in maintaining the benefits achieved on the course. This is hardly surprising; the beneficial impact of an empathic communication style and the demonstration of understanding by a manager are considered conducive to return to work (Aas, Ellingsen, Lindøe, & Möller, 2008), whereas sick leaves tend to be more frequent in the absence of such support (Väänänen et al., 2003).

Support promoted the next steps of the process – mainly the increase in self-knowledge and awareness, which led to enhanced self-mercy and self-approval. This is in accordance with prior research indicating the same order of awareness leading to self-approval (Eriksson et al., 2010). The process of recovery culminated in regained joy manifested in rekindled social relationships, renewed interest in hobbies and life and a general sense of well-being and control. The path described by the participants was similar to that described in earlier studies, where the process was also gradual and step-wise (Fjellman-Wiklund et al., 2010). In contrast to the Swedish* study, however, the rehabilitees' accounts in the present research were more anchored to the present moment, whereas future orientation or "Choice of track" was one of the main categories in Fjellman-Wiklund et al.'s (2010) study.

Not surprisingly, support was of significance not only to the burnt-out individuals, but also to their spouses, who were vicariously affected by the other spouse's burnout, as demonstrated in Study III. This underlines the fact that burnout has a wider impact, extending to family members, especially spouses. Placed in the role of supporters to the burnt-out spouse, spouses suffer the negative consequences of having to take over household duties, childcare and at times also financial responsibility, which leads to subjective, interpersonal and family distress as also reported in earlier research (Hjärthag, Helldin, Karilampi, & Norlander, 2010; Peiponen, 2015; van Wijngaarden et al., 2004;). Spouses who participated in the rehabilitation course on the day reserved for them demonstrated solidarity and support for their burnt-out spouses, but at the same time received beneficial support themselves. Thus, support from a peer group and rehabilitation professionals led to validation of their experiences, which was seen by the spouses as particularly beneficial and affirmative, as demonstrated in Study III. Similar effects have been found in earlier studies, although in the context of much more burdensome disorders, e.g. psychosis, where knowledge about the disorder helped the family members to accept the person (Hultsjö et al., 2009). Conversely, the lack of social support and inefficient coping mechanisms may exacerbate the adverse consequences for spouses and other family members (van Wijngaarden et al., 2004).

The present study confirmed the importance of support from different sources in the context of burnout, for both the rehabilitees and their spouses. This finding proves that burnout, although not as detrimental as chronic somatic or severe mental health disorders, necessitates the mobilization of a comprehensive support network, which mitigates the psychological, physical and social damage inflicted by the syndrome and prepares the ground for subsequent recovery.

4.2 Long-term development of recovery from burnout

While recovery from burnout has been largely underexplored, long-term recovery is an almost uncharted area. Study II embarked upon investigating this topic in greater depth by analysing the narratives of four rehabilitees over a two-year period. The results revealed, on the one hand, highly individual and heterogeneous paths to recovery, and, on the other, common factors deemed conducive to the maintenance of recovery across the sample: beneficial organizational changes and supervisors' support; personal factors; and strong personal and proxy agency. These two aspects – heterogeneity of recovery paths and common factors – will be discussed in detail below.

4.2.1 Heterogeneous paths

Two years after rehabilitation the rehabilitation participants shared stories containing changes, successes and setbacks. The recovery process appeared to follow a non-linear trajectory including phases of progress, but also of regression. Outside the realm of a structured rehabilitation course and after a certain period of time, the paths to recovery became more divergent and heterogeneous. The variety of outcomes confirms the finding that burnout is a complex and multifaceted phenomenon as evidenced in other studies (Rutherford & Oda, 2014). On the one hand, participants adopted different strategies: job change vs. no change; exercising personal or proxy agency vs. resorting to no-agency or having their agency rendered ineffective. Participants were still in the throes of change and their stories reflected an attempt to make sense of the new situation and of themselves, trying to integrate old aspects of themselves into new ones, as is common in periods of transition (Adler, 2012).

A change of workplace was not necessarily a guarantee of continued recovery, thus challenging the earlier suggestion by Bernier (1998) and Regedanz (2008). Instead, other factors, such as supervisors' support, family-related factors (e.g. a spouse's health, changes in marital status) had a greater impact on the exacerbation of burnout or continuity of recovery. This is in line with earlier studies suggesting that when favourable occupational factors persist at a low level for an extended period of time, they tend to predispose employees to health-related problems (Hakanen, Bakker, & Jokisaari, 2011; Kivimäki et al., 2002). Such factors may be job control or supervisor support at the workplace, and in the absence or insufficient presence of these, employees may be in a very vulnerable position. In addition, psychosocial factors in the workplace, such as work content, specific job characteristics, interpersonal relations and leadership have been found to affect the development of burnout (Bonde, 2008; Borritz et al., 2005), as was also found in the present study. Exposure to unfavourable characteristics such as role conflicts, lack of work clarity or low predictability may undermine an already commenced recovery and lead to exacerbation of burnout (Borritz et al., 2005), as was found for two of the four participants in Study II.

4.2.2 Stability of recovery depends on several factors

Despite the heterogeneity of individual paths, it appears that the stability of recovery was greatest when organizational and personal factors were conducive to the maintenance of recovery achieved after the intervention. Three distinctive aspects facilitating recovery emerged in the analysis. First, recovery was continued and undisrupted if the participants were met by an understanding and supportive supervisor, who took into consideration the challenges posed by burnout and made every effort to ensure an adequate workload, work tasks matching the capabilities of the employee and sufficient resources. This is in line with earlier findings that burnout interventions tend to be most effective when employees are presented with challenging job demands, but do not struggle with too many hindrance job demands; and in addition have sufficient job and personal resources (Bakker & Demerouti, 2014). Furthermore, it has been demonstrated that the maintenance of subjective well-being is associated with the initially achieved improvement in well-being and alleviation of burnout (Kinnunen et al., 2020).

Second, strong personal agency expressed as an active agentic attitude towards one's healing and a belief in the ability to affect one's well-being promoted a path to continued recovery. The stability of recovery was an outcome of conscious and deliberate exercising of skills acquired on the rehabilitation course, for instance, self-mercy, self-approval and recognition of one's own needs and limits. Agency was thus associated with a perceived improvement in wellbeing, although the relationship may be reciprocal, i.e. improved well-being may reinforce a sense of agency. This concurs with earlier research that increases in agency correlate with improved mental health (Adler, 2012), well-being (Gallagher, 2012) and recovery of occupational functioning (Polkinghorne, 1996). In this research, recovery was also facilitated and accelerated when proxy and collective agency were strong. This implies that individuals have sufficient trust in structures that may be instrumental in changing their work environment, confirming the assumption that resources are needed first in order to engage in job crafting (Bakker & Costa, 2014). Therefore, an attempt to modify one's work environment has as a pre-requisite the accumulation of psychological resources, for example, on a rehabilitation course. Hakanen and Bakker (2017) comment that interventions tailored to the preferences and abilities of employees may hold promise for the prevention of burnout, because through job crafting employees optimize their job demands and job resources and increase their personal resources.

Finally, the participants' personal domain including own or family members' good health and functioning interpersonal relations played a part in the maintenance of recovery. Disruptions in the personal sphere, such as a divorce, poor health of a family member, and special needs of children, may slow down or impede recovery. This underlines the need to view individuals holistically and not merely as entities unaffected by events outside the work domain.

4.3 Restoration of agency and the presence of nonagency

As posited earlier, one of the primary goals in rehabilitation is to strengthen individuals' agency (Järvikoski et al., 2013). References to examples of regained agency were made above in discussing the short- and long-term recovery processes, but as agency is a central concept in the present study, it deserves discussion in a separate section. The participants in Studies I and II gave ample evidence of the achievement of this objective, not only for the duration of the rehabilitation course, but also to a considerable extent thereafter. The restoration of sense of agency to counter the feeling of disempowerment so common in burnout (Regedanz, 2008) was a prominent element in the stories of recovery. All three forms of agency – personal, proxy and collective – were discernible in the accounts of the recovery process. The enhancement of personal agency was evident in the participants' efforts to adopt a healthier lifestyle in which work demands were counterbalanced by taking care of one's own well-being through exercise, healthy nutrition and increased sensitivity to the needs of one's body and mind. By adopting an active, agentic attitude and viewing themselves as capable of recovering, the rehabilitees took advantage of the lessons learnt in rehabilitation and reported improved well-being in a manner similar to that reported in psychotherapy research (Coleman & Neimeyer, 2015).

Proxy agency, i.e. turning to others with sufficient influence and ability to make changes to act on one's behalf, was visible in the rehabilitation phase, when participants relied on professionals' expertise to learn about the syndrome of burnout, to receive validation and to reinstate their feeling of self-confidence. Proxy agency was especially pronounced in the post-rehabilitation phase, when participants could not lean on a structured and protected environment and were expected to transfer the lessons learnt to their work and personal domains. Relying on a supervisor's support in order to achieve modifications to the work environment, a more reasonable workload, or work tasks better matching the individual's competences, is an apt example of exercising proxy agency. Proxy agency can also find expression in job crafting (Hakanen & Bakker, 2017), i.e. employees can resort to other people with influence – for example, colleagues and/or supervisors – to modify their work environment or immediate tasks.

Collective agency was seen in the participants' references to the power of peer groups, group spirit and the experience of affirmation received in group discussions. Participants reported staying in contact with their group members and thus receiving continuous affirmation of their experiences, gaining motivation to make changes in their professional or personal lives, and maintaining a sense of belonging.

As presented in the introduction, agency is identifiable not only in its positive, active form, but also in its inactive, absent form. Weak agency or nonagency was an important finding in the analysis of the long-term development of recovery. It appeared that those participants who did not exercise personal or proxy agency, or whose efforts to exercise it were rendered ineffective by external factors, were not able to maintain the course of recovery, i.e. they experienced an increase in burnout symptoms. They reported not being able to change their work environment and make changes that might lead to improvements in their well-being. It may also be that the participants who did not view themselves as capable of healing did not invest time and energy in efforts to improve their current state and consequently reported an increase in burnout symptoms. Such an example was the anticipation of retirement in Diana's narrative, which would remove the fundamental cause of burnout.

However, due to the small sample, it remains unclear whether exacerbation of burnout symptoms hindered the exercising of agency or if lack of agency in the first place prevented participants from maintaining their recovery (Polkinghorne, 1996). A larger sample and a quantitative approach with a longer follow-up period may be warranted as this could help reveal causal relationships between burnout and agency.

4.4 Spouses' experiences of burnout and recovery

4.4.1 The multiple roles of the spouse in the process

The analysis of the interviews showed that spouses played a major role in the recovery process. Although burnout is not as incapacitating as mental health disorders or somatic diseases (Kuhlman, 2013; Rautiainen, 2010; Sales, 2003; Stengård, 2005), it placed a substantial burden on the spouses of the burnt-out individuals. In line with Schene's framework (1990), spouses experienced both objective and subjective burden. A big share of their time and energy was devoted to being present and listening to the burnt-out spouse, providing support and comfort - a role that taxed their emotional resources. Earlier studies have likewise noted this major role, not only in the context of burnout, but also for more complex and chronic diseases (Ericson-Lidman & Strandberg, 2010; Hultsjö et al., 2009; Peiponen, 2015).

Spouses took over a considerable share of household chores, which was labelled as *Compensation*. This finding is in line with those of earlier research reporting similar outcomes. The role of assuming greater responsibility for household related matters was labelled *Household Routine* in Schene's framework (1990), and Ericson-Lidman and Strandberg (2010) referred to it as *Shouldering responsibility for the household*. It was particularly pronounced in the most severe phases of burnout, which shows that the impact of severe burnout approximates that of a serious mental health disorder (e.g. schizophrenia) or a somatic disease (e.g. cancer) regarding the extent of debilitation it causes. In addition, this finding highlights the importance of recognizing and validating burnout as a serious threat to the working-aged population, but also to people related to burnt-out individuals. At the same time, the very fact of taking over additional responsibility merits further attention as spouses may inadvertently contribute to maintaining a vicious cycle of excessive commitment to work, which exacerbates rehabilitees' burnout. Such outcomes have been reported, for example, in studies on workaholism (Robinson, 1998).

Spouses played a role in the *prevention* of future recurrence of burnout. This was enabled, on the one hand, by their position as external observers of the burnout process, and, on the other by their unique status as co-participants and co-creators in these same processes. Thus, once familiar with burnout symptoms, they were able to recognize subtle changes in the state of their burnt-out spouses, sensitize them to these and play a decisive role in encouraging them to seek timely help from professionals. Nevertheless, prevention did not come automatically and difficulties in recognizing burnout symptoms have been reported previous (see, e.g., Ericson-Lidman & Strandberg, 2010; Peiponen, 2015).

4.4.2 Experienced distress and boundary setting

Spouses experienced a great amount of distress in the process of being pillars of support. The spectrum of emotional reactions ranged from bafflement and helplessness to sadness, frustration and anger. Such reactions are common among carers of sick relatives and research provides evidence of their existence (see Ericson-Lidman & Strandberg, 2010; Fadden, Bebbington, & Kuipers, 1987; Gonçalves-Pereira, Xavier, & van Wijngaarden, 2013; Peiponen, 2015; Tsang, Tam, & Chan, 2003; van Wijngaarden et al., 2004). Particularly in cases of mental health disorders, spouses tend to experience psychological distress expressed as worrying about the patient's health, financial stability and outcomes of treatment combined with urging the patient to seek help (Gonçalves-Pereira et al., 2013; van Wijngaarden et al., 2004). The intensity of the psychological distress usually correlates positively with the severity of the mental health disease, and is particularly pronounced when the functioning capacity of the patient has diminished. Burnout as such does not cause incapacitation similar to that, for example, in psychotic disorders, but prolonged burnout can lead to depression, which increases the burden on caregivers, as shown in earlier studies (van Wijngaarden et al., 2004). Usually, after a certain period of time, spouses resorted to actions that either protected them against the emotional burden or provided them with a source of personal pleasure. The spouses in Study III reported distancing themselves, setting boundaries and adopting a stance of healthy egoism in order to preserve their own mental health. Ericson-Lidman and Strandberg (2010) refer to this action or attitude as *Re-energizing and finding strength.* As spouses' health is usually affected by individuals' burnout (Bakker, 2009), the actions towards maintaining or regaining one's well-being seem logical, and deter or delay further deterioration.

4.5 Impact on the interspousal relationship

The impact of burnout on the interspousal relationship was not unidimensional and unambiguous. In the most acute phases of burnout, the negative impact was more pronounced. The results are comparable with the effects of depression on caregivers (Fadden et al., 1987), especially in the phase of acute burnout or when burnout was accompanied by or had led to the development of depression. This appears to be in line with research on caregivers' experiences. Relational strains were found in families where a member suffered from depression (van Wijngaarden et al., 2004). A later study also concluded that interspousal tensions are more commonly experienced by caregivers of depressed individuals than, for example, of individuals with psychotic disorders (van Wijngaarden et al., 2009).

In moderate burnout such effects were less pronounced, which may suggest that in such cases the burden on spouses is lower. The adverse impact was expressed as interspousal conflict and stagnation, the latter being considered even more detrimental to the relationship than conflict. Spouses shared that the prolonged duration of burnout and the incapacity of the burnt-out spouses to perform routine tasks lowered the threshold for conflict. It has been shown that interspousal conflict is a common result of prolonged stress (Randall & Bodenmann, 2009; Timmons, Arbel, & Margolin, 2017). However, conflict in this sample was considered more obvious consequence, which was only briefly mentioned in the accounts.

Stagnation, on the other hand, was reported to be much more detrimental as it robbed the couple of the opportunity to spend quality time together. The experience of making suggestions and taking the initiative to organize common time was particularly exhausting and demotivating, despite a rational understanding of the reasons behind rehabilitees' declining any offers of something pleasurable. These outcomes are consistent with those reported in earlier research. The consequences of lack of time spent together have been discussed in the literature. Peiponen (2015) observed similar distancing from social activities by burnt-out individuals, and Ericson-Lidman and Strandberg (2010) referred to these as *Being constrained in everyday life*. This category implied spouses' giving up leisure activities and social engagements in order to be closer to the burnt-out spouse. In the present study, stagnation was viewed as harmful on both an individual and interspousal level, as it appeared that withdrawal from social life or foregoing enjoyable activities led to sustaining burnout instead of overcoming it. Thus, some initial decrease in burnout symptoms was necessary to counteract the air of stalemate and constraint that pervaded the relationship and this could be achieved once the most acute phase of burnout was overcome.

In light of the two main consequences discussed above – conflict and stagnation, it may seem somewhat contradictory that participants did not find the effect on the relationship to be excessively detrimental. The theme *New Chances* reflected this aptly. Similar results have been obtained earlier (van Wijngaarden et al., 2004), which suggest that spouses may also give socially desirable responses. However, such a finding may be the result of a specific coping mechanism: in the stage of recovery the spouses were able to employ more meaning-focused coping strategies (Folkman & Moskowitz, 2000) as they analysed the impact of burnout on the interspousal relationship. This type of coping is typical when an individual cannot make objective changes to the status quo and resorts to cognitive re-evaluation, which entails a proclivity towards searching for the meaning of the lived suffering. The spouses were thus able to find positive outcomes from an otherwise wearing and detrimental experience. For example, they reported that the shared hardship had opened a door to more frequent and effective communication between the spouses, an increased openness and mutual trust that were strengthened in the face of a common adversity. Many spouses also re-stated their conviction that marriage was sacred and they were willing to support the burnt-out spouse as this was a natural course of action in a steady marital union.

4.6 Methodological considerations and evaluation of the research

4.6.1 Research methodology

Qualitative research methods were chosen as the study aimed to answer questions related to the subjective experiences of burnout and recovery. Semi-structured interviews were considered an appropriate method for capturing participants' experiences of recovery both on the rehabilitation course and during the follow-up period. This type of interview was also seen as appropriate for eliciting the spouses' experiences of the rehabilitees' burnout and recovery. The use of a qualitative approach gives an opportunity to reveal something that has not yet been discovered, but which may be equally significant and tested in future quantitative research. Qualitative research also enables the free, unrestricted exploration of human experience (Bell, 2002) and the recognition of this experience as a source of knowledge (Clandinin, 2013).

Content analysis and thematic analysis were chosen for Study I and Study III as they enabled the identification of topics in a previously underinvestigated area (see Braun & Clarke, 2006, p. 83). These two types of analyses have much in common and may sometimes be difficult to distinguish as separate methods, thus leading to the interchangeable use of the terms. The analyses of the datasets in each of these two studies were conducted by following the instructions given by the authors of each of these analytical methods (Braun & Clarke, 2006; Krippendorff, 2012) at the time of writing the articles. Content analysis tends to adopt a more quantitative approach to qualitative data by utilizing frequency counts (Wilkinson, 2000) and uses single words or phrases as meaningful units, whereas themes usually reflect the content of the entire dataset (Braun & Clarke, 2006, p. 83). In accordance with this, a more quantified version of content analysis was applied to the dataset in Study I, and a criterion was set that a meaningful unit should be mentioned in a minimum of three interviewees in order to be recognized as a pattern common across participants. In contrast, in Study III, where thematic analysis was applied, no such requirement was set. As a result, a theme based on one account only (*Validation*) was identified due to its 'keyness' (see Braun & Clarke, 2006, p. 82), i.e., its significance for the research topic of interest.

For Study II, narrative analysis (Riessman, 2008) was seen as a particularly suitable method, as the dataset contained the stories of four participants, collected at three different points and viewed as the three parts of a narrative. This type of analysis probed the depth of the accounts and enabled the voicing of individual experiences and exploration of deeply ingrained spheres of meanings interwoven in the narratives, which had the potential to reveal aspects of individuals and their worldviews (Patton, 2015).

The study also utilized self-report data collected by BBI-15 (Näätänen et al., 2003). As the participants were recruited in a rehabilitation context in Finland, the choice of a measurement tool was pre-determined by practices in occupational health care. The BBI-15 is a measure that has been validated among Finnish employees (Näätänen et al., 2003), has good reliability (Salmela-Aro et al., 2011) and is commonly used in the context of occupational health care and rehabilitation. However, it is worth noting that, in addition to drawing upon the theoretical definition of burnout and using a validated scale for measuring it, the rehabilitation centre psychologist's expertise was utilized in determining eligibility for participation in the studies.

4.6.2 Credibility

Participants in the studies were selected from different rehabilitation groups to reduce groupthink (Denzin, 1970), which may develop due to increased group cohesiveness typically encouraged in burnout rehabilitation. Researcher triangulation was used in all three studies. The interviews in Studies I and III were conducted by independent interviewers, who were master's students of psychology. The authors of the individual studies discussed the interview transcripts and codes until consensus was reached on the codes. Method triangulation was also applied in all three studies with the aim of increasing the validity and reliability of the research. It was based on: a self-report questionnaire BBI-15 (Studies I, II, III); an electronic questionnaire (Study II); semi-structured interviews (Studies I, II, III); and interviews with the burnt-out individuals to contextualize the interviews with their spouses (Study III).

4.6.3 Ethical considerations

The appropriate permission for the research was requested from the ethics committee of the University of Jyväskylä, Finland and granted for Studies I and II. Study III was approved by the chief physician of the rehabilitation centre upon examining the rationale and aims of the study as well as the data collection documents. The rehabilitation centre psychologist was a liaison officer in all three studies and was responsible for introducing the studies to the potential participants and providing them with oral and written information. Participants in the studies were informed continuously of the voluntary nature of participation, and of the confidentiality and anonymity of personal data. Consent forms were signed prior to the interviews and participants were also notified of their option to discontinue their participation at any point. Audio recording was conducted only with participants' explicit consent. The interviews were conducted individually, with no rehabilitation centre personnel present. Results were presented with special attention to preserving the anonymity of participants in accordance with the guidelines provided by the Finnish National Board on Research Integrity (TENK) and the Data Management Guidelines, Finnish Social Science Data Archive. This entailed pseudonymization of data, anonymization of certain distinctive features that might lead to recognition of the participants and, particularly in Study II, omission or modification of direct identifiers that might otherwise compromise the anonymity of the participants.

4.6.4 Limitations

This research has some limitations that need to be mentioned. Due to its qualitative design, the results of the studies constituting this dissertation make no claim of generalizability to wider population (Patton, 2015). Instead, the contribution of this type of research is to uncover topics and issues that may easily be overlooked in quantitative research, but may nevertheless be meaningful and worthy of further investigation.

First, semi-structured interviews, although deemed particularly appropriate for the purpose of the studies, may inadvertently affect the participants' accounts by steering them in a certain direction. Although every effort was made to ensure uniformity of guidelines regarding the interview situation, the use of several interviewers with different interviewing styles is also to be taken into account, as this may have had an influence on the flow of the interview.

Second, the samples were fairly small, which is common in this type of research exploring subjective experiences. The participants in the first two studies were predominantly female and while this reflects the common gender distribution in the rehabilitation context in Finland (Hätinen et al., 2009; Hätinen, Kinnunen, Pekonen, & Kalimo, 2007; Hätinen et al., 2013), it is crucial to note that the experiences of recovery described in Studies I and II are mostly pertinent to middle-aged women in Finland. Male rehabilitees' burnout experiences remain still unexplored, as male participants are typically underrepresented on these rehabilitation courses, largely because men are more reluctant than women to seek help for psychological stress, including burnout (Ahola et al., 2008; Oliver, Pearson, Coe, & Gunnell, 2005).

Third, Study II was a pilot study which utilized purposeful sampling to select the participants. Thus, despite its contribution to the understanding of long-term recovery, the results may reflect the experiences of these particular individuals and not be transferrable to larger groups or entire populations. Therefore, further longitudinal studies with larger samples are needed in order to gain a better picture of the stability of recovery and the various phases it may go through before full convalescence is achieved.

Fourth, the rehabilitation context in which the studies were conducted most likely exerted a substantial influence on the experiences of recovery. In Studies I and II, only participants whose burnout scores had diminished were selected for the study as the aim was to explore successful recovery. Different results may have been elicited if all participants in the rehabilitation courses for burnout had been interviewed. Furthermore, rehabilitation provided scaffolding to the couples who opted to participate in Study III. The partially positive results shared by the spouses may in reality be attributable to the burnt-out individuals already being part of a recognized rehabilitation course intended to provide support not only to the rehabilitees, but also to their family members. A study conducted outside such a context may indeed reveal different, and supposedly more negative, consequences of burnout and family burden.

Fifth, a limitation labelled *selection bias* has to be recognized; only couples with a functional relationship volunteered to participate in the study, which may have skewed the results. The results might have been different if the data collection process had been different, i.e., if the spouses of all burnt-out individuals had been interviewed. Additionally, spouses may on certain occasions have given socially desirable responses and refrained from revealing overly negative consequences of rehabilitees' burnout.

Sixth, the rehabilitees in Study III had additional conditions besides burnout, and thus the spouses' accounts may have referred to the effect of these co-morbid conditions, which rendered their experiences more wearing and complex. This underlines the difficulties in differential diagnostics and the fact that burnout is often associated with depression (Ahola et al., 2014), and that prolonged and untreated burnout may lead to clinical depression (Bianchi, Schonfeld, & Laurent, 2015; Hakanen & Schaufeli, 2012) or anxiety (Koutsimani, Montgomery, & Georganta, 2019).

Finally, as recognized on numerous occasions, burnout rehabilitations combining person-oriented and organization-based approaches appear to be most effective in alleviating burnout (Awa et al., 2010; Morse et al., 2012). The participants in the three studies conducted were recruited from rehabilitation courses, which focus on increasing and strengthening individual resources. However, recovery requires specific changes in the workplace in addition to enhancing psychological resources, thus exploring the modification of job characteristics, improvements in the leadership style, communication and supervision is crucial in order to understand the full spectrum of factors conducive to recovery.

4.7 Avenues for further research

Although research on burnout has continued for over forty years, many areas still remain unexplored. Recovery from burnout is a line of research that deserves much more attention than it has so far received (Hakanen & Bakker, 2017). Varied and innovative methodological approaches applying a longitudinal design with sufficient time lags should be used to reveal the drivers of recovery and validate the findings across larger data sets. The results of the present study confirmed the essential role of agency and recovery strategies. The role of recovery strategies as mediators from job demands to ill-health as well as from job resources to work engagement has been recognized in earlier research (Kinnunen, Feldt, Siltaloppi, & Sonnentag, 2011) and they have been included as important buffers between job demands and job strain in the Job Demands-Resources theory (Bakker & Demerouti, 2014; Bakker & Demerouti, 2017; Bakker & de Vries, 2021). Therefore, the investigation of these strategies in the context of recovery from burnout appears to be a justifiable line of research.

Personal resources have been typically seen as important in the motivational path leading to work engagement (Bakker & Demerouti, 2017) but the results of the present study also suggest that agency as a personal resource may play a role in the health impairment process, i.e., from job demands to burnout. Thus, active and strong agency may have a protective function even when job demands are high and job resources are low, whereas in the presence of weak agency job demands can become stressors leading to energy depletion and subsequently to burnout. Agency may also have a direct effect on reducing burnout symptoms, and such effects should be considered more closely in future research. It is also conceivable that agency as a concept may describe an individual's actions more broadly than the typically studied self-efficacy.

The results also revealed prioritization and reorganization of life values as significant drivers to recovery, which has been recognized in the literature on burnout (see e.g., Kinnunen, 2020), but not in the JD-R model. Thus values, value pondering and work with values may be included as personal resources in the JD-R model as they seem central to protecting individuals from burnout as a result of high job demands and especially in the absence of job resources.

Future studies should use a combination of research methods, combining the strengths of a rigorous quantitative study design with the valuable contribution to understanding subjective processes afforded by qualitative research methods. Currently, challenges related to the definition, operationalization and recognition of burnout as an occupational health disorder across industries impedes productive cross-national co-operation yielding comparable findings. Co-ordination of research on a national and even European level could potentially produce an unprecedented body of knowledge that might help both scientists and practitioners to understand, prevent and combat burnout more effectively.

Studies have so far been conducted in a given organization or within a particular context. Research should try to reach those outside the realm of structured interventions, as the intervention context provides scaffolding, structure and guidance, but may miss those who are most susceptible to the negative effects of burnout and who do not have access to occupational health care or rehabilitation courses. Furthermore, in future studies, it will be important to distinguish between groups of burnt-out individuals exhibiting severe symptoms and requiring timely intervention (e.g., sick leave and/or rehabilitation) and those experiencing mild burnout, who may have retained their working capacity, but may nevertheless be susceptible to deterioration unless provided with adequate support. These distinct groups most likely require different modes of response measures in terms of content and frequency and comparative studies may reveal the specific factors most effective in alleviating burnout at various levels of severity.

More diverse samples in terms of gender and age should be used in future studies. Even though the dataset included in Studies I and II reflects the typical gender distribution on rehabilitation courses, it is crucial to include the perspectives and experiences of male rehabilitees, as certain differences are to be observed in the intensity of experienced burnout dimensions (Purvanova & Muros, 2010) as well as in the propensity to seek help (Oliver et al., 2005). Exploration of burnout incidence and recovery strategies among various age groups is a worthwhile line of research, as different approaches to tackling burnout may be adopted by employees in mid-career compared to employees nearing the end of their career paths.

Furthermore, individuals who do not benefit from interventions should also be identified and the specific factors inhibiting recovery should be analysed and, if possible, removed, as differences in subjective well-being between those who initially benefit and those who do not most likely do not diminish over time (Kinnunen et al., 2020). In addition, more focus should be directed towards those who are not part of the labour market, on sick leave or unemployed (Hakanen & Bakker, 2017). Studies show that recovery is heterogeneous (Hätinen, 2008; Siltala et al., 2016), which may necessitate tailored approaches to burnt-out individuals depending on their employment status, the nature of their work, and personal factors.

As Study III demonstrated, spouses are affected by the processes of burnout and recovery. Although outside the realm of the present research, the need for investigating children's experiences was recognized and future studies should focus on this particular aspect. Effects on children have been identified in samples including individuals with depression (van Wijngaarden et al., 2004) and it is conceivable that burnout may lead to similar, if not equally intensive, outcomes. Studying the impact on family members, including children, may offset the negative effects on the most vulnerable members and potentially reveal hidden potential essential for the recovery of burnt-out individuals.

4.8 Conclusions and recommendations for practice

Based on the studies in the present research, it can be concluded that rehabilitation courses were useful for burnt-out individuals, as they provided support, expertise and affirmation of the experiences. The structure and protective environment of the courses led to a positive spiral of resources (Hobfoll, 1989; Hobfoll, 2012), in which support led to increased awareness and enhanced self-approval. Upon gaining sufficient resources, rehabilitation participants were able to regain their joy in life and interest in social contacts.

Regarding the long-term perspective, it is warranted to claim that burnout typically develops in a similar mode across individuals, including hindering job demands, unclarity in the workplace and lack of supervisors' support. The paths of recovery are, however, heterogeneous, as a multitude of different factors affect the outcome. It appeared that the most favourable path was observed when personal agency was strong, the employee received sufficient organizational support, for example, from the supervisor, and other life domains – family and health - facilitated recovery.

Spouses were also an important element to be considered in recovery. Even if burnout is not as debilitating as mental health disorders or somatic diseases, it may, in its most severe forms, put a significant burden on spouses and impair their own physical and mental health. Spouses' inclusion in rehabilitation was perceived as beneficial and these benefits should be strongly highlighted in national policies. The interspousal relationship was affected to some degree, but a strong prior foundation of the relationship offsets to a substantial extent the negative effects of burnout. In addition, it merits attention that burnout did not yield only negative consequences. Particularly in the phase of recovery, the beneficial effects of a hardship lived through together were recognized by the spouses, and positive outcomes such as improved communication and increased openness were reported.

As mentioned on several occasions, recovery from burnout is a viable and highly recommended line of research in the future. Scientific communities in Europe may be able to explore the phenomenon of burnout more systematically and in a more consistent form if burnout becomes recognized as a syndrome jeopardizing occupational health across fields and professions, without considering it limited to the human service professions, as in some EU countries (e.g., Bulgaria, see Eurofound report, 2018, for more details).

On a practical level, several recommendations can be made. First and foremost, awareness of burnout symptoms and paths should be raised in workplaces. Despite the ubiquity of burnout and its increased media presence, particularly in recent years, the concept continues to be shrouded in mystery, and differentiating it from other disorders, notably depression, causes controversy even today (Heinemann & Heinemann, 2017). Managers need to be more aware of the risk of burnout antecedents (Alarcon, 2011), which can be achieved through dissemination of information and on-target trainings. Focusing on early support in the workplaces is recommendable in order to identify individuals at high risk of burning out and to prevent severe burnout and the associated negative consequences such as long sick leaves, work disability and early retirement. Societal policies, financial incentives and practical guidance for workplaces actively engaging in early support for and prevention of burnout may lead to an increased interest and to a spread of such initiatives. Additionally, work communities and fellow employees should also be able to recognize the symptoms of burnout as they can be a source of valuable social support that can be seen as a job resource (Demerouti et al., 2001; Hobfoll, 1989).

Supporting burnt-out individuals in their return to work may require the concerted efforts, for example, of human resource professionals, return-to-work coordinators, occupational health care and management (Kärkkäinen, 2019). The demarcation of the roles of each of these actors will most likely lead to better allocation of resources and avoidance of overlapping activities. It is simultaneously crucial to keep in mind that burnout patients do not necessarily return to the levels of functioning as in normal samples, i.e., exhaustion, psychological distress and depressive symptoms continue to be on elevated levels even after treatment (van Dam, Keijsers, Eling, & Becker, 2012). Thus, rehabilitees need certain changes in the workplace that can be executed should a sufficient understanding of the processes of burnout and recovery be reached. The significance of these changes should be elucidated and underlined to management to allow for top-down processes, but employees can also be encouraged to engage actively in job crafting long before burnout symptoms start to develop.

Hybrid interventions combining person-based and organization-based approaches may be the most effective in combatting burnout. Most recent studies speak in favour of mindfulness, acceptance and value-based (MAV) approaches and those applying third-wave cognitive-behavioural psychotherapeutic methods, for example, Acceptance and Commitment therapy (ACT) (Dindo, van Liew, & Arch, 2017; Khoury, Sharma, Rush, & Fournier, 2015; Reeve, Tickle, & Moghaddam, 2018). MAV interventions seem to be beneficial even in severe burnout, thus making the development of such skills a viable treatment option (Kinnunen et al., 2019). Psychological flexibility has also been found to be associated with enhanced well-being at work (Puolakanaho, Tolvanen, Kinnunen, & Lappalainen, 2018). Among the mindfulness skills, in particular, a non-judgemental attitude seems to be the skill that affects beneficially all three dimensions of burnout (Kinnunen, 2020), and therefore its learning should be encouraged and reinforced in interventions.

Although interventions for burnout carry potential, the effects established are in many cases marginal (Ahola et al., 2017; Wallensten et al., 2019), which calls for more effective *pre*vention instead of *inter*vention once burnout has developed (Walsh et al., 2019). Such interventions should also tackle deficiencies in resourcing and leadership by aiming to improve staffing levels and enhance management and leadership skills, as summarized by Johnson et al. (2018). Organizations can also adopt more proactive approaches and strive consciously to improve the psychosocial safety climate (PSC), i.e., shared perceptions of work practices, procedures and policies reflected in management commitment, organizational communication and organizational participation to safeguard employees' psychological health and safety (Dollard & Bakker, 2010). As PSC has been shown to play a vital role in decreasing burnout, minimizing workaround behaviours and reducing unsafe practices (Mansour & Tremblay, 2019), it appears to be an effective route to alleviating stress and burnout. Combatting burnout may also call for more robust political decisions and labour market improvements, such as working hours regulation, employee protection and requirements for early support programmes, as burnout is essentially an occupational disorder.

As Study III demonstrated, the inclusion of spouses in rehabilitation courses is a highly recommended course of action as support from rehabilitation professionals and the peer group reduced the negative effects of burnout and had a protective function for family members. Therefore, in the future, their role in the overall process of recovery should be recognised and given the attention it deserves.

YHTEENVETO (SUMMARY)

Työuupumus on stressiperäinen tila, jota luonnehtii uupumusasteinen väsymys, kyynisyys ja alentunut ammatillinen itsetunto (Maslach, Jackson, & Leiter, 1996). Tutkimuksessa on pitkään kiinnitetty huomiota työuupumuksen syihin, oireisiin ja seurauksiin (Schaufeli & Enzmann, 1998; Schaufeli, 2000). Tutkimus on osoittanut, että työuupumus on melko krooninen tila hoitamattomana (Hätinen, 2008; Mäkikangas & Kinnunen, 2016; Schaufeli & Enzmann, 1998). Työuupumusinterventiot voidaan luokitella kolmeen ryhmään: yksilösuuntautuneet (jolloin työuupumusta hoidetaan erilaisin rentoutus- ja tietoisuusmenetelmin, kognitiivis-käyttäytymisterapeuttisin keinoin ja lisäämällä itsehyväksyntää ja itsearmollisuutta); organisatoriset (jolloin toteutetaan muutoksia työpaikalla, muutetaan työrakenteita ja parannetaan tiimin toimivuutta, johtajuutta ym.); ja näiden kahden yhdistelmä (Schaufeli & Enzmann, 1998). Systemaattiset katsaukset ja meta-analyysit eivät ole tuottaneet yksiselitteisiä todisteita tietyn interventiotyypin tehokkuudesta muihin verrattuna. Esimerkiksi Dreison ym. (2018) totesivat, että yksilökeskeiset interventiot ovat tehokkaampia kuin organisaatiosuuntautuneet, kun taas Westin ja kumppaneiden (2016) mukaan molemmat interventiot tuottavat samansuuntaisia tuloksia tai organisaatiokeskeiset ovat tehokkaampia (Awa ym., 2010; Westermann ym., 2014). Suomalainen tutkimusryhmä puolestaan päätteli, että yksilökeskeisillä interventioilla ei ole vaikutusta työuupumuksen lievittämiseen (Ahola ym., 2017).

Suomessa työuupumukseen on tarjottu kuntoutuskursseja työssäkäyville, joiden työkyky on ollut vaarantunut. Kuntoutusinterventioilla on Suomessa pitkät perinteet. Taloudellinen tuki sekä työpaikan säilyminen kuntoutuksen aikana ovat tekijöitä, jotka toimivat kannustimena hakeutumisessa kuntoutuksen piiriin.

Vaikka työuupumusta on tutkittu suhteellisen pitkään ja laajasti, toipuminen siitä on edelleen alue, joka vaatii lisää tutkimusta. Tämän tutkimuksen tavoitteena oli tutkia yksilöllisiä kokemuksia työuupumuksesta toipumisesta kuntoutuskontekstissa. Tutkimuksessa selvitettiin työuupumuksesta toipumisen kokemusta kuntoutuskurssin aikana ja kaksi vuotta sen päättymisen jälkeen. Kolmantena tavoitteena oli tutkia työuupuneiden puolisoiden kokemuksia sekä työuupumuksesta että toipumisprosessista. Lisäksi tutkimus pyrki selvittämään miten nämä prosessit – työuupumus ja siitä toipuminen – vaikuttavat puolisoiden väliseen suhteeseen puolisoiden kokemana.

Osatutkimus I tarkasteli kahdentoista kuntoutujan kokemuksia toipumisesta kuntoutuskurssin aikana. Kuntoutujat rekrytoitiin tutkimukseen kolmelta eri kuntoutuskurssilta eräästä Keski-Suomen kuntoutuskeskuksesta. Kriteeri tutkimukseen osallistumiseen oli työuupumuspisteiden laskeminen ainakin yhdellä luokalla. Muutokset työuupumuspisteissä mitattiin Bergen Burnout Indicator (BBI-15) -kyselymenetelmällä (Näätänen ym., 2003). 15:sta soveltuvasta kuntoutujasta 12 antoi suostumuksensa tutkimukseen ja heitä haastateltiin puolistrukturoiduilla haastatteluilla ensimmäisen ja toisen kuntoutusjakson välisenä aikana. Haastattelut pohjautuvat erilaisiin teemoihin: työuupumuksen historia, saatu apu työterveyshuollosta, kokemukset kuntoutuskurssista, havaitut merkit toipumisesta sekä toiveet ja odotukset tulevaisuudesta.

Tulokset osoittivat, että kuntoutujat hyötyivät kuntoutuskurssista. Sisällönanalyysi (Krippendorff, 2012) tuotti yhden yläteeman, Hyvinvointi omissa käsissäni, ja neljä kategoriaa: tuki, tietoisuus, hyväksyntä ja palautunut ilo. Yläteema kuvasi toipumisen kokonaisprosessia fyysisine ja psyykkisine muutoksineen ja ilmaisi kuntoutujien kokemaa oivallusta, että he itse ovat vastuussa omasta hyvinvoinnistaan. Muut kategoriat (tuki, tietoisuus, hyväksyntä, palautunut ilo) rakentuivat toistensa varaan kuvaten toipumisen prosessia. Tuki viittasi saatuun kannustukseen kuntoutusammattilaisilta sekä vertaistukiryhmästä. Kuntoutujat kokivat, että heidän kokemuksiaan kuultiin ja ymmärrettiin validoiden näin heidän kokemaansa kärsimystä ja tuoden lohtua, etteivät ole yksin. Tietoisuus kuvasi lisääntynyttä tietoa työuupumuksesta, sen oireista ja kulusta sekä korostunutta sensitiivisyyttä omaa kehoa ja mieltä kohtaan. Hyväksyntä sisälsi itsehyväksynnän ja itsearmon lisääntymisen sekä omien tarpeiden ja rajojen tunnistamista. Toipumisprosessi kulminoitui palautuneeseen elämäniloon, sosiaalisen vuorovaikutuksen elävöittämiseen ja uudenlaiseen asenteeseen työhön ja elämän prioriteetteihin.

Osatutkimus II laajensi tietoutta toipumisprosessista tutkimalla neljän kuntoutujan toipumisprosessin jatkoa ja toimijuuden ilmentymiä 1,5 ja 2 vuotta kuntoutuskurssin jälkeen. Tutkimuksessa tarkasteltiin kuntoutujien narratiiveja pitkittäistutkimusasetelmalla. Osallistujat tähän osatutkimukseen valittiin harkinnanvaraisella otannalla (engl. *purposeful sampling)* noudattaen kahta kriteeriä: jatkunut toipuminen vs. pahentunut työuupumus sekä työpaikan vaihto vs. ei työpaikan vaihtoa. Osatutkimus I:een osallistuneille kuntoutujille lähetettiin kutsu sähköiseen kyselyyn 1,5 vuotta kuntoutuskurssin päättymisen jälkeen. Yhdeksän kuntoutujaa vastasi kyselyyn. Heistä kahdeksan antoi suostumuksensa jatkoyhteydenottoihin. Kahdeksasta kuntoutujasta valittiin neljä kuntoutujaa, joista kaksi oli jatkanut toipumisen tiellä ja kahdella työuupumuspisteet olivat nousseet seurantajaksolla. Heistä kaksi oli vaihtanut työpaikkaa ja kaksi oli jäänyt edelliseen työpaikkaansa. Työpaikan vaihto ei välttämättä kuitenkaan taannut toipumispolulla pysymistä. Kaksi vuotta kuntoutuskurssin jälkeen, syksyllä 2014, heitä haastateltiin puolistrukturoidulla haastattelulla. Haastattelut vuodelta 2012 ja 2014 sekä vastaukset sähköiseen kyselyyn yhdistettiin muodostamaan kokonaisnarratiiveja. Narratiivit nimettiin ja toimijuuden ilmentymiä tulkittiin toipumisen näkökulmasta. Lisäksi tarkasteltiin merkityksenantoprosesseja ja identifioitiin emotionaalisen, eettisen, moraalisen ja kausaalisen merkityksen alueita narratiiveissa. Kokonaisuudessaan voi todeta, että toipumisen polut kuntoutuskurssin jälkeen olivat hyvin heterogeenisiä ja yksilöllisiä, mikä osoittaa työuupumuksen monisyisyyttä ja moniulotteisuutta (Rutherford & Oda, 2014). Vaikuttaa siltä, että toipumisen polku oli suotuisin silloin kun henkilökohtainen ja lähitoimijuus olivat vahvoja, ja muut elämän osa-alueet kuten esimies, työympäristö ja perheenjäsenet edesauttoivat toipumista ja toipumisen polulla pysymistä. Työpaikan vaihto ei toisaalta osoittautunut ratkaisevaksi tekijäksi toipumisen pysyvyyden kannalta, vaan nimenomaan työpaikalla toteutetut muutokset tukivat toipumista tai johtivat työuupumuksen pahenemiseen.

Osatutkimus III tutki puolestaan osa-aluetta, joka on jäänyt pitkälti tarkastelematta työuupumuskirjallisuudessa eli puolisoiden kokemuksia työuupumuksesta ja siitä toipumisen prosesseista. Työuupumusta on tutkittu pitkään yksilön tai organisaation näkökulmasta, mutta vaikutus perheenjäseniin ja tarkemmin puolisoihin on jäänyt lähes huomiotta. Syyskuun 2017 ja helmikuun 2018 välisenä aikana haastateltiin 10 kuntoutujaa ja heidän puolisoaan, jotka rekrytoitiin samasta kuntoutuskeskuksesta Keski-Suomesta. Kuntoutujien haastatteluja käytettiin kontekstualisoimaan prosesseja, ja analyysin varsinaisena fokuksena olivat puolisoiden kokemukset näistä prosesseista sekä heidän kokemuksensa työuupumuksen ja toipumisen vaikutuksista parisuhteeseen.

Tulokset osoittivat, että kokemukset asettuvat yksilö- ja parisuhdetasolle ja luonteeltaan ne olivat sekä negatiivisia että positiivisia. Temaattinen analyysi (Braun & Clarke, 2006) tuotti kolme teemaa yksilötasolla: puolisot turvasatamana, kuormitus puolisolla ja validaatio, ja kaksi teemaa parisuhdetasolla: sitoutuminen parisuhteeseen ja negatiivinen vaikutus parisuhteeseen. Puolisoilla oli tärkeä rooli erityisesti työuupumusvaiheessa, jolloin puolisot tarjosivat tukea, kompensaatiota ja ennaltaehkäisyä. Puolisot ottivat paljon vastuuta perheen ja talouden pyörittämisestä erityisesti silloin, kun työuupuneen puolison kunto oli huonoimmillaan. Lisäksi puolisoilla oli mahdollisuus tarkastella työuupumusoireita riittävän läheisenä, mutta silti ulkopuolisena tahona ja näin ehkäistä työuupumuksen uusiutumista. Kolikon kääntöpuolena puolisot kokivat paljon ahdinkoa työuupumuksen aikana ja joutuivat miettimään omaa hyvinvointiaan vetämällä rajoja puolison työuupumuksen ja oman mielenterveyden välille. Varsin tärkeänä teemana nousi validaatio eli puolison kokemus kuulluksi tulemisesta kuntoutuskurssin puolisoille varattuna päivänä. Vaikka vain pieni osa puolisoista oli hyödyntänyt tätä mahdollisuutta, kokemukset siitä olivat hyvin myönteisiä ja vahvistivat puolisoiden toimintaa ja tekojen oikeellisuuden. Parisuhteen osalta puolisot kokivat, että työuupumus ei ole horjuttanut lojaliteettia puolisoa kohtaan, ja he olivat kaiken lisäksi löytäneet uusia merkityksiä ja mahdollisuuksia parantaa puolisoiden välistä kommunikaatiota ja avoimuutta. Negatiivisina seurauksina puolisot nostivat konfliktit sekä stagnaation parisuhteessa. Konflikti ei ollut vahingollisin seuraus vaan stagnaatio nähtiin erityisen vaurioittavana, sillä se tyrehdytti puolisoiden yhteisen ajan. Kaiken kaikkiaan työuupumus vaikutti parisuhteeseen lievemmin kuin oletettiin, minkä voi selittää osaltaan tutkimukseen valikoituminen, ts. vain pariskunnat, joiden parisuhde oli vankalla pohjalla, osallistuivat vapaaehtoisesti tutkimukseen.

Kokonaisuudessaan osatutkimukset osoittivat, että toipuminen työuupumuksesta on moniulotteinen ja monisyinen prosessi, johon vaikuttaa moni tekijä. Kuntoutuskurssi oli omiaan käynnistämään toipumisen prosessia ja osa kuntoutujista kykeni ylläpitämään hyvinvointiaan esimerkiksi korkean henkilökohtaisen tai lähitoimijuuden ansiosta. Toipumisessa on kuitenkin äärimmäisen tärkeää huomioida muut elämän osa-alueet, erityisesti työympäristö, mutta myös perheeseen liittyvät tekijät. Tutkimuksen tärkeä kontribuutio on myös puolisoiden näkökulman ja kokemusten esilletuominen. Voi todeta, että työuupumus vaikuttaa myös perheenjäseniin, vaikka se ei ole yhtä lamauttava kuin vakavat somaattiset tai mielenterveysongelmat.

Tulevan tutkimuksen täytyy kiinnittää entistä paremmin huomiota työuupumuksen laajakantoisiin vaikutuksiin ja kattavasti työuupuneiden työ- ja perheympäristöön. Kuntoutuskurssit olivat erittäin hyödyllisiä toipumisen prosessin käynnistämisessä ja niiden turvaaminen myös tulevaisuudessa on suotavaa. Yhteiskunnallinen tavoite Suomessa on ollut pidentää työuria (Järvikoski & Härkäpää, 2004) samalla kun yhä useampi jää pois työelämästä työuupumuksen tai masennuksen vuoksi. Työuupumuksesta toipumisen mekanismeja tulee ymmärtää paremmin, jotta voitaisiin vaikuttaa juuri heihin, joilla toipumisen ylläpito on vaikeaa.

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APPENDICES

APPENDIX I

Study I: Interview Scheme: Recovery from burnout

Instructions before starting the interview: The aim of the interview is to go through your experience of recovery from burnout and the factors that have been beneficial in the process.

Before we start the interview, I would like to request your consent on the following matters. (--> give the Letter of Consent).
--> First, your consent to have the information that you share with me, in an anonymous form, in a scientific study. This means that everything you share with me is confidential and will be reported in a manner that does not reveal your identity at any stage.
--> Second, I hope that it is ok for you that I record the interview so that I don't have to write everything down.

I would start by asking a few background details, which are essential for grasping the overall situation. (--> Proceed according to the background details form).

Topics in the interviews

History of burnout/ background before the rehabilitation intervention

Describe your burnout process on the timeline starting from your recollection of when burnout symptoms started until you came to the rehabilitation course.

- When did it start, what did you do for work then, how did you notice the symptoms?
- What factors were related to the development of burnout (work, family, relationship with a partner, your own health)?
- Were there any absences or sick leaves?
- Any interventions or help seeking? Changes in the work conditions, discussions with someone (at work, in occupational health care, in therapy)?
- Are you still in the same workplace or in the same position? If you changed your workplace, why?

Present: the factors accounting for recovery an experience of the rehabilitation intervention

I *Current situation*

1. What is your current situation?

- Symptoms? How do you know you are on the path of recovery? What has changed? How have your symptoms changed?

- Actions and interventions? Are you in therapy or in occupational health care? Have there been changes in your work conditions?

II *Factors accounting for recovery*

1. What made the start of your recovery possible?
- A change in yourself (thoughts, attitudes, working style, habits and health
  behaviour, health)?
- Any changes in your job, position, work conditions, organization, workplace relationships?
- Any changes in private life: free time and recovery, relationships and events?

2. Other measures that have facilitated recovery Support from occupational health care:
- Sick leave: if yes, how did it help?
- Medication: if yes, how did it help?
- Discussions (for example, occupational psychologist): if yes, how did it help?
- Therapy: if yes, how did it help?

3. Support measures at work
- Changes in your tasks: if made, how did it help
- Discussions in your workplace: if yes, how did it help?

The role of rehabilitation in the process of recovery

1. Starting point of rehabilitation
- How did the need for it emerge?
- Who suggested attending a rehabilitation course?

2. Rehabilitation

- What did the rehabilitation course mean for you?
- What has been meaningful for you, what has happened to and within you?
- How have you experienced the rehabilitation course?
- What have you experienced as being rehabilitated?
- What changes have you executed?
- How have you changed? What is different now?
- What changes in your thinking and actions have taken place?
- Have any changes taken place in your environment and workplace, that have supported your personal objectives?

- Have any changes taken place in your workplace, work community, in your attitude towards work?

3. Evaluation of recovery and the factors that have facilitated or impeded it

- What has facilitated your recovery?
- What contribution have the peer group members, the rehabilitation professionals, occupation health care, your employer and work community have had?
- What has impeded your recovery?
- What support would you have still needed?
- What kind of support do you hope to receive in the future and from whom/where?

Life Evaluation

- What is meaningful in your life?
- What brings you joy, life satisfaction and positive state of mind?
- What helps you manage in life?
- What role do work life and its demands play in your life?
- What role do your family, close relationships, hobbies, and societal activities play in your life?
- Have you achieved the things you wanted in life? Has your life attitude changed? What do you still want from life?

Future

- How do you see your future?
- Has rehabilitation had a role in your life?

Evaluation

- What have you learnt during the process of burnout?
- Do you think you can prevent burnout in the future? If yes, how?

APPENDIX II

Study II: Electronic questionnaire

Background data

1. Gender
2. Age
3. Are there children living in your household? (number of children)
4. How old are the children living in your household?
5. What is your highest education level?
   No education
   Professional course
   Vocational high school
   Vocational institute
   Polytechnic/University of Applied Sciences
   University
6. What is your job title?
7. Are you in a managerial position?
   Yes, how many subordinates do you have?
   No
8. Your job is:
   Full-time
   Part-time
9. On average, how many hours a week do you work, including regular working time, overtime and work done at home?
10. How many years have you worked in your present position?
11. How many years have your worked for your present employer?
12. At present you are:
    At work
    On sick leave. For how long and due to what?
    Other, please specify.

BBI-15

Please choose the alternative that best describes your situation. (Response options: Completely disagree, Disagree, Partly disagree, Partly agree, Agree, Completely agree).

1. I am snowed under with work.
2. I feel dispirited at work and I think of leaving my job.
3. I often feel inadequate.
4. I often sleep poorly because of the situation at work
5. I am frequently annoyed with my customers or my other employees
6. I frequently question the value of my work.
7. Pressure related to my work has caused difficulties in my private life
8. I feel that I have gradually less to give.
9. My desire to help others is greater than what I can achieve.
10. Even when I am off work, I often think about work-related affairs

11. I find it difficult to involve myself in my customers' or my other employees' problems.
12. My expectations of my job and my performance have fallen.
13. I constantly have a bad conscience because my work forces me to neglect my close friends and relatives
14. I feel that I am gradually losing interest in my customers or my other employees.
15. Honestly, I felt more appreciated at work before.

DEPS

During the last month how have you felt? (Response options: Not at all, A little, Quite a lot, Extremely)
1. I have suffered from insomnia.
2. I have felt blue.
3. I have felt everything was an effort.
4. I have felt low in energy or slowed down.
5. I have felt lonely.
6. I have felt hopeless about the future.
7. I have not got any fun out of life.
8. I have had feelings of worthlessness.
9. I have felt all pleasure and joy has gone from life.
10. I have felt that I cannot shake off the blues even with help from family and friends.

Open-ended questions

1A. Have you changed jobs after the rehabilitation course?
Yes / No
1B. What was the reason for the job change?
1C. How has the job change affected your well-being?
2A. Have any significant changes taken place after the end of the rehabilitation course (e.g., in your work conditions, tasks, working time, job climate or supervisor relationship).
Yes /No
2B. What positive changes in your workplace have taken place after the end of the rehabilitation course (e.g., in your work conditions, tasks, working time, job climate or supervisor relationship)?
2C. What negative changes in your workplace have taken place after the end of the rehabilitation course (e.g., in your work conditions, tasks, working time, job climate or supervisor relationship)?
2D. Have the changes in your workplace affected your well-being? How?
3. How has your supervisor treated your burnout and recovery from it? How has he/she influenced your recovery with his/her action?
4A. Have any significant changes taken place in your family life or in life in general after the rehabilitation course?
Yes / No

4B. What positive changes have taken place in your family life or in life in general after the rehabilitation course?
4C. What negative changes have taken place in your family life or in life in general after the rehabilitation course?
4D. Have the changes in your family life or life in general affected your well-being? How?
5. How have your burnout symptoms changed after the rehabilitation course.
    The burnout symptoms have increased, why?
    The burnout symptoms have decreased, why?
6. How do you take care of your well-being?

Rehabilitation factors
1A. Please recall your rehabilitation in the rehabilitation centre. Which of the individual discussions facilitated your recovery from burnout? (You can choose several options)
    With the psychologist
    With the physician
    With the physiotherapist
    Other, please specify
1B. Please tell more specifically how the individual discussions that you mentioned above made an impact.
2A. Which of the following rehabilitation course elements facilitated your recovery? (You can select several options)
    Peer support
    Sports
    Relaxation exercises
    Ergonomics
    Goal-setting and follow-up
    Knowledge on sports and muscle maintenance
    Knowledge on sleep
    Information on burnout
    Information on nutrition
    Other, please specify
2B. Please tell more specifically how these factors made an impact.

APPENDIX III

Study II: Interview Scheme (modified from Andreou, 2015)

Introduction before the interview
Before we start the actual interview, I would like to briefly tell you about this study and the interview. This interview will be used in my Master's thesis, which explores recovery from job burnout focusing on the time period after rehabilitation.
First of all, I would like your written consent on participating in this interview. (briefly explain the main points of the letter of consent and let the participant read and sign it). I also hope it is ok for you that I record the interview so that I don't have write everything down? (put the tape recorder on)
I would still like to tell you that my aim is not to study the rehabilitation or its effectiveness, but to hear about your experiences during these two years after rehabilitation, so feel free to talk frankly about your experiences as there are not any right or wrong answers.
Do you have any questions before we start the actual interview?
Interview Questions.
1. What was your experience of the rehabilitation?
    - Was the rehabilitation course beneficial for you?
    - Were you away from work at the time of rehabilitation? How soon did you return to work?
    - Have you been on sick leave due to burnout after the rehabilitation course?
    - How did it feel going back to work from rehabilitation? How were you perceived in your workplace?
2. Have you changed your workplace during these two years? / Have you considered changing your workplace?
    - When did the change happen?
    - Why did you change your workplace?
    - How did it happen in practice?
    - What is your new job like? How have you adapted to your new job and new work community?
    - How do you feel about the job change when you reflect on it now?
3. If you compare to the time after rehabilitation, what is your well-being right now?
    - How is your physical well-being? Do you still have symptoms?
    - What is your most prevalent mood?
    - What are feeling when you go to work every morning? / How do you feel when you come home from work? Why?
    - What are the reasons for this well-being / mood / energy level?
4. What kind of changes have happened during these two years after rehabilitation?
    - In your own thoughts and behaviour?
    - At work or in the environment? In the work community?
    - In your own attitude towards work?

5. How has work been during these two years?
    - What is your normal day at work like?
    - What kind of work community and atmosphere do you have there?
    - What is your manager like?

6. Questions about day-to-day situations.
(Positive)
    - Are there things at work that make you feel happy and glad?
    - Can you think of any specific situations that have made you feel happy? What kind of situations have these been?

(Negative)
    - Has there been situations at work that have left you feeling a bit unpleasant or anxious?
    - Can you think of any exhausting aspects at work?
    - Has there been any kind of conflicts at work? Have they affected your recovery?
    - What has your role been in these situations? Have you had an impact on these situations?
    - How about other people's roles?

7. Questions addressing agency
    - Have there been situations at work when you felt that things have went unfairly?
    - Have you intervened in these situations?
    - Has there been situations where you have felt that things have gone unfairly, but when you felt like it was out of your control?
    - Have there been other kinds of situations where you have felt some sort of frustration or hopelessness?

8. Free-time.
    - Have there been changes in the way you spend your free time?
    - New hobbies?
    - What do you when you come home from work? What else do you do during your free time?
    - What kind of things give you joy and energy during your free time?
    - Are there things in your free time that are exhausting?

9. How do you take care of your well-being? What kind of things do you do to recover and re-energize from the day at work?

10. Can you name a few things that you feel have been main reasons for recovery / lack of recovery?

11. Values. What kind of things are important to you right now?
    - What is the importance of work?
    - Have there been changes in values in the last years?

12. Future.
    - What does the future look like?
    - What kind of thoughts do you have about continuing in your current workplace?
    - Are there things that you will absolutely continue doing in the future?

- Do you have some aspirations or goals for the future, work-related or wellbeing/health-related?

13. Is there something on your mind related to the themes of the interview that has not been asked?

Thank you for the interview.

APPENDIX IV

Invitation to participate in the study

September 2017

INVITATION TO PARTICIPATE IN RESEARCH ON RECOVERY FROM BURNOUT

Dear rehabilitee,

Burnout affects both the burnt-out individual and his/her family. We therefore invite you and your spouse / family member to a new study examining the experiences of rehabilitators and their families about burnout and recovery. Your participation in this study would lead to a more profound understanding of burnout and recovery from it, and help rehabilitation institutions to develop more effective rehabilitation programs.

The study has received consent from Dr. Mika Pekkonen, Chief Physician of Peurunka Rehabilitation Centre, who encourages participation in the study.

PARTICIPATION IN THE RESEARCH:

You and your spouse or other close family member (child, sister) can participate in the study if:

- You are in a rehabilitation course in Peurunka and you feel burnt out
- Your spouse / family member is also willing to participate

HOW DO I REGISTER FOR THE STUDY?

You inform the psychologist of Peurunka rehabilitation course that you and your spouse want to take part in the study, preferably before the start of the follow-up period. She will provide you with more information on the schedule of the study.

HOW IS THE RESEARCH CARRIED OUT?

You and your spouse or another close family member will be interviewed during the second rehabilitation period at Peurunka's premises. You will probably be interviewed during the rehabilitation period and your family member on a Thursday afternoon or Friday (on the day reserved for family members). The interview will last approx. 45-90 minutes and cover the following topics: the history and recovery from burnout, experiences of rehabilitation, and the impact of recovery on the family member and relationship. We ask your family member to share his or her feelings about the different stages of the path of burnout and recovery and their impact on your family life / relationship.

USE OF DATA

The research material is to be used and stored by the principal researcher, Stela Salminen, who will utilize the material in her own dissertation research. Ms. Salminen's dissertation is supervised by Docent Anne Mäkikangas (Department of Psychology, University of Jyväskylä, e-mail: anne.makikangas@jyu.fi).

CONFIDENTIALITY

The issues you report will be treated in the strictest confidence. No one but Stela Salminen and her research team will have access to these files. No individual participant can thus be identified. Participation in the study is completely voluntary and can be discontinued whenever you wish.

As a thank you for your participation, we offer you and your family member a 30 euro gift voucher for the S-Group's products and services.

QUESTIONS?

If you have any questions regarding the research, please do not hesitate to contact:

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We look forward to your participation.
On behalf of the entire research team,
Stela Salminen, PsM, M.Soc.Sc.

APPENDIX V

Study III: Interview Scheme with the Spouse

Instructions before starting the interview: The aim of the interview is to go through your experience of your spouse's burnout and recovery from it and the factors that have been beneficial in the process.

First, I would like to request your consent on the following matters. (--> give the Letter of Consent).
--> First, your consent to have the information that you share with me, in an anonymous form, in a scientific study. This means that everything you share with me is confidential and will be reported in a manner that does not reveal your identity at any stage.
--> Second, I hope that it is ok for you that I record the interview so that I don't have to write everything down.

I would start by asking a few background details, which are essential for grasping the overall situation. (--> Proceed according to the background details form).

Topics in the interview

History / background of burnout before rehabilitation health

Please describe your spouse's burnout process on the timeline from the time you remember the burnout symptom started until your spouse came to rehabilitation.

- What factors do you think were associated with the development of exhaustion (work, family life, relationship, personal health)?
- How did you notice your spouse's burnout?
- What changes took place in him/her?
- How did burnout affect your relationship?
- How did it affect your interaction?
- What kind of support were you able to provide to your spouse at that time?
- How did your spouse react to the provision of help?

Present: Factors Explaining Recovery and Experience of Rehabilitation Intervention

- What is the situation of your spouse now?
- What symptoms do you still notice? How do you know he/she is on the path to recovery? What has changed? How have the symptoms changed?
- How can you support him/her right now?

Factors explaining recovery

1) What or what things allowed your spouse to begin recovering?

- What changes have you noticed in him/her? (thoughts, attitudes, work style, lifestyle / health behaviours, health)
- What changes have taken place in his work, work situation, organization, interpersonal relationships in the workplace?
- Change in private life: leisure and recovery; privacy relationships and events

2) Support measures that may have boosted recovery
- How have the various support measures contributed to his/her recovery?
- Occupational health care support:
- Sick leave: if so, how did it help?
- Medication: if so, how did it help?
- Discussions (e.g., occupational health psychologist, etc.); if so, how did it help?
- Therapy: if so, how did it help?
- Support measures at work
- Changes in job responsibilities; if done, how did they help?
- Discussions in the workplace; if so, how did they help?

The role of rehabilitation in the recovery process

1. Rehabilitation process / rehabilitation
- What has rehabilitation meant for your spouse?
- What changes have you noticed during it?
- How has your relationship changed with rehabilitation?
- Have you been involved in the process and in what way (e.g., by visiting a rehabilitation centre, supporting him / her between sessions)?
- What kind of support have you provided to him/her during this time?

Life assessment
- How do you feel about your spouse after the burnout?
- What would you have liked to do differently?
- What does your relationship feel and look like now?

The future
- How do you see the future of your spouse?
- Has rehabilitation had an impact on your life?
- What have you learnt during your spouse's burnout process?
- Do you feel that he/she can avoid a recurrence of burnout in the future? If so, how?
- How can you help him/her?

Thank you for the interview!

ORIGINAL PAPERS

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MY WELL-BEING IN MY HANDS: EXPERIENCES OF BENEFICIAL RECOVERY DURING BURNOUT REHABILITATION

by

Stela Salminen, Anne Mäkikangas, Marja Hätinen, Ulla Kinnunen, & Mika Pekkonen, May 2015

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My Well-being in My Own Hands: Experiences of Beneficial Recovery during Burnout Rehabilitation

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ABSTRACT

Purpose: To explore how burnout rehabilitation clients experienced their recovery from burnout and what they found beneficial in rehabilitation.

Subjects: Twelve clients whose burnout levels had declined during rehabilitation were interviewed at the end of the second period of the rehabilitation course.

Methods: Semi-structured interviews comprised the main material of the study and were analysed by content analysis. In addition, the Bergen Burnout Indicator (BBI-15) was used to measure the reduction in burnout levels.

Results: The analysis yielded a single overarching theme, *My well-being in my own hands*, and four categories. The overarching theme describes the overall process of recovery and the revelation experienced by clients that they are in charge of their own well-being. The process starts with *Support* from rehabilitation professionals, the client group and family or friends. The categories *Awareness* and *Approval* refer to specific changes in the attitude towards and recognition of one's needs and limits. The category *Regained joy* describes the culmination of the recovery process manifested in different spheres of life.

Conclusions: The Rehabilitation course proved particularly beneficial for individuals suffering from burnout. The accumulation of support, awareness and approval led to a revival of joy in life and greater perceived control over one's well-being.

Key words: interview, qualitative research, content analysis, occupational health, change

INTRODUCTION

Burnout develops as a consequence of a prolonged discrepancy between the individual and the job [1], and consists of three core symptoms: exhaustion, cynicism, and reduced professional efficacy [1]. The vast majority of burnout research has investigated the antecedents and consequences of burnout, as well as its developmental processes [2]. Knowledge has also accumulated on the effectiveness of various burnout interventions [2, 3], showing that different approaches are effective at least to some extent [2, 4]. Based on a few studies which have focused, in particular, on rehabilitation interventions, rehabilitation appears to be effective in reducing burnout [5, 6] and, more specifically, exhaustion [6-8] and, in some subgroups, also cynicism [6, 7].

Despite the studies published on the effectiveness of various interventions on burnout, a closer examination of the processes or mechanisms through which burnout interventions work is, for the most part, lacking. Only a few studies have focused on the mechanisms of change during burnout interventions [7, 9]. Participatory types of interventions, which commonly aim at helping participants identify the causes of burnout in the local context and then empowering them to design and implement solutions, have alleviated burnout [7, 10]. The mechanism held to be responsible for this kind of approach is increased job control, which has been associated with reductions in burnout [7]. Another recent study found that increased psychological flexibility mediated the amelioration of burnout [9]. Based on these studies, both individual and job-related characteristics serve as mechanisms of burnout reduction. These are also the common antecedents of burnout, since both the individual and the job contribute to the development of burnout [1, 2].

A broader picture of the factors related to burnout recovery has been gained in a few qualitative studies. One study explored the situational determinants of coping with severe burnout by gathering information retrospectively from 36 various professionals who had successfully recovered from burnout [11]. The study revealed that successful recovery was psychosocial in nature, comprising both internal (e.g., cognitive, emotional) and external (e.g., work environmental) change processes in which six stages could be identified: admitting the problem, distancing oneself from work, restoring health, questioning values, exploring work possibilities, and making objective changes. Another study explored the experiences of burnout patients during rehabilitation in which two different intervention programmes were used [12]. Both interventions were experienced as beneficial to recovery. The main finding was that both interventions provided tools, support and affirmation that enabled participants to regain control over their own lives, which, in turn, was experienced as conducive to recovery from burnout.

The present study explored rehabilitation clients' experiences during recovery from burnout and the specific factors they found beneficial to their recovery. This study differs from that mentioned above [12] by focusing on an established rehabilitation intervention, i.e., not one specifically tailored for research purposes. Additionally, we only targeted clients whose burnout had declined during rehabilitation, as the focus was on understanding a successful recovery process, which is an under-investigated research topic.

METHODS

Rehabilitation intervention

In Finland, rehabilitation interventions for burnout are categorized as discretionary medical rehabilitation. Discretionary implies that no subjective right to rehabilitation of this kind as yet exists, and it is financed with an annual appropriation from the Finnish Parliament. The Finnish social insurance institution both funds rehabilitation services and provides income security during participation in rehabilitation. Rehabilitation is based on holistic and multidisciplinary approaches. It includes a comprehensive evaluation of an employee's physical, psychological, and social conditions by various rehabilitation professionals (physician, psychologist, physiotherapist, and social worker). Burnout interventions conducted in the rehabilitation context function primarily on the individual level, meaning that the rehabilitation activities focus mainly on enhancing individual resources and supporting individual occupational health and well-being solutions and coping strategies.

Individual resources are enhanced through various physical, social and psychological means that are implemented in individual and group programmes. Individual programmes include individual guidance and counseling (with a physician, psychologist, physiotherapist, and social worker), tests and examinations, and individual tasks to be accomplished in the intervals between rehabilitation periods (such as testing rehabilitation goals in everyday life). Group programmes consist mostly of a fixed set of programmatic activities, including physical exercise, health education, and reflective group discussions. Group programmes also include social activation and guidance, and goal setting and attainment discussions (see Table 1).

The clients themselves sought or were referred for a burnout intervention by their occupational health care service. Potential clients were initially screened by the local branch of the state social insurance institution, after which a physician from the rehabilitation center made the final selection. The selected clients were diagnosed as having various job-related psychological health problems, mainly burnout. The clients with mild depression or anxiety were not excluded, since these problems usually co-occur with burnout symptoms. To be eligible for the burnout rehabilitation, applicants had to be employed, but they could be on sick leave. The intervention was carried out in groups of 4-10 employees, and lasted for 15 days altogether, starting with a 10-day period and ending with a 5-day follow-up period within at most 7 months after the first period.

Study Design and Participants

The study clients were selected from rehabilitation courses with a seven-month follow-up held between August 2012 and December 2012. Of the three rehabilitation courses which started during that time ($n = 23$), 15 eligible employees, whose burnout had diminished, were identified. We used the Bergen Burnout Indicator (BBI-15) [13] to define the baseline levels and change in burnout. The BBI-15 measures 3 subdimensions of burnout: exhaustion, cynicism, and reduced professional efficacy. Responses are rated on a 6-point Likert-type scale (1= totally disagree, 6 = totally agree). Total scores vary between 15 and 90, and burnout symptoms are classified as severe, moderate, mild, and no burnout. To be eligible for the study, burnout scores had to have diminished by at least one class, for example from severe to moderate, and the decline had to have occurred in at least in one symptom. The psychologist at the rehabilitation center informed clients with diminished BBI -15 scores about the possibility to participate in the research.

Of the 15 eligible clients, 12 (80%, one male) participated in the study. Sample age varied between 38 and 63 years (mean 51.3 years). Most (58%) clients had been educated to vocational school level, and 33% worked as supervisors. Time with current employer ranged from 0.5 to 38 years. Most were currently working, one had become unemployed and one was on study leave at the time of the research. At the beginning of the rehabilitation, the mean burnout score among the participating clients was 63 ($SD = 12.09$), indicating severe burnout. At the follow-up period, 7 months later, the mean burnout score was 41 ($SD = 12.28$) [13] indicating no presence of burnout symptoms. The decline in the burnout scores was statistically significant, $F(1,11) = 66.57, p < .001$.

Based on previous Finnish studies, women and employees in their 50s typically participate in rehabilitation courses of this type [6-8]. Therefore, the present clients were well representative of rehabilitation course participants in Finland.

Data collection

At the end of the 5-day follow-up period, the clients with decreased burnout were interviewed. Semi-structured interviews were used to capture the clients' experiences and perspectives on the factors they perceived as beneficial to their recovery during rehabilitation. This type of interview was chosen, as the clients were interviewed on only one occasion by one of three different interviewers. The interviewers were MA students in psychology at the advanced level of studies who had already performed a 5-month training period in the field and were working in the research project. To obtain reliable and comparable data in cases where multiple interviewers are used, it is important that the interviewers are properly instructed. To this end, we provided training sessions focusing on interviewing techniques and familiarization with the topic and interview questions before the interviews took place. In addition, before the research interviews proper, each interviewer conducted three practice interviews. Topics covered in the interviews included, for example, clients' burnout history, their experiences of general factors related to their recovery and the rehabilitation intervention, and their future expectations regarding their recovery process.

The interviews were conducted in the rehabilitation center at the end of the last official rehabilitation period. The interviews lasted 45 to 90 minutes. The interviews were audio-recorded and transcribed verbatim by the interviewers.

Credibility

The study clients came from all three of the target rehabilitation courses, which can be argued to enhance the reliability of the study. Burnout rehabilitation is carried out in groups and hence intragroup dynamics is expected to occur and group cohesiveness is encouraged. For this reason, groupthink may develop, which in turn may inhibit the voicing of individual opinions during the interview [14]. Therefore, by studying different groups we may be able to increase the reliability of the information gathered in the interview. To further increase the validity, reliability, and interpretative potential of the study, method triangulation, based on 1) a self-report questionnaire (BBI-15) [13] and 2) semi-structured interviews, was used [15-17].

Ethical considerations

The study was examined and approved by the Ethical Committee of the University of Jyväskylä, Finland. Clients were recruited by the psychologist at the rehabilitation center. She introduced the study to the clients and provided them with written information. The voluntary basis of participation, confidentiality, and anonymity were emphasized before the start of the study and the individual interviews. The clients signed a consent form, on which the possibility to interrupt participation in the study without any consequences or to withhold permission for the use of the interview or other research material was emphasized. Consent for audio recording was also requested. No rehabilitation center staff members were present during the interviews. As only one of the clients was male, the results are presented without specifying the gender of any of the interviewees.

Data Analysis

The interview texts were analysed by content analysis [18]. Qualitative analysis software Atlas.ti 7 was used to read and code the interviews. The first three authors read all the interviews to grasp the general content. Thereafter, the first author analysed the data by first assigning open codes to meaningful parts of the text. In the analysis, the meaningful units were condensed and coded according to their content. To ensure that the meaningful unit was mentioned by more than a single client, we set a criterion requiring a code to be present in a minimum of three interviews. The counting of codes allowed for a more structured and systematic process of analysis. The codes that were most prominently used were further explored to find similarities and differences. Codes with similar content were counted and merged into subcategories. Finally, the subcategories were formed into categories, which reflected the content on a more abstract level. The quotes to which the codes were linked were re-read continuously to ensure that all the relevant information was captured in the description of the subcategory or category. During the analysis, an overarching theme related to the entire process of successful recovery was identified. All parts of the analysis were continuously discussed by the first three authors in order to improve credibility.

RESULTS

The content analysis resulted in one overarching theme: *My Well-being in My Own Hands*, and 4 categories: *Support, Awareness, Approval* and *Regained Joy*. The overarching theme describes the overall process of physical and mental change and the revelation experienced by the clients that they are in charge of their own well-being. The content of the four categories describes a slowly progressive healing process, starting with *Support* from various persons, leading to increased *Awareness* and enhanced *Approval*, and culminating in *Regained Joy*. The categories, subcategories and the core category are presented in Figure 1 and illustrated with excerpts from the interviews.

<Insert Figure 1 here>

My Well-Being in My Own Hands

The overarching theme describes the entire process of recovery and the insight acquired by clients that they are responsible for their own well-being. The process comprised the whole journey from the denial of burnout symptoms, accompanied by feelings of guilt and shame, through actively seeking or accepting help, recognizing one’s own limits and acknowledging one’s needs, to enhanced self-approval and regained joy in life. During this journey, the clients mitigated their aspiration towards perfection and re-evaluated their priorities in life. These internal changes were encouraged and fostered by support from rehabilitation professionals and one’s peer group as well as from family and friends. The process enhanced the clients’ awareness of burnout and the limitations of the body, and thus made them more sensitive to possible future re-occurrences of burnout. Gradually, their hope of recovery was also reinforced and their vision of the future was, in general, positive. Almost all the clients expressed a wish for support in the future, either in the form of a follow-up rehabilitation course or from occupational healthcare services.

Support

Throughout their accounts, the clients emphasized the significance of the support they had received from healthcare and rehabilitation professionals, from the rehabilitation course group, and from family members and friends. The importance of group support was present in all the stories, and they expressed their satisfaction with the warm group spirit, group cohesiveness and interpersonal match they had experienced. Realizing that they were not alone in their suffering and that others had similar experiences was an affirmation of the objective existence of burnout problems and pain.

"[Interviewer: What has been most important to you?]- Well, it's been this group, because well, we all come from different fields, which is terrific. I was able to go there as myself, and it was confidential, and then if we think about the funny side, we have laughed a lot! You can joke about things and they're not so awfully serious, so that also does you good. And then you have help on offer here, so in that sense it has become clear, I know that I can seek help if necessary." [*Interview 7*]

"We have a very good group. We all come from different places and circumstances. The group discussions have been very good and fruitful" *[Interview 4]*

Clients were met with understanding, patience and empathy by the rehabilitation professionals, who encouraged them in their healing process. The support received further activated the clients' own mechanisms of coping and control.

"The personnel here have been very nice, professional and encouraging, in no way do you get the feeling that you have to do something, but instead you're given the opportunity, you get the tools and help and if you're ready to take them, then even better…so the personnel indeed is hugely important." [*Interview 12*]

"The rehabilitation professionals are extremely competent: they have seen so many similar cases they're able to draw on that experience. So if you have burnout and come to this course, you are indeed lucky, because you're in good hands, you get help here!" *[Interview 10]*

Parallel to this, many clients reported that support from family members and friends was an additional source of hope and a stimulus for recovery.

"The value of one's family is so enormous! I have now realized it's so important that they're out there and we stay in touch. I've received a lot of support from them!" *[Interview 9]*

Awareness

The clients described how their increased knowledge of burnout symptoms and the effect of stressors on the body and mind facilitated the process of recovery. Many reported that they felt embarrassment at being unable to cope with their duties at work and at home, and were not aware they were suffering from burnout before meeting the occupational health physician, nurse or psychologist. During the rehabilitation course, they realized how common burnout has become in worklife and became more sensitive to the symptoms of burnout experienced on both the physical and psychological level. This nourished a motivation to seek help at a very early stage, as well as hope that the knowledge they had acquired would protect them against a renewal of burnout.

"Now that I have recovered from this illness and got good tips from the courses and found myself, I can recognize the symptoms, so if I feel they're coming on again, I know how to seek help and I'll seek it…I won't let myself get in that state anymore. You have to take care of yourself, nobody else will do that for you". [*Interview 1*]

"I have learnt things I couldn't even think of before. For example, that my stomachache may be the result of burnout.[…] I've learnt that I shouldn't let burnout develop that far, and if it happens to come again, I should look for help earlier." *[Interview 3]*

Approval

Greater self-mercy was one of the most frequently mentioned outcomes of the rehabilitation course. It included realization of one's limits and acknowledgement of one's individual needs. Many clients had an insight into which of their own personality characteristics were conducive to the emergence of burnout, such as aspiring to perfection and an inability to delegate tasks. During the course they began to learn to accept themselves, along with both their vices and virtues, and in this way attained a state of self-approval, enhanced assertiveness and increased self-respect. They also actively implemented or requested changes in the workplace, or changed jobs in accordance with this new understanding of and respect for themselves.

"I don't have to manage. In that sense it's merciful thinking…of course you get help from somewhere. When you think about it, you don't have the energy of the young, of a 30-year-old. Age has its say. You need to adapt to your age…and to the fact that the ability to recover weakens with age. So you need to accept this as well." [*Interview 2*]

"What I have taken from here is that I now have set objectives and understand that I don't have to realize them in a week or two, but can set them and let them be and get back to them every now and then…and in a way this is a kind of clarification of my own life and it brings tranquility…so really it is small steps but going forward all the time." [*Interview 7*]

Regained Joy

The rehabilitation process culminated in a feeling of regained joy in several or all spheres of life. Clients described how their life space expanded and they saw their work and their social and personal life through new lenses. As they described this transformation, they often referred back to their physical, mental and emotional state prior to rehabilitation and juxtaposed their experiences then with how they felt now. The metaphors used in their account emphasized the darkness and bleakness of their burnout at its worst as opposed to “being on the right track” after rehabilitation.

“I have got my joy in life back and I enjoy my life, I am present here, life has a meaning, this job has a meaning…I’m outside and smell the air, hey, there’s the wonderful scent of summer lilac… [..] I have to say that if I compare myself to let’s say a cross-country skier and I’m out there on the ski trail then I can say that last autumn I was somewhere in a dark forest, in a dark pine forest, I was skiing in complete darkness somewhere…don’t even know where, but now I have returned to my own ski trail and home, I am back on track, on the right track.” *[Interview 1*]

Many reported a changed attitude to their work and rediscovered positive features in their job environment and in the meaning of work. The feeling of joy fostered by both objective (e.g., workload) and subjective (e.g. attitude, self-esteem) changes was translated into a revival of social interaction, hobbies or, in a few cases, into the ability to choose to have time to oneself when needed.

”Work means a lot. It’s a big part of life…and somehow when you’re on sick leave and then you start to recover a little…then you think, wonderful that I have a job and wonderful that I can go to work”. *[Interview 6*]

”I took time out for myself…and then with my friends, I have started keeping in touch with them again, it’s not one-sided anymore in that they only ask me, but instead I call them now. And the same with my family. My husband told me at some point, great to hear you laughing!” [*Interview12*]

DISCUSSION

The present qualitative study investigated the experiences of clients who had recovered or were recovering from burnout in a rehabilitation course. The results demonstrated that these clients benefitted from the course and attributed a sizeable proportion of their recovery from burnout to it. The entire process of successful recovery, embodied in the overarching theme *My well-being in my own hands*, represents a shift in clients' perceptions from denying their burnout symptoms to a realization that they are ultimately in charge of their own physical and mental well-being. The process was initiated by actively seeking or accepting the offer of help from their occupational healthcare service, and thereafter fostered by multi-faceted support from rehabilitation professionals, the course group and family and/or friends. Clients experienced a gradual change in their attitude towards their health and well-being. Encouraged by positive changes in their physical condition or work environment, they were able to modify their self-perceptions, resulting in psychological and behavioral changes such as increased self-approval, self-mercy and recognition of their inner needs and limits. Ultimately, they were able to restore or build a positive attitude towards different spheres of life.

The ongoing, comprehensive nature of the rehabilitation process has been recognized in previous studies on rehabilitation. Fjellman-Wiklund et al. [12] described patients' overall process during a rehabilitation programme as one of "taking charge". Bremander et al. [19] in a study of a multimodal cognitive treatment programme for people with musculoskeletal diseases summarized the process as "changing one's life plan", and identified subcategories very similar to those found in our study: self-acceptance and self-insight, along with support by health professionals and the fellow patients. Bullington et al. [20] used the metaphor "order out of chaos" as descriptive of the path from seeking medical help to successful rehabilitation for chronic pain patients.

The overarching theme *My well-being in my own hands* bears a resemblance to Bandura's concept of agency [21]. Bandura distinguishes among three forms of agency – personal, proxy and collective. Personal agency refers to the control or influence individuals bring to bear on their own functioning and on environmental events. Individuals also exercise proxy agency by influencing others who have the resources, knowledge, or means to act on their behalf to achieve the outcomes they desire. Collective agency refers to people's shared belief in their power to produce desired results. In the interviews, all three forms were discernible. Personal agency was visible in the clients' conscious decision to make an effort towards attaining a more balanced life through physical exercise, enhanced sensitivity to the signals of their bodies and the determination to seek professional help when symptoms of burnout become present. Proxy agency was distinguishable in the clients' positive feedback on the rehabilitation professionals' expertise, empathy and encouragement. Collective agency was evident in the clients' accounts of group cohesiveness, support and the validation of personal experience through sharing. The reinforcement of agency is one of the key objectives in rehabilitation [22], and thus the feeling of taking control of one's personal well-being is testimony to the successful achievement of this objective [see also 20].

In our study, *Awareness* and *Approval* were significant drivers of change and recovery. Acquiring theoretical knowledge of the antecedents, forms of manifestation and methods of handling burnout was the key to becoming aware of one's own state. Clients were able to modify their view of their body and mind, and replace negative perceptions about being weak or lacking in resilience with a perception of a body and mind with natural limits. The internalization of this knowledge was translated into the motivation and ability to actively seek and/or accept help. Self-approval and self-mercy emerged out of this enhanced awareness and functioned as important factors in reducing the behaviors which had led, and could potentially again lead, to burnout, e.g., aspiration to perfection. These two categories have also been identified in earlier research: awareness was seen as a key to developing conscious strategies, while self-approval led to changing attitudes towards one's activities in the study by Eriksson et al. [23].

Support from the rehabilitation group was a significant source of empowerment, as it gave individuals the opportunity to learn from others' experiences and draw a parallel between one's own and others' perceptions of burnout symptoms. This is in line with findings from several studies indicating that the group helps its members to identify themselves with others and is instrumental in decreasing feelings of shame caused by the inability to handle everyday tasks at the beginning of rehabilitation [19, 23]. The group also offers an opportunity for emotional support through sharing experiences and exchanging information [24]. Fjellman-Wiklund et al. [12] consider the experience of affirmation and support from healthcare professionals and the group to be of particular importance during the early stages of recovery. In addition, Hållstam et al. [25] also confirm the role of support provided by health care professionals, family members and the rehabilitation group to be essential facilitators of change during the rehabilitation process.

The outcome of the process, *Regained joy*, was actively present in the clients' experiences. Ragained joy focuses on the present moment by comparing it to the time when burnout was at its most severe. As such, the outcome is less geared towards the future, as found by Fjellman-Wiklund et al. [12], who delineate Choice of track, with its subcategories of faith and hope, as one of the main categories. Discussion on clients' vision of the future was also present in our interviews, but was not a central theme spontaneously brought up in their accounts of the process. Clients adopted a systematic, planful attitude towards the future and expressed a wish for a follow-up course or support from occupational healthcare in the future. They also felt confident in their newly acquired ability to recognize burnout symptoms early enough and thus prevent the renewal of burnout, although they were slightly apprehensive of the possibility of suffering again from burnout.

On the whole, the categories identified in the present study are in line with earlier research findings [12, 19, 23, 25]. This is further evidence that recovery from burnout is experienced in a similar manner in rehabilitation programmes, and underlines the importance of the accumulation of affirmative events, knowledge and enhanced sensitivity to signals from the body and mind. On the other hand, Bernier's [11] assertion that changes in the work environment are associated with recovery was not suppported, which may, however, be ascribed to the fact that our study focused on individual-level factors for recovery.

Methodological considerations

To increase the validity, reliability and interpretative potential of the findings, we used various types of triangulation [15-17]. Triangulation between methods was applied by gathering data from semi-structured interviews and self-report data (i.e., BBI-15). Triangulation between researchers was also applied. The interviews were conducted by three trained independent interviewers who were not involved in the rehabilitation course, thus providing a neutral perspective. The interviews were coded by the first author and regularly discussed with the second and third author. The fourth author, who is an experienced burnout researcher, provided expertise in ascertaining the external validity of the categories that emerged. The fifth author, who is a rehabilitation physician and who enabled access to the clients in the three rehabilitation courses, provided practical expertise in burnout rehabilitation and recovery.

A possible limitation of our study is the fact that a semi-structured interview, despite its advantages, may unwittingly lead the client's account in a certain direction. In addition, where several interviewers are used their different interviewing styles may influence the flow of the interview and thus the production of accounts. Generalizations based on the results of this study are not warranted, as we only interviewed clients whose burnout symptoms had decreased during the rehabilitation process. While we can justify our focus in light of our objective of understanding a successful recovery process, we acknowledge that a different picture of the recovery process might have emerged if we had interviewed all the clients on all three courses. In addition, although the study clients well represented the typical population participating in rehabilitation courses of this type [6-8], it has to be borne in mind that the results mostly describe the recovery process as experienced by middle-aged women, as only one interviewee was male. Furthermore, as job burnout is caused by a mismatch between an individual and his/her environment [1], the role of the job environment is also crucial for recovery. However, since the main interest of this study was in individual-level facilitators of burnout recovery, the role of job characteristics in burnout recovery remains an important avenue for future research.

All the interviews were audiotaped and transcribed verbatim to ensure maximum data completeness. The first three authors read or listened to the interviews and discussed the codings. Categories were further discussed until mutual agreement on the representativeness of the process was reached. Semi-structured interviews were seen as an apt method for collecting data and capturing client experiences of the rehabilitation process.The use of qualitative methods to study subjective experiences and beneficial factors is a fruitful approach, as it increases the possibility of finding something as yet undiscovered, and thus also helps to develop hypotheses that later can be measured and tested by quantitative means. Additionally, a qualitative research approach to a burnout intervention allows a more holistic picture to be built of the factors clients find beneficial before and during the intervention as compared to quantitative research.

In conclusion, the rehabilitation courses studied here proved to be particularly beneficial to clients suffering from burnout symptoms. The course structure provided an effective setting for the activation of affirmative experiences and accumulation of knowledge, thus fostering recovery and potentially preventing the renewal of burnout. The professional support provided by the rehabilitation personnel along with the experience of sharing with and learning from others are crucial for triggering a process of enhanced awareness and self-approval towards a more rewarding life and more active control of one's personal well-being.

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CONFLICT OF INTEREST

Stela Salminen, Anne Mäkikangas, Marja Hätinen, Ulla Kinnunen and Mika Pekkonen declare that they have no conflict of interest.

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Table 1

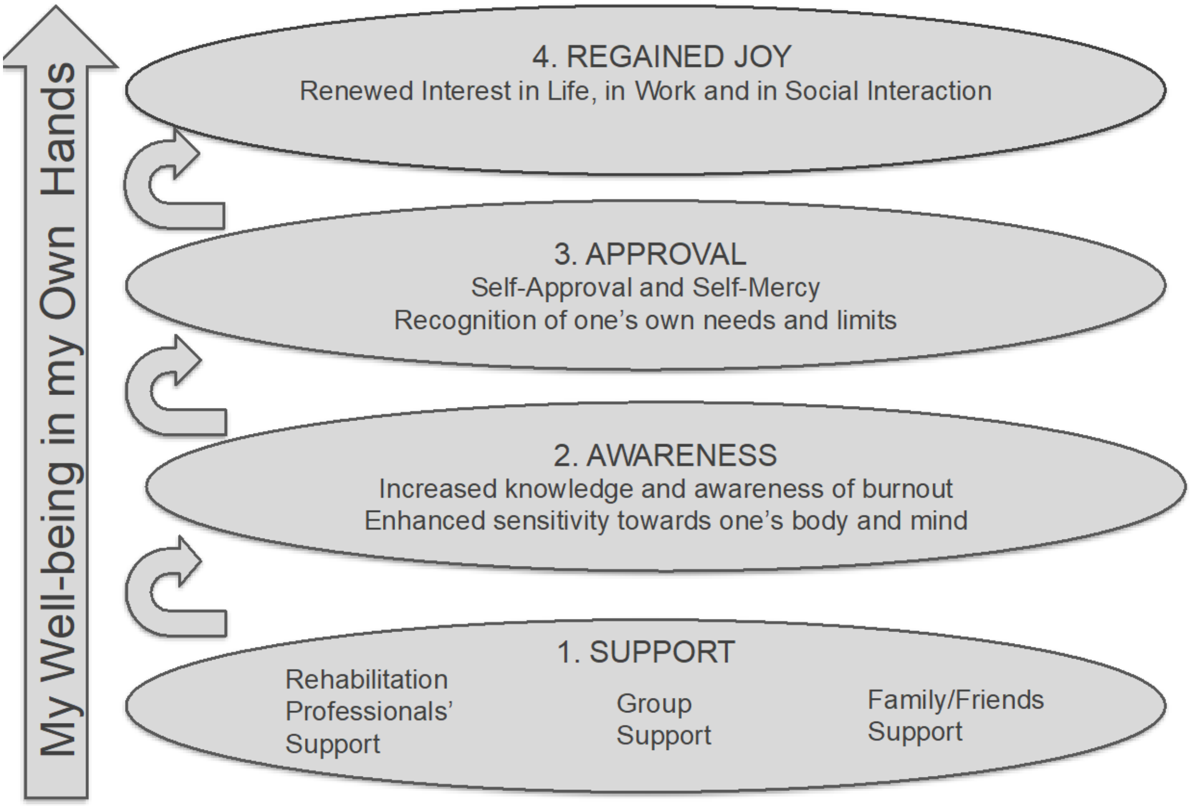
The contents of burnout rehabilitation

	Psychosocial activities	Physical activities	Other
Individual-level	• Individual guidance and counseling sessions with psychologist	• Interviews, tests and examinations by physician and physiotherapist	• Individual tasks between rehabilitation periods (individual rehabilitation plan)
Group-level	• Participative group discussions with psychologist* • One group discussion with psychiatrist • One group discussion with physiatrist (e.g., pain, medication) • Goal setting and attainment discussions • Social activation and guidance	• Physical exercise • Relaxation • Group discussions with physiotherapist • Health education (e.g., nutrition, exercise) • Ergonomics	• Different group activities with occupational therapist

* Examples of participative group discussion topics during rehabilitation:
’Stress, burnout, and depression’, ‘Sleep and relaxation’,’ Assertiveness’, ‘The relationship between thoughts and well-being’, ‘Means for reducing burnout’

FIGURE CAPTION

Fig. 1 Clients' experiences of recovery in a national burnout rehabilitation course. Categories, sub-categories and the overarching theme *My Well-Being in My Own Hands*, which emerged from the content analysis, are shown. My Well-Being in My Own Hands describes the entire process of recovery and the insight that clients themselves are responsible for their well-being.


My Well-being in my Own Hands
4. REGAINED JOY
Renewed Interest in Life, in Work and in Social Interaction
3. APPROVAL
Self-Approval and Self-Mercy
Recognition of one’s own needs and limits
2. AWARENESS
Increased knowledge and awareness of burnout
Enhanced sensitivity towards one’s body and mind
1. SUPPORT
Rehabilitation Professionals’ Support
Group Support
Family/Friends Support

II

NARRATIVES OF BURNOUT AND RECOVERY FROM AN AGENCY PERSPECTIVE: A TWO-YEAR LONGITUDINAL STUDY

by

Stela Salminen, Elena Andreou, Juha Holma, Mika Pekkonen, & Anne Mäkikangas,
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Narratives of burnout and recovery from an agency perspective: A two-year longitudinal study

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ABSTRACT

Purpose: To provide knowledge about the recovery process during rehabilitation and two years later by exploring the manifestation of agency and spheres of meaning in the narratives of participants in a national rehabilitation course.

Material and methods: The subjects of the study were four participants in a national rehabilitation course, whose burnout levels had decreased between the initial and follow-up periods of the course. Semi-structured interviews on two occasions and an electronic questionnaire 1.5 years post rehabilitation comprised the main material. In addition, the BBI -15 (Bergen Burnout Indicator) and DEPS-screen were used.

Results: Thematic narrative analysis revealed highly individual and heterogeneous paths of recovery. The first parts of the narratives demonstrated a high degree of proxy and collective agency. As recovery progressed personal agency was strengthened. The spheres of meaning participants attached to their stories also varied, with the rehabilitation course and the professionals involved being viewed as morally good. Three major common themes were identified: 1) the benefits of the rehabilitation course; 2) supervisor support; and 3) personal factors.

Conclusions: Burnout and recovery are not the consequence of work-related or individual-related factors alone, but rather the outcome of a combination of these. Regardless of common factors, the process and the degree of recovery may vary. The most beneficial path was observed when personal agency was high and was reinforced by a supportive job environment and favourable personal factors.

1. Introduction

Burnout is a work-related stress disorder, which affects a large number of people of working age in industrial countries. In Finland, in the latest national representative survey conducted in 2011, 2% of men and 3% of women in the workforce suffered from severe burnout, while the percentage of those with mild burnout was significantly higher: 23% and 24% for men and women respectively (Duodecim, 2015). In occupational health psychology, burnout is typically described as a reaction to long-lasting untreated occupational stress, which is characterized by three symptoms: exhaustion, cynicism and reduced professional efficacy (Maslach, Jackson, & Leiter, 1996). It is not classified as a medical disease, but instead an additional code (ICD-10: Z73.0) (Duodecim, 2015), which indicates the presence of a problem related to life control, is added to the diagnosis. The relatively high prevalence of burnout underlines the need for a better understanding of its antecedents, development processes and, above all, the paths to recovery. In response to this need, this study sought to capture subjective experiences from the onset of burnout to recovery.

Since burnout investigation began, a large body of research – mainly quantitative – has focused on the causes, symptoms and consequences of burnout (Schaufeli & Enzmann, 1998; Schaufeli, 2000). Although no single psychological theory offers a full explanation of burnout, it is commonly agreed that the causes of burnout can be divided into three categories (Schaufeli & Enzmann, 1998; Schaufeli, Maslach, & Marek, 1993): *individual* (burnout is regarded as the outcome of intrapersonal factors); *interpersonal* (burnout is seen as the result of difficult relations with others at work); and *organizational* (burnout is viewed as a mismatch between the person and the job). Consequently, burnout interventions have focused on these same categories of causes (Schaufeli & Enzmann, 1998). While rehabilitation interventions have been found to exert a positive effect on burnout reduction (Norlund et al., 2011; Stenlund, Ahlgren et al., 2009; Stenlund, Birgander, Lindahl, Nilsson, & Ahlgren, 2009; Stenlund, Nordin, & Järvholm,

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2012), particularly in the components of exhaustion (Hätinen et al., 2009; Hätinen, Kinnunen, Pekkonen, & Kalimo, 2007; Hätinen, Mäkikangas, Kinnunen, & Pekkonen, 2013) and cynicism (; Hätinen et al., 2007), the focus tended to be on investigating correlations between variables rather than individual developmental trajectories of burnout and recovery (Mäkikangas & Kinnunen, 2016).

The few qualitative studies on rehabilitation have highlighted an important concept – that of agency – and argued that the strengthening of agency is one of the primary goals in rehabilitation interventions (Järvikoski, Martin, Autti-Rämö, & Härkäpää, 2013). Theoretically, three different modes of agency are distinguished: personal, proxy, and collective (Bandura, 2000). Personal agency implies taking control or exercising influence with the aim of achieving or producing given effects. In many cases, however, individuals are unable to directly impact their social environment. Instead they employ a mediated form of agency, proxy agency, in which they turn to others in possession of the appropriate resources, knowledge or means to act on their behalf to produce the outcomes they desire. The third mode, collective agency, emphasizes the fact that many outcomes are achievable only through joint effort. At the core of it is people's shared belief in their power to achieve desired outcomes.

Although other studies on burnout rehabilitation do not refer specifically to the concept of agency, they identify similar themes and categories. In a study of an established rehabilitation intervention in Finland, utilizing the same baseline interview data as in the present study (Salminen, Mäkikangas, Hätinen, Kinnunen, & Pekkonen, 2015), the importance of the accumulation of support, awareness and approval led clients to the revelation that they are primarily responsible for their own well-being. The overarching theme of *My well-being in my own hands*, which emerged in the analysis, strongly resembles the concept of agency (Bandura, 2000). Another study, conducted in Sweden, of patients' experiences of rehabilitation consisting of two different intervention groups – one with cognitively-oriented behavioural rehabilitation and QiGong (a programme combining tension-relieving movements, relaxation and meditation), and the other with QiGong alone – produced similar results (Fjellman-Wiklund, Stenlund, Steinholtz, & Ahlgren, 2010). During the recovery process, patients emphasized the beneficial effects of affirmation and support from rehabilitation professionals and group members, in enabling them to restore control over their lives. Despite their contribution to the understanding of the mechanisms of change, a common feature of these studies is the use of a cross-sectional design, which does not yield sufficient information about participants' post-intervention experiences.

To our knowledge, there are no published qualitative studies which have tracked the development of the recovery process over time. To fill this gap, the present study is a pilot research comprising four narratives, which sets out to investigate the entire process from the onset of burnout to recovery at different time points during and after rehabilitation. The main focus was on the content of the narrative, i.e., on what participants told about the various stages of the process. As the reinforcement of agency is an important goal in rehabilitation and its significance has been demonstrated in previous studies (Järvikoski et al., 2013; Salminen et al., 2015), a further aim was to explore the role of the three modes of agency (personal, proxy and collective) in more depth along with their impact on recovery within this sample. Narrative inquiry was chosen as the primary method of investigation, as recovery paths are typically individual and heterogeneous (; Hätinen et al., 2013).

1.1. Narrative analysis

Narratives enable the exploration of human experience in a holistic manner by preserving its rich and complex nature (Bell, 2002) and recognizing lived experience as a source of knowledge and understanding (Clandinin, 2013). Within the framework of narrative research, a plethora of different definitions, approaches, and specific methods exists (Pinnegar & Daynes, 2007). For the purposes of this study, thematic narrative analysis, as described by Catherine Riessman (2008), was applied. It is one of the most commonly used types of narrative analysis, and one in which exclusive emphasis is placed on the content of the story told. While preserving the features of the individual narratives, this type of analysis enables identification of common thematic elements across the participants' accounts (Riessman, 2004). This type of analysis, with its exclusive focus on narrative content, was considered particularly suited to capturing both participants' experiences over time and the meanings they attribute to the process of recovery.

At the core of narrative inquiry lie questions about what the story reveals about the person and his/her world and what light interpretation of the story can shed on the cultural and social milieu in which the narrative is produced (Patton, 2015). In constructing their stories, individuals both incorporate their understanding of the surrounding world into the fabric of their narratives and engage in a sense-making process. Several spheres of meaning – emotional, explanatory, moral and ethical – can be discerned in narratives (Hänninen & Koski-Jännes, 1999) and these are explored in this study. Emotional spheres of meaning refer to the emotional underpinning of a narrative – whether the goals of the main character are achieved or thwarted, whether the story has a positive (happy) or negative (tragic) ending, what its high and low points are (Gergen, 1988). The explanatory perspective is related to the manner in which events are linked with each other as causes and consequences. The moral sphere of meanings deals with the allocation of responsibility for events and whether there are elements of accusation or excuse in the narrative (Baumeister & Newman, 1994). The ethical aspect articulates the deeper resonating elements of good and bad as well as right and wrong in life. Thus, in addition to the manifestation of agency and the exploration of the entire process of recovery, these four spheres of meaning are all discernible in the participants' narratives. Their identification provides a yet deeper level at which subjective experiences can be captured, while simultaneously revealing important perceptions about the broader social and cultural milieu in which the narratives are produced.

2. Material and methods

2.1. Study design, participants and data collection

This study comprises the narratives, collected on three occasions, of four participants in a Finnish national rehabilitation course. These courses were state financed, i.e., the Finnish Social Insurance Institution funds rehabilitation services and provides income during participation in the course. Participants either apply or are referred by their occupational health care service for a burnout intervention. Applicants and referrals are screened by the local branch of the Social Insurance Institution and the final selection is made by a physician from the rehabilitation centre. These rehabilitation courses start with a 10-day period and end with a follow-up period, which takes place within at most 7 months after the first period. Rehabilitation includes an evaluation of an employee's physical and psychological status by various professionals, including a physician, psychologist, physiotherapist, and social worker. The rehabilitation activities in burnout interventions focus primarily on enhancing individual resources and supporting coping strategies. This is achieved through various individual- and group-level activities. Individual-level activities, which account for 11 h of the 70-h rehabilitation programme, include guidance and counselling with various rehabilitation professionals, tests and examinations, and specific tasks to be completed between the rehabilitation periods. Group-level activities, amounting to 59 h, comprise physical exercise, education on nutrition, ergonomics and health, and participatory group discussions.

Participants for this longitudinal study were selected from various rehabilitation courses that took place in 2012 at a rehabilitation centre in Central Finland (Salminen et al., 2015). Of the three rehabilitation courses with a follow-up period between August and December 2012, 15 eligible employees, whose burnout levels had decreased, were identified, and 12 participated in the first phase of the study (Salminen et al., 2015). The psychologist at the rehabilitation centre informed clients whose burnout score had diminished of the possibility to participate in the study. Their willingness to participate in the follow-up phases of the study was also inquired. The baseline levels of burnout and the subsequent change were measured with the Bergen Burnout Indicator (BBI-15) (Näätänen, Aro, Matthiesen, & Salmela-Aro, 2003). The BBI-15 comprises the three symptoms of burnout: exhaustion, cynicism and reduced professional efficacy. Total scores vary between 15 and 90, forming four different classes of burnout: severe, moderate, mild and no burnout. Eligibility was determined if the burnout symptoms had decreased by at least one class and in at least one sub-dimension. The first interviews, which provide accounts of burnout development and experiences of the rehabilitation course were conducted after the end of the course follow-up period in the autumn of 2012 on rehabilitation centre premises (Salminen et al., 2015).

Participants were approached 1.5 years later (in Spring 2014) via an electronic questionnaire sent to their private e-mail addresses. The follow-up questionnaire measured participants' burnout and depression score with the BBI-15 (Bergen Burnout Indicator, BBI-15, Näätänen et al., 2003) and with the DEPS-screen (Salokangas, Poutanen, & Stengard, 1995). The questionnaire also included open questions, in which participants were asked to evaluate, e.g., their manager's activities, changes that had occurred at work and the impact different rehabilitation factors had had on their well-being. A reminder to those who had not answered was sent at the end of May 2014. Nine out of twelve participants sent back the filled-out questionnaire. Of the three participants who did not respond, one was on sick leave at the time of data collection and thus did not receive information about the questionnaire. The other two participants could not be reached.

Of the nine respondents, eight gave their consent to be contacted for further inquiry. Of these eight, four were selected through purposeful sampling (Patton, 2015) for an in-depth interview with a view to collecting differing stories of burnout and recovery. The sampling was based on the degree of recovery (continued recovery or worsened burnout) and on whether job change had taken place (two of the participants had changed jobs and two were in the same job). They were approached by e-mail and their willingness to participate in a follow-up interview was elicited in October 2014. Sample age at the last data collection point varied between 41 and 64 years (mean 55.8 years). Two of the participants had a vocational school education, one had completed a professional polytechnic qualification and one had a university degree. Time with the current employer varied between 3 months and 40 years. All participants were currently working, but one was on part-time retirement. The four participants whose recovery process was explored in more detail were interviewed by means of a thematic interview by a Master's student of Psychology in November-December 2014. The interviews were conducted in a quiet place in the participant's home. Each interview lasted between 1 and 1.5 h. The interviews were transcribed verbatim; however, the precise length of pauses, stutters and other sounds, and non-verbal language were not written down as the main emphasis was on the content of the story told. The total length of the transcribed interview material from the first and third data collection points was 138 pages, while the questionnaire administered at the second data collection point was 12 pages in length.

2.2. Data analysis

The accounts given at these three data collection points were regarded as three parts of the same person's narrative. This approach was adopted to honour the longitudinal design of the study and, more importantly, to allow the tracking of change over time through comparison of each participant's descriptions of burnout and recovery at the different time points, and of the different social conditions and places in which the data had been collected. This accords with the three commonplace features of narrative inquiry posited by Connelly and Clandinin (2006): attention to temporality, sociality, and place. Temporality refers to the continuity of experience and the fact that people and events are situated in time and are described with a past, present and future. The sociality commonplace reflects the notion that personal and social conditions shape the individual's context. The third commonplace draws attention to the fact that all events occur in a concrete physical place. In line with Riessman's (2008) presentation of thematic narrative analysis (p. 54), data were interpreted in light of the agency theme, which served as the theoretical framework for the study, i.e., the participants' accounts were viewed through the lens of agency and how its different modes were interwoven therein. In the analysis, the focus was on the content of the narratives, i.e., on what participants reported about the process, and not on how they reported about it. Furthermore, the choice of narrative analysis was justified as we wanted to view the narratives as whole entities instead of identifying categories as, for example, is done in other types of qualitative analysis.

The narratives for each participant from the three collection points were first read to grasp the general meaning and spirit of the story. During successive readings we focused on uncovering the particular manner in which the participant reconstructed the formation of burnout, how change started to emerge in the story, particularly in the rehabilitation stage, and how the process had continued at 1.5 and 2 years after the end of the rehabilitation course. While reading, we attempted to discern all three modes of agency as well as the presence of weak agency or the absence of agency. Once we had obtained a better understanding of the story, we proceeded to identify its emotional, causal, moral and ethical aspects. These were based exclusively on the participants' subjective experiences and their interpretation of the events before and during the burnout stage and throughout the recovery period. Finally, we assigned a title to the narrative, which reflected its core meaning. When the narratives of all the participants were analysed, we isolated the most important common themes for closer examination. The common themes were recurring topics, events or factors, found in all four narratives, which were experienced as particularly impactful in the whole process, and were thus indicative of either successful or impeded recovery. The participants were identified by a pseudonym to guarantee their anonymity and avoid any risk of their being recognized based on the narrative presented in the study.

2.3. Credibility

To increase the credibility of the study, the participants were originally selected from three different courses. The rehabilitation courses comprise a lot of group exercises, which aim to enhance group cohesiveness. However, this may lead to groupthink, and inhibit the expression of individual and differing opinions. By studying participants from different groups, we aimed to minimize this effect. To increase the credibility and interpretive potential of the study, data triangulation based on (1) a self-report questionnaire (BBI-15); (2) a written questionnaire at Time 2; and (3) semi-structured interviews at Time 1 and 3, was used (Denzin, 1970).

2.4. Ethical considerations

The study was approved by the Ethical Committee of the University of Jyväskylä, Finland. The study was introduced to the rehabilitation centre clients by the psychologist, who provided them with written materials. The voluntary nature of participation, anonymity and confidentiality were emphasized before the start of the study and were mentioned at each subsequent stage of the data collection. The participants signed a consent form and were informed of the possibility to discontinue their participation at any time during the study without any

Table 1
Open-ended narrative "Change is the only constant".

Massive constant changes − > very severe burnout − > rehabilitation 1st period − > change of job − > rehabilitation follow-up period − > improved well-being − > exacerbation of the work situation − > change of job − > mixed feelings/cautious optimism − > contemplation of change − > open-ended narrative
Emotional tone: mixture of optimism and disappointment
Explanatory: constant changes, no firm ground
Morally blamed: the lack of stability undermines one's foundations; problems are not taken seriously by management
Morally praised: daughter and dog
Ethically good: presence of support
Ethically bad: being treated without respect; being robbed of professional dignity

consequences. A consent for audio recording was also requested. Rehabilitation staff representatives were not present at any point during the interviews.

3. Results

3.1. Sara, age 57, kindergarten teacher, divorced: "Change is the only constant"

Sara's narrative reveals the story of a woman who found herself grappling with massive and constant changes in the workplace (Table 1). As these changes spun out of her control, they affected her well-being and eventually led to very severe burnout. It is important to note that she did not perceive that her burnout was caused by the nature of her work, personal conflicts or team-related schisms, but as a result of the rapid accumulation of changes, which undermined her feeling of belonging, role clarity and professional identity.*"What then started increasing my feelings of burnout was the constant, incessant change and the fact that there was no stability or clarity. I myself had the feeling sometimes that I don't know who I am anymore, let alone at the time when I was my colleague's supervisor for a year – a year and a half, and then all of a sudden I was an ordinary line worker alongside fellow workers."*

Her personal agency was present in the burnout stage in her efforts to call the management's attention to the detrimental effects of the constant organizational changes, but this mode of agency seemed to lack efficacy and failed to make an impact on the overall situation.

> *"When we then started falling ill and taking sick leave absences and substitutes came in, and they started falling ill, then occupational healthcare started to take an interest in our problem, the thing is that we tried very hard to communicate this and spread the word that things are not all right here, but simply nothing happened."*

The question of the accumulation of stress becomes particularly evident here: as Sara's burnout co-occurred with physical ailments and family problems (divorce), she attributed her symptoms of exhaustion, loss of professional pride and cynicism to these problems and thus failed to recognize the primary cause of her burnout.

> *"You are as burnt out as you could possibly be…you really need a break...I myself thought in a way that…that I have to demand more and more from myself, I have to just manage and cope with it, and so...I just didn't realize how deep I was in my own burnout."*

The high point in Sara's narrative was at the end of rehabilitation, which she saw as good, useful and affirmative. She also praised the role of her daughter and pet dog, who gave her the gentle push she needed for recovery. Her personal agency remained somewhat in the background, whereas proxy agency (help from rehabilitation professionals as well as family members) and collective agency (help from the rehabilitation group) were boosted.

After her first change of job, Sara continued on the road to recovery, but soon the same problems as in the previous workplace started to emerge. She had three different managers during the two years she spent in the second workplace. Thus, her account of the events during the 1.5 years after rehabilitation, was tinged with disappointment: replication of the same problems after her change of job following the rehabilitation course led to severe burnout, as also identified by her score on the burnout scale (BBI-15). Eventually, after this first job change she moved to her third workplace, shortly before the interview two years after the rehabilitation course.

The third sub-narrative was evaluative and retraced the full spectrum of events and emotions accompanying her burnout, rehabilitation and present state of well-being. Sara also discussed the effects of personnel turnover and the lack of stability in the workplace, thus attaching a morally negative meaning to the latter. It is noteworthy that despite the disappointment caused by her first job change her narration of events was informed by a certain degree of awareness and serenity. She was able to offset the full development of burnout by demonstrating proactivity, exercising personal agency and changing jobs again. The emotional tone in the third sub-narrative was cautiously optimistic and pronouncedly realistic, and Sara was not resigned to helplessness or hopelessness. Personal agency was manifested in her intentions to keep looking for a satisfying job:

> *"It hasn't at any point entered my mind, oh, what did I do, I mean I haven't thought, did I make the right decision or anything like that...I haven't really…and I saw that my coming to X. (her new workplace) happened just at the right point, it was good…[…]. My earlier workplaces were somehow...I always had to start from scratch and again from scratch and create routines…and I would have liked to create something, to drive something forward, but the reality of work somehow devoured so much. […] Now I feel I want to look at all the possibilities…'cos you know this job can be done in so many different ways…and especially here in [this] area there are so many ways…and it's an experience for me."*

The fact that Sara had moved to a new workplace prior to the interview explained why the narrative remained open-ended. She recognized that her recovery was a long process and was aware that she was not yet fully recovered. She hoped for a better outcome this time, and allowed herself to explore further opportunities, should the right moment arise.

Sara's personal agency, although existent, was rendered ineffective and futile by poor management of problems in the workplace. Proxy and collective agency were the most actively exercised during rehabilitation, which in turn boosted her personal agency.

The main cause for developing burnout were the constant organizational changes, which undermined Sara's feeling of stability, blurred her role clarity and robbed her of her sense of belonging and control. The narrative blamed the multitude of, in her view, pointless changes in the workplace which were not handled adequately by the management. Credit was given to family members (daughter and dog), who provided support without passing judgement. On a deeper, value-driven level, Sara saw the attitude of disrespect and disregard for her suffering as ethically bad even when these were openly raised. What Sara emphasized as ethically good was the support, despite all her suffering, provided by occupational health care, the rehabilitation professionals and family members.

3.2. Diana, age 61, reception nurse, married: "Eyes set on retirement"

Diana's narrative represents the path of an employee who suffered from severe burnout, which could not be completely treated, and who expects retirement to resolve the problem (Table 2).

For Diana, the accumulation of stressors leading to exhaustion was something that started a long time ago, when the number of reception nurses remained unchanged while the amount of work steadily increased. Before the onset of her burnout Diana described her working conditions as inadequate and the organizational climate as

Table 2
Narrative "Eyes set on retirement".

Inadequate work conditions and chronic overload − > severe burnout − > rehabilitation − > Harnessing burnout − > Subjectively perceived exhaustion − > part-time retirement − > looking forward towards full retirement
Emotional tone: resignation and fatigue
Explanatory: work overload and lack of adequate response thereto; physical ailments
Morally blamed: injustice
Morally praised: rehabilitation professionals and part-time retirement
Ethically good: own work ethic
Ethically bad: perceived injustice

unsupportive. Employees' needs were disregarded and the management failed to react to inequalities. Her hopes of improvement were shattered when, contrary to promises, an extra person was not hired, which led her to see herself as a victim of severe injustice. It was at this point that Diana felt she could no longer cope, and she started complaining of stomach aches and sleeplessness, which in turn led to increased exhaustion and sensitivity.

> *"And then the moment came…that I couldn't cope anymore. I had somehow managed up to when they promised again and again extra help, but then in the winter it just came to the point where I couldn't cope anymore. I had come up against a wall."*

An additional burdening factor mentioned by Diana was her sick mother who required daily care and taxed her resources. Through exercising proxy agency, with the help of occupational health care professionals and the rehabilitation course, Diana was able to moderate her burnout symptoms and achieve an improvement in her well-being. This was translated into increased energy levels and the motivation to engage in more physical exercise. However, Diana's focus regarding her means of recovery lay mainly in reducing her workload and being granted part-time retirement. She recognized the impact of her physical ailments on her well-being, and thus her efforts were directed towards minimizing strain rather than achieving full recovery in order to return to her pre-burnout work capability.

This slightly passive approach to recovery presumably led to an interesting discrepancy between her measured levels of burnout and the burnout she reported at the second time point. Although Diana's overall burnout score diminished between the first and second data collection time points, she nevertheless reported an increase in burnout symptoms. Such a mismatch could perhaps be accounted for by her approaching full retirement age as well as the various physical ailments she suffered from. Presumably, she invested less effort in recovery, i.e., she exercised personal agency on a smaller scale, and instead focused her attention on retirement.

The last part of the narrative at two years post-rehabilitation was more contemplative and oriented towards the family. Both sides of the burnout and recovery process were voiced. The overall tone became more philosophical as realisation of one's age and finiteness grew. In relating her expectations of the future, Diana expressed a wish to be healthy and able to spend time with her children and grandchildren. Hence, her personal agency was more directed towards reaching and maintaining good physical health so as to be fit to serve her family members.

> *"I'm waiting for retirement and then I hope I'll be healthy again, so that we can travel and have hobbies, and then of course that I'll have the energy to take care of my grandchildren and play with them…this is a wonderful time that I'm looking forward to."*

In Diana's narrative, proxy agency is the most prominent mode of agency and the mode exercised most actively across the study period. Diana holds experts' tips and recommendations in high regard and relies strongly on their knowledge and encouragement. Occupational health care and rehabilitation professionals along with her rehabilitation group played a significant role in the process of recovery and they remained instrumental in maintaining it. Personal agency was also identifiable in her account, although to a lesser degree. It was reactivated during and after the rehabilitation course, and was primarily visible in Diana's attempt to maintain a healthier lifestyle through sports and balanced nutrition.

The overall emotional tone was of slight resignation and fatigue, although in the last part hope and expectations for the future were also voiced. The narrative did not incline towards a positive or a negative end, but could rather be categorized as suspended. The cause of burnout was perceived as work overload and the lack of an adequate organizational response thereto, combined with personal ailments. From a moral perspective, the rehabilitation programme and the peer support were praised whereas the disregard for employees' suffering and the injustice inexperienced were harshly blamed. On a deeper level of values, Diana viewed her work ethic and her connection to her family members as good and the injustice perpetrated toward a particular employee group as ethically evil.

3.3. Paula, age 41, management secretary, married: "The successful job changer"

Paula's narrative describes the burnout and recovery process, starting from breakdown to the regaining of joy and clarity by means of a mental shift (Table 3). She depicts the accumulation of an excessive workload, to which she responded with habitual conscientiousness, and the implementation of managerial changes. Paula realised that the amount of work was becoming intolerable, but despite her attempts to bring the problems of understaffing to the management's attention, her concerns were not adequately responded to and nothing changed to lighten the burden. Simultaneously, she had health problems which caused fatigue and prevented her from recognizing that she had symptoms of burnout. She also started suffering from sleeplessness and anxiety over unfinished work until her breakdown, which happened "overnight". With regular help from occupational health care professionals (a physician, a health nurse and a psychologist), in other words, through exercising proxy agency, she was able to articulate her problems and become aware of her burnout. The identification of the problem triggered an initial reaction of fear:

> *"It was awfully scary…you know, all of a sudden I can't manage anymore. But the scary thing was that I had been walking with my eyelids shut, in a tunnel. And it (burnout) had been there for a long time, but I hadn't realized it myself. So… fear was the biggest thing, I guess."*

Paula demonstrated initiative and sought the services of a private therapist to gain an outside perspective on her state. She also spoke about the enormous gratitude she felt towards her dog, who was by her side, non-judgemental and supportive, throughout the entire process. After several stints of sick leave, she returned to work part-time, but continued on partial sick leave. Specific changes regarding the division of labour were introduced and agreed upon in writing, and an additional person was hired to lighten the workload.

Table 3
Narrative "The successful job changer".

Excessive workload − > Unawareness of the symptoms − > Utter exhaustion and breaking down overnight − > Occupational health care support − > Stints of sick leave and commencement of recovery − > Return to work − > Rehabilitation − > Processing − > Job change − > Revival − > Maintenance of balance
Emotional tone: revival
Explanatory: excessive workload combined with extreme conscientiousness
Morally blamed: work ethic in the childhood family
Morally praised: rehabilitation
Ethically good: mental maturation
Ethically bad/evil: perceived injustice

For Paula, rehabilitation came after the acute stage of burnout had been overcome and the initial phases of recovery had commenced. She believed this enabled her to benefit from it the most and she described the experience thus:

> *"[What did rehabilitation mean for you?]*
>
> *P: Pausing…and complete and thorough processing of these things. It has been…let's see how I am, how I feel. Perhaps I had always pushed myself into the background before, to make room for other things. So [in rehab] I could be myself, for myself. "*

Paula had to go through a profound and thorough process of reprioritizing her values: coming from a family with entrepreneur-mother, Paula believed that work had to be done and was top priority. Positioning her own well-being higher in the hierarchy required conscious effort and personal agency, but the outcome, already at the first time point, was improved work-life balance. Overall, despite the positive changes, Paula was aware that the process of recovery was slow and time-consuming, and she admitted the possibility of a renewal of burnout. As a preventive measure, Paula brought up "talking earlier" and "strongly desiring change".

Factors hindering recovery were related to the management, who instigated the subsequent changes. Problems with her indirect supervisor led to an increase in burnout symptoms. With the help of her direct line manager, who was supportive and helpful, she was transferred to another unit within the same organization between the first and second data collection points.

At the second time point, Paula experienced a lot of positive changes. She felt accepted and welcome in the new team, enjoyed greater responsibility and was able to craft her job more freely. Despite the long distance between her home and the workplace, Paula felt that she was in charge of her life again, which in turn had a positive effect on her relationship with her husband and children. The emotional tone of the narrative was elated and hopeful. The amount of personal agency she exercised had grown and was visible in her motivation to engage in sports, eat healthily and maintain her well-being. She also actively revisited the lessons learnt during rehabilitation and could now see her burnout in a positive light:

> *"Burnout can affect anyone. I am happy I went through that hell, because I was able to grow as a person."*

Paula's state two years after rehabilitation (at T3) was good, although at the time of the interview she was on a sick leave due to physical ailments. She was able to reflect more extensively on her change of job and the apprehension she had felt at that time. Her motivation to avoid burnout or be able to detect it in time was visible in her conscious monitoring of her state, in her efforts to keep her workload within manageable proportions and in her ability to listen to her body's signals, all of which are manifestations of enhanced personal agency. Proxy agency was exercised through the supervision provided by her workplace, which served as a forum for self-reflection and additional monitoring of her well-being. Paula had adopted a new mindset through a mental shift:

> *"I've realised I'm not omnipotent […] a kind of tranquillity has settled in…being merciful to oneself […] I've done so much…that I find joy in things in a new way or in a bigger way than earlier. Earlier I would have stared at the unfinished work…oh, there are still so many things to do, and I've only done this…now it's the other way around: I have finished so much, and well, there are still unfinished tasks…but they don't stress me...I'll get down to them next."*

A factor taxing her resources was her mother, who was recovering from cancer, but this was counterbalanced by an increased pool of physical, mental and interpersonal resources. However, she reported an enhanced maturity and prudence in accepting additional tasks. In summing up the main reasons for her recovery Paula gave credit to the rehabilitation programme for providing her with valuable knowledge about burnout and helping her adopt a mindful attitude and an ability to be present. She expressed gratitude to her husband, who had been a source of support during the burnout period, and was thankful for the opportunity to have a new rewarding job. Her vision of the future was positive and more family-oriented.

Paula demonstrated a lot of personal and proxy agency, both at the beginning, prior to her development of burnout, during her sick leave and after rehabilitation. It is noteworthy, however, that personal agency, even when present, failed to lead to the desired results at the workplace. The restoration of balance was a slow process in which personal agency was supported through the deployment of proxy and collective agency. Her extensive use of occupational health care was essential not only in raising awareness and initiating a mental shift, but also in building robust personal agency in the form of assertiveness and self-mercy.

Paula held the accumulation of excessive workload and the mindset of being in charge accountable for the development of her burnout. This combination generated a vicious circle of increasing extra duties and an inability to put a stop to it. Breaking point was reached "overnight". She found fault with the work morality adopted in her childhood family, whereas she praised the rehabilitation programme. On a deeper level of values, "evil" was seen in the injustice present in the workplace, in which employees were not treated equally. The ethical virtue in turn can be seen in Paula's mental maturation. Her mental awakening and strengthening of personal agency, which occurred through the reception of external help, transformed her from being a victim into being an active agent.

3.4. Astrid, age 64, director, married: "Turning being married to the job into a happy marriage"

Astrid's narrative is an example of successful recovery (Table 4). It demonstrates well the recovery of personal agency in a balanced manner, although it should be borne in mind that her initial burnout level was not high. Astrid felt the onset of burnout two years before the rehabilitation course, when the pace at work intensified and she started having problems sleeping. Astrid's exhaustion was the main reason she sought help and participated in rehabilitation. The pressure caused by work was intensified by personal factors (her husband's disease and aggravated poor health) and accelerated by her own health problems, which taxed her physical and mental resources. The onset of burnout also caused Astrid to rethink what work meant to her: although she was close to retirement she did not want to leave her life's work unfinished.

Her response to burnout was proactive and personal agency was discernible in several aspects: she sought means to alleviate the situation by learning to delegate, by accepting social support from friends and colleagues, and by listening to music. The programme gave Astrid many take-home messages and led her to make significant shifts in her thinking and in her perception of her own boundaries. She became aware of her tendency towards perfectionism and adopted a more merciful and self-approving attitude. Her well-being even started

Table 4
Narrative "Turning being married to the job into a happy marriage".

Pressure at work and concerns about husband's health − > exhaustion − > unawareness of her own state − > recommendation by a doctor − > rehabilitation programme − > raised awareness − > increased self-mercy and assertiveness − > mental shift − > re-ordering of priorities − > full recovery
Emotional tone: happy and relieved
Explanatory: own perfectionism
Morally blamed: feeling of insufficiency
Morally praised: rehabilitation and husband's recovery
Ethically good: re-ordering of priorities in life and being reconnected to her family
Ethically bad: –

improving between the two periods of the programme through an accumulation of positive events (improvement in husband's health, normalization of working hours, time spent with grandchildren) and personal agency (sports, conversations at home about her spouse's disease, changes in nutrition). The work environment and the hiring of an extra person allowed for a more long-term planning and forecasting, which in turn exerted a beneficial effect on Astrid's well-being. She also attributed the commencement of recovery to the peer support received from the rehabilitation group, which reinforced her proxy agency. A significant mental shift was discernible in her account:

> *"When I came here it felt like being in a tunnel, with no light at the end of it. The walls were falling in. But now I see so many other possibilities, that work is not always the only right thing to do, that there are other things you can spend your time on. I don't know, I don't understand if I was really so burnt out that I didn't see anything else. But now my mind has begun to clear in a totally different way"*

Astrid's well-being was maintained after the rehabilitation programme and was detectable already at the second time-point. This was also confirmed by the BBI-15 measurement score, which showed no presence of burnout. The third sub-narrative was assertive, imbued with positive emotion, self-confidence, dedication and commitment to work. Work was perceived as manageable and enjoyable, and Astrid's leadership was visible in decision-making, conflict resolution and her handling of minor problems in the workplace. Astrid perceived herself as fully recovered. There is also a sense of relief, as her husband's suspected disease turned out not to be serious. As her recovery advanced, Astrid put renewed effort into her hobbies, which further accelerated recovery. Astrid's personal agency was high, and she argued that recovery starts from oneself, but she also exercised proxy agency by relying on the occupational nurse's recommendations:

> *"Recovery starts from oneself...I've learnt work the hard way and also I use the word letting go and I have delegated to the others...I have just learnt it and come to the realisation that if I don't let go then I won't be able to manage…and then there's the occupational health nurse […] who always reminds me of my well-being…so this is also a means of help"*

She concluded her narrative in a slightly humorous way, which condensed the meaning of the transformation she had undergone:

> *"When I turned 60 I said in my thank you speech that the theatre has been my second home and my husband corrected me saying that it was the first (laughter)…and then I pondered for the first time whether everything is in the right order (laughter), that indeed it has been like that...I don't know if it's inherited from home, but work has always been number one…and it has been extremely difficult to change this, but I think I have succeeded in it."*

Astrid's narrative demonstrates the power of proxy agency represented by the doctor, who suggested taking a distance from work, and the occupational health nurse, who supported her at a later stage. Astrid was able to avail herself fully of the lessons learnt in rehabilitation. Her narrative, describing her raised awareness, mental shift and a changed attitude towards herself and work also shows the strengthening of her already existing personal agency. Her motivation to manage at work until retirement was high, but this was handled in a balanced way, allowing for the incorporation of other meaningful and important aspects of life such as the family, social engagements and sports activities.

The narrative is complete, and its emotional tone is one of happiness and relief. Her recovery, commenced two years earlier, continued on a stable path, along with a realignment of her values and priorities in life. The explanation for burnout was found in oneself: Astrid's perfectionism and inability to delegate duties is perceived as the main reason for her burnout. She blames her own feeling of inadequacy and her desire to maintain control over everything, whereas she expresses her gratitude to the rehabilitation professionals and for the positive events related to a family member's health. On the ethical level, Astrid did not identify anything as "evil", but instead celebrated the re-ordering of her priorities in life and the re-emergence of connectedness with her family.

3.5. Common themes

According to Riessman (2004, 2008), thematic narrative analysis enables common thematic elements to be tracked across participants' accounts while at the same time preserving the story as an entity. Following Riessman's guidelines (2008), we identified three common themes that were encountered across the narratives and which were particularly meaningful for all four participants.

3.5.1. The benefits of the rehabilitation course

There was common agreement that the rehabilitation course was crucial for the recovery process. The course was regarded by all participants as highly beneficial and awareness-raising. The support and affirmation given by the rehabilitation group validated the experiences each participant had individually gone through. The knowledge and practical advice provided by the rehabilitation professionals, along with their non-judgmental attitude, helped participants articulate and comprehend their burnout situation and achieve bodily and mental awareness. Through rehabilitation and the exercise of proxy (via the professionals) and collective (via the group) agency, the participants' personal agency was re-activated and strengthened, with its effects extending well beyond the duration of the course. Rehabilitation was also an object of the participants' sense-making process and came in for moral praise.

3.5.2. Supervisor support

Supervisor support was of immense importance for recovery. An understanding, empathic supervisor was able to alleviate the symptoms of exhaustion and facilitate the re-adaptation to work by ensuring adequate working conditions and providing emotional support. An unsupportive or neglectful supervisor, on the other hand, rendered one's personal agency completely ineffective (in Diana and Sara's cases), led to an increase in burnout symptoms and the experience of injustice. Furthermore, such a supervisor could precipitate a change of job (as in Paula and Sara's narratives).

3.5.3. Personal factors

Personal factors such as divorce, the sickness of a close family member or of oneself had a substantial impact on both the onset of burnout subsequent recovery from burnout. The simultaneous presence of a disease prevented or obstructed the participants from registering or distinguishing the onset of burnout. The fear and anxiety as well as physical ailments caused by the disease in question led in general to a decrease in personal resources and an increase in reported symptoms of exhaustion and impaired work capacity, as seen in Paula's and Diana's stories. Crises such as divorce slowed down recuperation, as demonstrated in Sara's narrative. The suspicion of a major disease in the participant's partner, as in Astrid's case, had a similar effect, causing the participant to experience an enormous emotional burden on while the removal of that threat had an immediate positive impact on the participant's well-being.

4. Discussion

The present study investigated the narratives of four participants covering the onset of burnout and recovery therefrom over the course of two years. The results demonstrated that recovery from burnout is a slow and individual process, which does not follow a uniform path.

The most crucial factors for recovery in this particular sample were agency, participation in the rehabilitation course and the supervisor support. Agency bears a resemblance to taking control of one's life, being in charge and assuming responsibility, and studies have shown that it plays a significant role in rehabilitation (Järvikoski et al., 2013; Salminen et al., 2015). Agency is a robust predictor of well-being and adaptive psychological functioning across time (Gallagher, 2012), which emphasizes further the long-term effects of a strengthened sense of agency. Congruent with this finding, rehabilitation was instrumental in reinforcing personal agency through proxy and collective agency with a relatively long-term impact. Conversely, the phase of burnout was associated with ineffective personal agency and the absence of other modes of agency. It is noteworthy that even in the narratives of interrupted recovery and increased burnout personal agency remained present, although to a lesser degree than in the narratives of stable recovery. The combination of high personal agency with a supportive job environment and conducive personal factors provided the most favourable prerequisites for beneficial recovery.

The rehabilitation course was perceived by all participants as having had an enormous positive effect on their recovery. It provided numerous healing experiences, affirmation and valuable knowledge instrumental for the early recognition of burnout symptoms. Rehabilitation interventions have been recognized as means for the validation and affirmation one's experiences of burnout in previous research, although the overall benefit has varied depending on the structure and content of the intervention (Salminen et al., 2015; Fjellman-Wiklund et al., 2010; Söderberg, Jumisko, & Gard, 2004).

Supervisor support or the lack thereof had a huge impact on the ease of making the return to work and was an essential factor influencing participants' perception of stress. A supportive manager had a positive impact on well-being by alleviating the symptoms of exhaustion and helping the recovering employee re-adapt to work. This relationship has been demonstrated in other studies as well: Aas and colleagues (Aas, Ellingsen, Lindøe, & Möller, 2008) showed that certain leadership qualities, e.g., the ability to make contact, being understanding, being empathic, facilitate the return to work after sick leave whereas lack of support leads to an increase in the frequency of sick leave (Vaananen et al., 2003).

The narratives presented here were highly individual and heterogeneous, which bears testimony to the fact that burnout is a multiplex phenomenon as confirmed by other studies (Rutherford & Oda, 2014). Participants were able to voice their understanding of the path they had walked and attribute particular meanings to the events and experiences encountered. As expected, there were also certain similarities and common features, particularly in the phase preceding the onset of burnout, e.g., heavy responsibilities, bodily manifestations, fatigue and ultimately breakdown, which have been reported in other studies as well (Ekstedt & Fagerberg, 2005). The recovery phase manifested more variation as the participants adopted partially divergent strategies (e.g., change of job vs. no change; agentic versus passive/receptive approach) and were affected by factors beyond their control, e.g., adverse changes in the workplace and attitude of supervisor. The narratives presented here demonstrate that a change of workplace per se was not a decisive factor either contributing to or impeding healing, as found in previous research (Bernier, 1998). A significant factor was the amount of change in important areas such as supervisor support, and the possibility to influence one's workload and implement changes aimed at diminishing work stress. Personal factors such as deterioration in one's own or partner's health, or disruption in the family (divorce or death of a close relative) also played a major role in the exacerbation of burnout and impeded the path to recovery. This demonstrates that burnout does not occur in isolation from other life events, but in parallel with them, which in turn presents the risk of burnout remaining unrecognized. Furthermore, recovery may be slowed by these personal factors even when the necessary changes are implemented in the workplace.

4.1. *Methodological considerations*

To increase the validity and reliability of the findings, we applied different types of triangulation. Triangulation between methods was implemented by collecting data from semi-structured interviews and self-report data (i.e., BBI-15, Näätänen, 2003) at the first and second data collection points). Researcher triangulation was also employed. The first interviews in 2012 were conducted by three independent interviewers who were not involved in the rehabilitation course and thus provided a neutral perspective. The interviews at two years post rehabilitation were conducted and transcribed by the second author. The third author, who is a clinical psychology researcher, provided knowledge of and practical guidance on the application of qualitative methods. The fourth author, who is a physician and an expert in burnout, provided access to the rehabilitation course and participants and ensured a smooth data collection. The last author and the project leader, who is an experienced work and organizational psychologist as well as an occupational health researcher, provided expertise on the theoretical background and data analysis.

All the interviews were audiotaped and transcribed verbatim to ensure maximum data completeness. The filled-out questionnaires were stored in accordance with the ethical guidelines of archiving in Finland, and the BBI-15 scores were calculated by the first author to determine participants' burnout category at the second collection point. Purposeful sampling (Patton, 2015) was applied in the study as we wanted to explore the effect of job change on subsequent recovery. Semi-structured interviews were regarded as a suitable method for capturing the experiences of participants, and the use of a questionnaire containing both structured and open questions was seen as an apt tool for reporting interim status. The use of narrative methods of analysis was justified due to the size of the sample and the longitudinal nature of the data. The use of narratives allowed a more integrated interpretation of the experiences reported by the participants (Bell, 2002) and a focus on the overall road from burnout to recovery or repeated burnout. Tracking the process of recovery over time offered a unique opportunity to uncover individual paths and sense-making processes.

The present study has naturally certain limitations. First, as it was the outcome of purposeful sampling, the size of the sample was very small (Patton, 2015). A larger number of studied participants could reveal further common themes and demonstrate in greater depth the impact on recovery of changing vs. not changing one's job. Additionally, all the participants were female and thus further studies with mixed samples are needed to validate the results across gender. However, the study participants were representative of the population typically attending such courses (Hätinen et al., 2009, 2007, 2013). The results cannot be generalized beyond the study participants owing to the size of the sample and the fact that participant selection was based on a decrease in burnout symptoms. On the other hand, such generalizations are also beyond the scope and purpose of qualitative studies. As this is the first study investigating long-term recovery from burnout by applying a narrative approach, it should be emphasized that the outcomes of the analysis may reflect characteristics of the burnout and recovery processes specific only to these four participants.

4.2. *Conclusions*

In all, the narratives demonstrated that the process and the degree of recovery from burnout vary, as a multitude of factors – individual effort, rehabilitation, change of workplace, and supervisor support – shape and modify the path each individual takes. The most favourable path to recovery appeared to be activated when personal agency was strong and other life areas – job environment, supervisor, and family members – were conducive to recovery. It should be recognised, however, that the relevance of agency may be overemphasized as the study participants were initially selected on the basis of successful recovery, even if purposeful sampling, using the criteria of degree of recovery and job change, was applied at the last data collection point. Although the aim of the study was not to evaluate the effectiveness of the rehabilitation course, it is noteworthy that the course was essential both in equipping the study participants with the tools to recognize and deal with burnout and in strengthening all three modes of agency, and thus its inclusion in burnout treatment should be considered. Future studies should aim at deepening the existing knowledge on the relationships between agency, job environment and long-term recovery in a larger and more diverse dataset, preferably including family members' subjective experiences of the entire process.

Conflict of interest

The authors declare that there are no conflicts of interest.

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III

SPOUSES’ EXPERIENCES OF REHABILITEES’ BURNOUT AND RECOVERY

by

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