

**A SALUTOGENIC PERSPECTIVE OF BURNOUT
IN THE
NURSING PROFESSION**

by

CHARL FRANCOIS DE WET

submitted in accordance with the requirements
for the degree of

DOCTOR OF LITERATURE AND PHILOSOPHY

in the subject

PSYCHOLOGY

at the

UNIVERSITY OF SOUTH AFRICA

PROMOTER: PROF F VAN N CILLIERS

JOINT PROMOTER: PROF C MOORE

NOVEMBER 1998



0001727982

I would like to thank the following people:

My wife, Lizette, who dragged this out of me,

My friends, Marita and Nico Breed, who never stopped nagging.

My Canadian supporters, Sharon Kirwan and Wayne Corneil who made this study possible,

My promoter, Frans Cilliers, who never gave up on me,

My joint promoter, Cora Moore, who gave me wise advice,

My parents, Abraham and Elzabe de Wet, who prayed for me,

My father in law, Gerhard Lourens who read the whole manuscript and was my South African connection and helped in so many ways,

My siblings, Christa and Abrie, who supported me and was proud of me, and Mariaan, who can kick butt with the best of them.

Maryna Haumann and Sandra Mills for their hard work,

All the research participants who shared their experience with me.

Thank you.

Charl de Wet

Canmore, Alberta.

Summary

The research has worked towards the general aim of generating a synthesis of burnout in the nursing profession, and also towards coming to a synthesis of burnout in nursing from the perspective of the salutogenic paradigm. Existing knowledge from the literature has been consolidated and integrated, and 'new knowledge' of the phenomenological experience of the causes and symptoms of burnout and how nurses stay healthy, were presented.

Firstly was discovered that burnout, over time is caused by various factors that are individual and personal and therefore not easily discovered by other than the phenomenological method, where the life world of each individual is described.

Secondly, the study of the strengths that nurses exhibit in order to manage the tension and stress in their lives and not to succumb to illness, proved to be a sound and descriptive paradigm with great utilisation possibilities. Three answers to the salutogenic question, namely sense of coherence, hardiness and learned resourcefulness were presented in great detail.

Thirdly, it was stated that the individual nurses and the nursing practice in general be made aware of: (1) the existence of burnout, (2) the contributing factors to burnout, (3) the various manifestations of burnout at work and in the organisation, and (4) the coping strategies available to counter this problem in a positive and salutogenic manner. The phenomenological results of this research revealed a number of issues that have implications for both the prevention and treatment of burnout in nurses. The results especially established how nurses can operationalise their inherent salutogenic qualities. Specific salutogenic coping strategies emerged via the respondents.

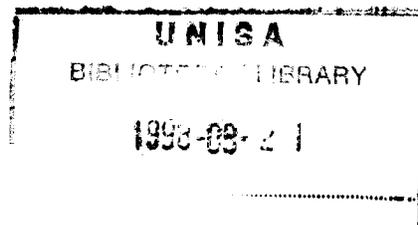
The research took a broad view of personality in health research. It studied the psychological processes underlying the observed connections between psychological variables and health outcomes. In order to study the operationalisation of these processes, a phenomenological, person-based approach was followed. The study focussed on health

phenomena and the individual nurse was retained as the unit of analysis. This approach represented a movement away from a fragmented science, infatuated with technology and linked to a singular epistemology, towards a focus on the process and dynamics of personal experience.

Key terms

Health research; Burnout; Salutogenesis; Hardiness, Sense of coherence; Learned resourcefulness; Personality; Individual strengths; Nursing staff and nurses; Phenomenological research method; Person-based approach; Management of burnout; Salutogenic coping strategies

158.723 DEWE



CONTENTS

	Page number
CHAPTER 1	1
ORIENTATION AND SCIENTIFIC BACKGROUND OF THE RESEARCH	1
Background to the Research	1
<u>The Nursing Profession</u>	2
<u>Burnout</u>	2
<u>The Choice of a Paradigm</u>	5
<u>The Choice of the Research Methodology</u>	8
Problem Statement	10
Research Questions	10
Aims	11
Research Model	12
Paradigm Perspective of the Research	16
<u>Field of Study</u>	16
<u>Relevant Paradigms</u>	17
<u>The Relevant Metatheoretical Views</u>	18
<u>Person</u>	18
<u>Illness</u>	18
<u>Health</u>	19
<u>Reality</u>	20
<u>The Market of Intellectual Resources</u>	20
<u>Theoretical Beliefs Regarding this Research</u>	21
<u>The Systems Model of Stress</u>	21
<u>The Transactional Model of Stress</u>	26
<u>Methodological Beliefs</u>	26
<u>Central Research Hypothesis</u>	28
Research Design	29
<u>Phenomenological Research Design</u>	30

<u>Quantitative Research Design</u>	31
Research Method	32
<u>Validity and Reliability of the Literature Survey</u>	33
<u>Validity and Reliability of the Operational Phase</u>	34
Designated Chapters	36
CHAPTER 2	37
BURNOUT	37
The Concept of Burnout	37
<u>Towards a Definition of Burnout</u>	38
<u>Characteristics of Burnout</u>	41
<u>Conceptual Issues</u>	44
<u>Burnout and the Public Service Professions</u>	45
<u>Burnout as a Distinctive Concept</u>	47
<u>The Diagnostic Criteria that would Allow Burnout to be Identified</u> <u>Within an Individual</u>	51
<u>Models of Burnout</u>	52
<u>Burnout and its Sequelae as Developing Stages or as a Random Occurrence</u>	55
<u>Differential Diagnosis</u>	57
<u>Anxiety</u>	57
<u>Acute stress</u>	59
<u>Delayed stress</u>	60
<u>Post Traumatic Stress Disorder</u>	63
Antecedents of Burnout	65
<u>Intrapsychic and Individual Factors in Burnout</u>	68
<u>Personal Characteristics as an Antecedent of Burnout</u>	68
<u>Personality as an Antecedent of Burnout</u>	68
<u>Human and Public Service as an Antecedent of Burnout</u>	69
<u>Lack of Control as an Antecedent of Burnout</u>	70
<u>Existential Issues as Antecedents of Burnout</u>	71
<u>Interpersonal and Social Factors in Burnout</u>	72

<u>Social Support as an Antecedent of Burnout</u>	72
<u>Asymmetry of the Helping Relationship as an Antecedent of Burnout</u>	74
<u>The Lack of Sense of Community as an Antecedent of Burnout</u>	75
<u>Organisational Factors in Burnout</u>	76
<u>Job and Role Characteristics as an Antecedent of Burnout</u>	76
<u>Organisational Characteristics as an Antecedent of Burnout</u>	78
Consequences of Burnout	79
<u>Physical Consequences</u>	79
<u>Emotional Consequences</u>	80
<u>Interpersonal Consequences</u>	81
<u>Attitudinal Consequences</u>	82
<u>Behavioural Consequences</u>	82
Coping Strategies	83
<u>Intrapersonal Coping Strategies</u>	84
<u>Interpersonal Coping Strategies</u>	86
<u>Organisational Coping Strategies</u>	88
Manifestations of the Burnout Concept in the Nursing Literature	89
Limitations in the Burnout Concept	92
<u>Limitations in the Conceptual Framework</u>	92
<u>Limitations for this Research</u>	94
Applicability of the Burnout Concept	95
Chapter Summary	96
CHAPTER 3	99
SALUTOGENESIS	99
The Concept of Salutogenesis	99
<u>From Concept to Paradigm</u>	100
<u>Towards a Definition of Salutogenesis</u>	102
<u>Stress and the Stress Response - Pathogenesis or Salutogenesis?</u>	103
<u>Characteristics of Salutogenesis</u>	105
<u>General Resistance Resources (GRRs) within Salutogenesis</u>	107

<u>Health Practices</u>	110
<u>Social Support</u>	110
<u>Personality Characteristics</u>	110
<u>Personal Coping Techniques</u>	111
<u>Three Answers to the Salutogenic Question: Whence the Strength?</u>	112
Sense of Coherence	113
<u>Historical Background</u>	113
<u>Definition</u>	114
<u>The Sub-Components</u>	114
<u>Manifestation in the Individual's Personal and Social Life</u>	116
<u>Sense of Coherence and Work</u>	118
Hardiness	119
<u>Historical Background</u>	119
<u>Definition</u>	119
<u>Sub-Components</u>	119
<u>Manifestation in the Individual's Personal and Social Life</u>	122
<u>Hardiness and Work</u>	123
Learned Resourcefulness	123
<u>Historical Background</u>	123
<u>Definition</u>	124
<u>The Subcomponents</u>	125
<u>Manifestation in the Individual's Personal and Social Life</u>	126
<u>Learned Resourcefulness and Work</u>	128
Manifestations of the Salutogenic Concept in the Nursing Literature	129
Limitations of the Salutogenic Concept	134
<u>Limitations in the Conceptual Framework</u>	134
<u>Limitations for this Research</u>	136
Applicability of the Salutogenic Concept	136
Chapter Summary	137

CHAPTER 4	140
THE PHENOMENOLOGICAL AND EMPIRICAL RESEARCH METHOD	140
Phenomenological and Empirical Aims	140
Selection of the Applicable Phenomenological Research Method	141
<u>Case Study Research Method (CSRM)</u>	<u>141</u>
<u>Duquesne Phenomenological Research Method (DPRM)</u>	<u>142</u>
<u>Towards an Integration of Methods</u>	<u>145</u>
Population and Sample	147
Measuring Battery	149
<u>The Qualitative Measuring Instrument</u>	<u>149</u>
<u>Unstructured Interview</u>	<u>149</u>
<u>Administration</u>	<u>149</u>
<u>Interpretation of Data</u>	<u>150</u>
<u>Motivation for the Use of an Unstructured Interview</u>	<u>152</u>
<u>The Quantitative Measuring Instruments</u>	<u>152</u>
<u>The Burnout Measure</u>	<u>153</u>
<u>Development and Rationale</u>	<u>153</u>
<u>Description</u>	<u>154</u>
<u>Administration</u>	<u>154</u>
<u>Scoring and Interpretation</u>	<u>154</u>
<u>Psychometric Properties</u>	<u>155</u>
<u>Justification for the Use of the Questionnaire in the Present Research</u>	<u>156</u>
Cumulative Stress Test	157
<u>Development and Rationale</u>	<u>157</u>
<u>Description</u>	<u>158</u>
<u>Administration</u>	<u>158</u>
<u>Scoring and Interpretation</u>	<u>158</u>
<u>Psychometric Properties</u>	<u>159</u>
<u>Justification for the Use of the Questionnaire in Present Research</u>	<u>159</u>
Sense of Coherence Questionnaire	160
<u>Development and Rationale</u>	<u>160</u>

<u>Description</u>	161
<u>Administration</u>	161
<u>Scoring and Interpretation</u>	161
<u>Psychometric Properties</u>	162
<u>Justification for the Use of the Questionnaire in Present Research</u>	164
Hardiness Personality Questionnaire	165
<u>Development and Rationale</u>	165
<u>Description</u>	166
<u>Administration</u>	167
<u>Scoring and Interpretation</u>	167
<u>Psychometric Properties</u>	168
<u>Justification for the Use of the Questionnaire in Present Research</u>	169
The Self-control Schedule	170
<u>Development and Rationale</u>	170
<u>Description</u>	171
<u>Administration</u>	171
<u>Scoring and Interpretation</u>	172
<u>Psychometric Properties</u>	172
<u>Justification for the Use of the Questionnaire in Present Research</u>	173
Administration of the Measuring Battery	174
Data Analysis	175
Hypotheses	176
Chapter Summary	176
CHAPTER 5	178
RESULTS	178
Qualitative Results	178
Central Themes	178
Theme Clusters	179
Central Themes - Respondent #1	181
Theme Clusters - Respondent #1	191

<u>What Causes Burnout in the Nursing Profession?</u>	191
<u>What are the Symptoms Experienced by the Individual?</u>	195
<u>How do Nurses Operationalise Salutogenic Qualities in their Lives when they Experience Burnout?</u>	198
Central Themes and Theme Clusters - Respondent #2	202
<u>What Causes Burnout in the Nursing Profession?</u>	202
<u>What are the Symptoms Experienced by the Individual?</u>	205
<u>How do Nurses' Operationalise Salutogenic Qualities in their Lives when they Experience Burnout?</u>	206
Central Themes and Theme Clusters - Respondent #7	209
<u>What Causes Burnout in the Nursing Profession?</u>	209
<u>What are the Symptoms Experienced by the Individual?</u>	211
<u>How do Nurses' Operationalise Salutogenic Qualities in their Lives when they Experience Burnout?</u>	212
Central Themes and Theme Clusters - Respondent # 8	214
<u>What Causes Burnout in the Nursing Profession?</u>	215
<u>What are the Symptoms Experienced by the Individual?</u>	216
<u>How do Nurses' Operationalise Salutogenic Qualities in their Lives when they Experience Burnout?</u>	217
Central Themes and Theme Clusters - Respondent # 9	221
<u>What Causes Burnout in the Nursing Profession?</u>	221
<u>What are the Symptoms Experienced by the Individual?</u>	223
<u>How do Nurses' Operationalise Salutogenic Qualities in their Lives when they Experience Burnout?</u>	225
Central Themes and Theme Clusters - Respondent # 10	228
<u>What Causes Burnout in the Nursing Profession?</u>	228
<u>What are the Symptoms Experienced by the Individual?</u>	230
<u>How do Nurses' Operationalise Salutogenic Qualities in their Lives when they Experience Burnout?</u>	232
Central Themes and Theme Clusters - Respondent # 15	234

<u>What Causes Burnout in the Nursing Profession?</u>	234
<u>What are the Symptoms Experienced by the Individual?</u>	237
<u>How do Nurses' Operationalise Salutogenic Qualities in their Lives when they Experience Burnout?</u>	239
Summary of Formulated Meanings	241
<u>The Work Itself - Engulfing Demands/Daily Realities</u>	242
<u>The Organisation - Rampant Bureaucracy/Lack of Organisational Support</u>	244
<u>The Community - Consumer Expectations and Demands</u>	248
<u>Intrapsychic Factors - Reduced Personal Accomplishment/Emotional Exhaustion/Depersonalisation</u>	254
<u>Interpersonal/Social Issues</u>	257
The Formulated Meanings from the Extracted Significant Statements of the Symptoms Experienced by the Individual	262
<u>Physically Debilitated</u>	262
<u>Emotionally Overwhelmed</u>	263
<u>Impaired Relationships</u>	266
<u>Decreased Motivation</u>	268
<u>Lack of Concentration</u>	270
The Formulated Meanings from the Extracted Significant Statement on how Nurses Operationalise Salutogenic Qualities in their Lives when they Experience Burnout	271
Quantitative Results	293
The Results of the Scores on the Measuring Instruments	294
Comparison of Quantitative Results with Normative Data	296
Interpretation of the Results	297
Exhaustive Description	303
Nurses' Lived Experience of the Causes of Burnout	303
Nurses' Lived Experience of the Symptoms of Burnout that they Experience	309
Nurses' Lived Experience of How They Stay Healthy	311
Discussion	316
Chapter Summary	316

CHAPTER 6	318
CONCLUSIONS, RESTRICTIONS AND RECOMMENDATIONS	318
Conclusions	318
Restrictions	322
Recommendations	323
Industrial and Clinical Psychological Practice	323
Health Psychology	324
The Individual Nurse and Nursing Practice	325
REFERENCES	330
APPENDIX A	372
APPENDIX B	407
APPENDIX C	437
APPENDIX D	455
APPENDIX E	474
APPENDIX F	497
APPENDIX G	518

CHAPTER 1

ORIENTATION AND SCIENTIFIC BACKGROUND OF THE RESEARCH

This chapter will provide an orientation to the research in terms of the background to the research, the problem statement, the research questions, the aims of the research, the research model and the paradigm perspective of the research. This will be followed by a description of the research design and method, and the designated chapters of this research.

Background to the Research

The effects of high stress levels on individuals in the work environment are many and varied (Cameron et al., 1994; Noble, 1993). It may lead to lower productivity, real and imagined pain disorders, absenteeism, turnover, and substance abuse. Cox (1978) has identified five categories of potential effects of stress: subjective, behavioural, cognitive, physiological and organisational. The most costly economic effect of stress stems from withdrawal and nonproductive behaviours (Gibson, Ivancevich & Donnelly, 1991). For example, one study indicated that over a 15-year period a type of withdrawal behaviour, namely absenteeism attributed to physical health problems, increased by 22 percent, while absenteeism associated with psychological health problems increased by 152 percent for men and 302 percent for women (Kearns, 1973). Even the relatively minor mental disruptions produced by stress, such as the inability to concentrate or reduced problem-solving capabilities, may prove very costly to an organisation (Gibson, Ivancevich & Donnelly, 1991). It follows then that the reason for concern about this issue is that there are many kinds of costs. There are financial costs. It is extremely costly to replace a professional service provider. There is the human cost. Job performance goes down, mistakes go up. Figley, Burgess and Mitchell (1994) mention that when morale drops, lies increase, stealing goes up, sabotage of the organisation goes up and people's home lives start to deteriorate, personality deteriorates, and eventually there is an overall decline in general health.

The Nursing Profession

People in the care-giving professions are especially prone to the development of specific stress related problems in their work (Muldary, 1983; Farber, 1983). This is the result of stressors experienced over a long period. These stressors can also be linked to specific jobs that care-givers are involved in. The nursing profession is a prime example of a group in a care-giving profession. This study focuses on the nursing profession since research shows that nurses do suffer from burnout (Antoni, 1985; Beck, 1995; Belcastro & Hayes, 1983; Ceslowitz, 1989; Duquette et al., 1994; Lysaught, 1970; McGrath, Reid, & Boore, 1989; Roach, 1994; Morano, 1993; Nolan, et al., 1995; Norbeck, 1985; Vachon, 1995; Vines, 1991; Weiman, 1977; Wright et al., 1993). With reference to professional functioning and the relationship of stress to illness and injury, researchers focusing on nursing have consistently reported positive correlations (Antoni, 1985; Belcastro & Hayes, 1983). Vines (1991) reported positive relationships between symptoms of psychosomatic illness symptoms and stress in nurses. Maslach and Jackson (1982, p. 228) termed these stress related problems "burnout". Numerous studies have since validated the construct (Belcastro & Gold, 1983; Cedoline, 1982; Cherniss, 1980; Cordes & Dougherty, 1993; Golembiewski & Munzenrider, 1988; Jones, 1981; Lempp, 1995; Manning, 1988; Maslach & Jackson, 1982; Minirth et al, 1990; Mitchell & Resnick, 1981; Pines & Aronson, 1981; Yia-kee & Tang, 1995).

Burnout

"Burnout is formally defined and subjectively experienced as a state of physical, emotional, and mental exhaustion caused by long-term involvement in situations that are emotionally demanding. The emotional demands are most often caused by a combination of very high expectations and chronic situational stresses. Burnout is accompanied by an array of symptoms including physical depletion, feelings of helplessness and hopelessness, disillusionment, and the development of a negative self-concept and negative attitudes towards work, people involved in work, and life itself" (p. 9) "... and it is a state that is difficult to get out of" (Pines & Aronson, 1988, p. 11).

Freudenberger (1974, 1975) was the first to use the term burnout as a concept conveying a specific theoretical meaning. Along with Pines and Aronson (1988) Freudenberger and Richelson (1980) believe that the most committed workers burn out the most severely, in other words, those that in general are the most likely to succeed. They therefore define the term as follows: "Burnout: To deplete oneself. To exhaust one's physical and mental resources. To wear oneself out by excessively striving to reach some unrealistic expectation imposed by oneself or by the values of society" (Freudenberger & Richelson, 1980, p. 17). In an influential definition by Pines and Maslach burnout is defined as "a syndrome of physical and emotional exhaustion involving the development of negative self concept, negative job attitudes and loss of concern and feeling for clients" (Pines & Maslach, 1978, p. 233). The most widely accepted definition found in the literature today states that "burnout is a syndrome of emotional exhaustion, depersonalisation and reduced personal accomplishment" (Maslach & Jackson, 1982, p. 228).

The working definition of burnout for the purposes of this study is as follows: Burnout is formally defined and subjectively experienced as an array of symptoms that include physical, psychological (emotional and mental exhaustion), and negative attitudinal (behavioural and work-related) components caused by individual, societal and work-related factors and/or stresses. Burnout seems to be of theoretical significance as judged from its associations with a broad range of variables relating to illness, health, well-being and productivity (Tishelman et al., 1991). This aspect alone demands a closer scrutiny of burnout research. In a general consideration of the burnout phenomenon it is found that the world is full of stressors, stimuli that can induce fight or flight responses, and therefore can agitate or energise. Some stressors, or eu-stressors are powerful motivators. Stressors are therefore not simply to be avoided in an attempt to avoid strain. Another very confusing issue is that anything can be a precursor of burnout for anybody at some time. What causes emotional upset in one nurse may not pose any problem for the next. Some nurses cope with great difficulty when faced with strain, and reach a state of exhaustion that seems extremely harmful to them and to the people who are in their care. Others again seem to draw strength from adversity and to stay healthy despite strain. The numerous problems associated with the syndrome lead a large number of nurses to leave the organisation and the job market.

The symptoms of psychological burnout, diminish the person's ability to function effectively in her or his role in the organisation (Armstrong et al., 1994; Berg et al., 1994; Cameron et al., 1994). Burnout happens over a period of time, with the result that the symptoms, like loss of energy, drive and self-esteem, manifest so gradually that they are almost imperceptible to the individual. "Die organisasie verloor dus 'n kreatiewe, betrokke werknemer en eis produktiwiteit van 'n ontnugterde, siniese persoon" (Breed, 1988, pp. 2-3). Kahn (1978, p. 61) sees burnout as "a syndrome of inappropriate attitudes toward patients and toward self, often associated with uncomfortable physical and emotional symptoms." Stress disturbances thus influence the individual negatively on the emotional, cognitive and behavioural levels and can also affect those being cared for by the caregiver suffering from burnout.

Perhaps the most significant conceptual contribution to the understanding of the burnout phenomenon comes from Maslach and Jackson (1982). They identify "the crux of the problem not as psychological per se, but as a particular type of stress arising from the social relationship between providers and recipients. It directs attention to certain classes of variables, such as perceptual biases, attributional inferences, and group processes, which provide many insights into possible solutions for burnout. Moreover, the traditional focus of social psychology on the context of individual behaviour provides an important framework for understanding the situational causes of the burnout syndrome" (Maslach & Jackson, 1982, pp. 228-229). This is echoed by Freudenberger (1983) who strongly emphasises the importance of the psychosocial context in which burnout occurs as an aid to the comprehensive understanding of burnout.

If it is accepted that burnout happens at the end of a long period of increasingly diminished functioning (Papadatou et al., 1994; Stewart & Arklie, 1994), then it is logical to assume that the person has tried a number of responses to lessen the stress, or to lessen the impact of the stress (Hallberg, 1994; McAbee, 1994; Berg et al., 1994; Morano, 1993). This is especially true because burnout is not an all or nothing diagnosis, but a problem that presents itself in many phases and facets over time. A simple pathogenic paradigm that states that an excess of stress in the helping professions leads to burnout is not sufficient to explain the process and development of this malady.

In similar vein, a simple quantitative measurement of this phenomenon is not enough to explain burnout.

The Choice of a Paradigm

Research indicates that stress affects nurses (Armstrong et al., 1994; Norrie, 1995; Oehler & Davidson, 1992; Papadatou et al., 1994; Tyler & Ellison, 1994; Van Servellen & Leake, 1993). Figley, Burgess and Mitchell (1994) reported that 86.7% of emergency personnel reported significant symptoms of stress within a 24 - hour period after having gone through one critical incident. It remains true, however, that a certain percentage of nurses who are subjected to the same stressors as the nurses who are affected do not suffer from stress and burnout. This might point to the fact that the experience of stressors does not necessarily lead to burnout. The positive correlation between stress and burnout and the resultant acceptance that individuals who are confronted with specific stressors will experience stress and burnout is largely a product of the pathogenic paradigm. The pathogenic paradigm has traditionally been accepted in stress research. This pathogenic thinking limits the understanding of the phenomenon.

Stress researchers (Cannon, 1932; Selye, 1974) initially assumed that all stress experienced by an individual will have a negative effect on the individual. Research, however, pointed to the fact that some individuals tend to maintain wellness even in situations characterised by extreme stress (Bryant, 1994; Farrington, 1995; Gallagher et al., 1994; Parkes, 1994; Slater & Depue, 1981; Tarolli-Jager, 1994; Turner, 1981). This tendency resulted in researchers attempting to explain these findings by examining several potential mediators and moderators within the individual that intervene in the stressor- stress reaction. For instance, the effect of the initial appraisal of a stressor as a challenge or a threat was researched (Mason, 1975; Lazarus, 1978). This still did not explain the differences in individual appraisal adequately and the focus remained mainly on the stress- illness relationship, that is to say, on a pathogenic perspective (or a medical model perspective). This resulted in a situation where the exceptions, the people who stayed healthy, fell through the cracks and were seldom investigated.

How or why certain nurses suffer from burnout and why others do not suffer from burnout therefore did not receive enough attention in research. From the literature it seems possible that certain personality characteristics may serve as moderators in this process. Some studies (Strümpher, 1990) have already shown that these personality characteristics mediate the stress- illness relationship. It is, however, not known how the individual operationalises these personality characteristics in the mediation process.

Salutogenesis (from Latin: *salus* = health; Greek: *genesis* = origins) is the opposite end of the continuum to pathogenic thinking. The pathogenic orientation is concerned with why people fall ill, and why they develop specific disease entities. Salutogenesis on the other hand “emphasizes the origins of health, or wellness” (Strümpher, 1990, p. 265). The effect and influence of personality constructs as moderators in the stress-illness relationship have been studied very successfully, as a partial listing of scholars who have worked on this issue will illustrate. Allport (1955) has, for example, studied the concept “proprie striving”; Antonovsky (1979, 1987) has studied the concept “sense of coherence”; Bandura (1982; 1989) and O’Leary (1985), among others, has studied “self-efficacy”; Bauman and Udry (1972) “powerlessness”; Ben-Sira (1985) “potency”; Boyce, Shaefer and Uitti (1985) “sense of permanence”; Cohen (1980) “predictability”; Colerick (1985) “stamina”; de Charms (1968) “personal causation”; Frankl (1959) “freedom of will, will to meaning, and meaning of life”; Fromm (1947) “productive orientation”; James (1911) “strenuousness”; Kobasa (1982) “hardiness”; Kohn and Schooler (1983) “self-directedness”; Libassi and Maluccio (1986) and White (1959) earlier, “competence”; Moos (1984) “domains of social climate”; Pearlin and his colleagues (1981) “mastery”; Rosenbaum (1988) “learned resourcefulness”; Rotter (1975) and Wallston and Wallston (1982) have studied “locus of control”; Seligman (1975) “learned helplessness”; and later, “learned optimism”, Seligman (1990); Senge (1990) “personal mastery”; Thomas (1981) “stamina”; and Werner and Smith, (1982) “invincibility”. This is by no means an exhaustive list but all of the constructs “are of significance to psychology in general, perhaps more so for clinical and counselling psychology. However, these constructs are of fundamental importance for research and practice in health psychology” (Strümpher, 1990, p. 265). What they all have in common is that they deal with how people stay healthy instead of succumbing to illness,

or even worse, to death.

The shift in focus brought about by the salutogenic paradigm includes the following:

- Regarding stressors as not being inherently bad. Assuming that stress is omnipotent and neutral in terms of effect on illness, the effect of the stressor is determined by the individual reaction to the stressor.
- Doing away with the dichotomy of illness-health and evaluating it as a continuum with an individual falling anywhere between the two extremes. Antonovsky calls it the health ease/dis-ease continuum.
- Focusing research on the deviant case. People staying healthy in spite of the numerous stressors they face.

Numerous studies have since used the salutogenic paradigm as a point of departure and the constructs have proved valuable in predicting where an individual is on the health-illness continuum. Most of these studies were empirical studies and the validity of the construct is thus now generally accepted (Antonovsky, 1987; Antonovsky & Bernstein, 1986; Boyce, Shaefer, & Uitti, 1985; Kobasa, 1982; Kobasa & Maddi, 1982; McSherry & Holm, 1994; Moos, 1984; Onega, 1991; Oosthuizen, 1994; Reiss, 1981; Strümpher, 1995; Strümpher & Louw, 1989; Werner & Smith, 1982).

The salutogenic paradigm does not deny the stress-illness relationship, but it concludes that “stressors are omnipotent in human existence” and that “the human condition is stressful” (Antonovsky, 1979, pp. 9, 10). But not all people become ill as a result of stress. Not all people become burned out. The literature states that personality traits possibly explain the stress - negative results relationships, or act as moderator variables in such relationships. Certain individuals may even move closer to the health side of the ease/dis-ease continuum.

The Choice of the Research Methodology

The quantitative measurements of the relevant personality traits have shown that they do influence the stress-illness relationship. This kind of research specifically focused on the assumption that there are coping mechanisms or moderator variables that the person can use to combat the negative effects of stress. Antonovsky (1979) called these coping strategies 'generalised resistance resources'. The generalised resistance resources in each personality can be used by individuals to cope with a diversity of pathogens and stressors (Boss-Victoria, 1992; Levi, 1989; Strümpher, 1990).

According to Antonovsky (1979), confronting a stressor results in a state of tension which one must deal with. "Whether the outcome will be pathological, neutral, or salutary depends on the adequacy of tension management. The study of factors determining tension management, then, becomes the key question of the health sciences" (Antonovsky, 1987, p. xii). The study of these factors that determine tension management was expressed in the concept of generalised resistance resources - cultural stability, ego strength, social supports, money - that is "any phenomenon that is effective in combating a wide variety of stressors" (Antonovsky, 1987, p. xii). "What are common to all generalised resistance resources, ... that they facilitated making sense out of the countless stressors with which we are constantly bombarded" (Antonovsky, 1987, p. xiii). Generalised resistance resources are by definition then moderators of stress, or stress regulators and the term "moderator variables" is sometimes used as a synonym for generalised resistance resources. Also, studies of resistance resource constructs found in the literature seem to overlap. Three stress regulators, namely sense of coherence, hardiness and learned resourcefulness, which are found in the literature (Boss-Victoria, 1992; Strümpher, 1990; Sullivan, 1993) will therefore be discussed.

Antonovsky (1987) developed the sense of coherence construct as his answer to what a generalised resistance resource is. Kobasa's (1982) answer to how people manage stress and stay well is hardiness, and Rosenbaum (1988) developed the learned resourcefulness construct. These constructs, which will be thoroughly discussed in chapter three, are all phenomena that are effective

in combating stressors and are therefore generalised resistance resources. It is clear from the above that personality traits play a role in buffering the effects of stress and are therefore important in combating burnout. In this research, however, the focus is on how the individual uses these personality traits in terms of her/his subjective constructions of reality or stated differently, how these personality traits find expression in behaviour. The emphasis is therefore on how healthy behaviour is triggered and operationalised by the individual.

Although the presence of moderator variables is acknowledged, the precise manner in which they are utilised or operationalised by the individual is not clear (Anson et al., 1993; Bart, 1992; Duquette et al., 1994; Huang, 1995; Noble, 1993; Tartasky, 1993; Vachon, 1995; Wright et al., 1993). The implication of salutogenesis is that more emphasis should be placed on individual cases and on where an individual finds herself/himself on the ease/dis-ease continuum. The mere presence or absence of symptoms is not enough to explain the individual's functioning. If this is not enough, then it seems to become important to enter the life world of the individual, to somehow gain existential and phenomenological understanding of the individual's experience of stress and coping.

Kobasa (1990, pp. 14-35) laments that "we are not taking a broad enough view of personality in our health research" (p. 15). She suggested that future studies should be undertaken regarding "the psychological processes underlying the observed connections" (p. 18) made between psychological variables and health outcomes. The study of the operationalisation of these factors by the individual can best be done by "data gathered through the use of person-based approaches to personality and health phenomena" (p. 18). This is echoed by others (Bart, 1992; Carlson, 1984; Dakof & Mendelsohn, 1986; Hartrick & Hills, 1993; Neimeyer, 1994) who note the importance of retaining the individual as the unit of analysis and describe how person-centered research needs to be done and integrated with the available work coming out of the pathogenic, salutogenic and variable-centered approaches. This is in line with suggestions for future contributions to knowledge within psychology that the individual should not be investigated only from the perspective of "a technology infatuated and fragmented science that is linked to a singular epistemology but that research from the phenomenological perspective will be conducted" with the focus on the process and dynamics of

personal experience (Cilliers, 1991, p. 16).

Problem Statement

Although there is statistical proof that nurses suffer from burnout, research has not yet focused on the idiosyncratic experience of the individual nurse and her/his experience of stressors. How are stressors experienced by the nurse and what attempts at successful coping have been undertaken by the individual? Within the salutogenic paradigm “the focus of our research should shift from studying the pathological parts of the human beings toward studying the ‘healthy’ aspects of human behaviour. This could further our understanding of how most individuals remain well adjusted despite their exposure to the stresses and strains of modern life” (Rosenbaum, 1988, p. 492). The research that has been done up to this point in the salutogenic paradigm looked primarily at the phenomenon from a quantitative perspective and therefore falls into the same one-sided trap as the pathogenic model.

When doing research on burnout in the nursing profession from the salutogenic perspective, questions that need to be answered are: What are the causes of burnout in the nursing profession? Also, what are the symptoms experienced by the individual nurse and the consequences of the symptoms for the individual nurse? What personality traits or moderator variables play a role in the stress-illness relationship? Even more important, how are the support systems operationalised (either externally or internally in terms of personality traits) by the individual nurse? How does a phenomenological praxis add to our understanding of the individual operationalisation of resistance resources? This may add help to explain how some nurses' personal dynamics contribute to whether they suffer from burnout or not. This has implications for the treatment and prevention of burnout, which in turn might have positive implications for the individual nurse and for the organisation.

Research Questions

The following questions can be formulated regarding this research:

- How does the existing literature on burnout contribute to the understanding of the burnout concept and how is burnout experienced in the nursing profession?
- How does the existing literature on salutogenesis and salutogenic constructs contribute to the understanding of the salutogenic concept and in how is it relevant to burnout in the nursing profession?
- If studied phenomenologically, what are the causes and symptoms of burnout and in what way are salutogenic constructs operationalised to affect the experience of burnout in the individual nurse?
- What recommendations regarding these findings can be made for the individual nurse and for nursing?

Aims

The general aim of this research is to generate a synthesis of burnout in the nursing profession from the perspective of the salutogenic paradigm in order not only to integrate the existing knowledge but also to contribute to the scientific paradigm.

The aims of the literature survey are as follows:

- **Aim 1:**
To present and integrate the existing literature on burnout with a specific focus on the experience of burnout in the nursing profession.
- **Aim 2:**
To present and integrate the existing literature on salutogenesis with a specific focus on the role of salutogenesis and salutogenic constructs in burnout in the nursing profession.

The operational aims are as follows.

- **Aim 1:**
To study the influence of salutogenic constructs on burnout from a phenomenological and empirical point of view. Three sub aims are formulated:
 - * Sub-aim 1:
To study the causes of burnout in the individual nurse from a phenomenological perspective.
 - * Sub-aim 2:
To determine the symptoms of burnout in the individual nurse from a phenomenological and empirical perspective.
 - * Sub-aim 3:
To study, from a phenomenological and empirical perspective, the influence of salutogenic constructs, as operationalised by the individual nurse, on the experience of burnout.

- **Aim 2:**
Based on the results, to make recommendations for the individual nurse and the nursing profession.

Research Model

Different types of statements in different situations or contexts perform different functions, and therefore comply with different criteria. Mouton and Marais (1990) call these language games. There are three types of strategies to follow when we give reasons why we hold a specific view. We could invoke our personal tastes or subjective feelings, or we could refer to some authority figure, or we could invoke a casual observation that we have made. When, however, "it is our aim to gain valid knowledge of reality in order to explain it, and also to predict future tendencies and events, ... a far greater premium is placed upon such values as reliability, credibility, accuracy, validity, and objectivity" (Mouton & Marais, 1990, p. 6). In order to facilitate these aspirations, Mouton and Marais presented a model which embodies a particular approach to the interpretation of the process of research in the social sciences. This model can be called the language game of statements made within the context of social sciences research. Mouton and Marais (1990) believe that the model

includes “the most important insights which have been gained from recent developments in the philosophy and methodology of science” (p. 7).

The research model of Mouton and Marais (1990) serves as the framework for this study. The aim of this is the systematisation of the five dimensions of social research, namely the sociological, the ontological, the teleological, the epistemological and the methodological dimensions, within the framework of the research process. The supposition of this model is that research is a social process. The subsystems are:

- the intellectual climate of a specific discipline
- the market of intellectual resources within each discipline
- the research process itself

The term intellectual climate refers to “the variety of metatheoretical values and beliefs which are held by those practising within a discipline at any given stage” (Mouton & Marais, 1990, p. 21). These beliefs, values and admissions do not have anything directly to do with the epistemic intentions of the research. The clear implication is that beliefs of this nature are frequently not testable nor were they ever meant to be tested. For the purpose of this research metatheoretical views regarding person, illness, health, and reality are formulated.

The “market of intellectual resources” refers to the collection of beliefs that has a direct bearing upon the epistemic status of scientific statements. Two major types of epistemic beliefs are the “theoretical beliefs about the nature and structure of phenomena on the one hand, and methodological beliefs concerning the nature and structure of the research process” (Mouton & Marais, 1990, p. 21). For the purposes of this research conceptual descriptions regarding burnout, salutogenesis and generalised resistance resources have already been presented.

In the explanation of “the research project the researcher internalises specific inputs from the paradigms to which he subscribes in a selective manner, so as to enable him to interact with the

research domain in a fruitful manner and to produce scientifically valid research” (Mouton & Marais, 1990, p. 23). Here there is a distinction between the determinants of research decisions on the one hand, and the decision-making process on the other. Regarding the determinants of the research decisions for this study, a description of the research design is given for descriptive, explanatory and contextual research. The research objectives are formulated in two phases of literature review and empirical research. Regarding the theoretical-methodological framework in phase one of this research, this refers to the relevant burnout literature as well as the literature on salutogenesis. In the second phase it refers to the quantitative and phenomenological integration of the results to contribute to the theoretical understanding of the paradigm constructs. Concerning the decision-making process in this research project the, research method is explained in two phases, each with clearly separate and consecutive steps.

In Figure 1.1 (see p. 15) the model is presented from a systems theoretical perspective, in which the three subsystems previously discussed interact with each other and with the research domain as defined in a specific discipline - in this case psychology.

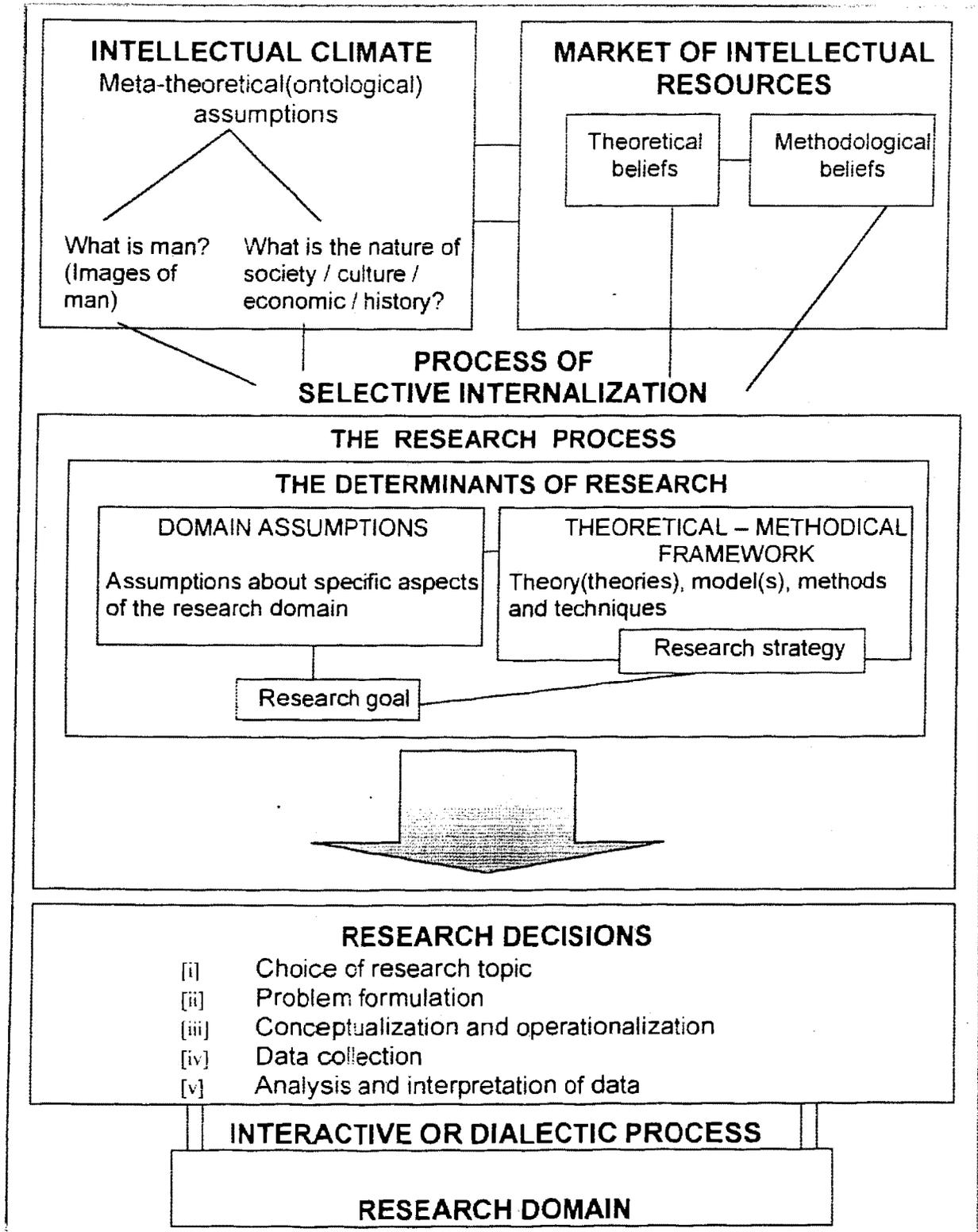


Figure 1.1 Research model
(Mouton & Marais, 1990, p22)

Paradigm Perspective of the Research

The research is guided by a specified paradigmatic perspective (Mouton & Marais, 1990) that includes the field of study, a delineation of relevant paradigms, the relevant metatheoretical views, the market of intellectual resources, methodological beliefs and the central research hypothesis. The research design and method follow this discussion.

Field of Study

The paradigm of this research originated from the metatheoretical supposition of working in the human sciences as a field of study. Within the human sciences the paradigm of the research is delimited to the science and art of psychology (Orcutt & Prell, 1994; Phares, 1979). These include an industrial psychological point of view, a clinical psychological point of view with a focus on phenomenology, and a health psychological point of view.

Industrial psychology is seen as the scientific study of human behaviour and psychological conditions in the work-related aspects of the individual's life. The purpose is to use relevant knowledge to minimise problems in this context. Put differently, industrial psychology is the study of human behaviour, attitudes and performance within an organisational setting (Gibson et al., 1991). For this research this means determining the guidelines for the retention of individuals for the organisation and establishing how they stay healthy themselves in the area of nursing, “deur vas te stel hoe die werker, nie alleen in sy werk nie, maar ook in sy totale lewensituasie sy bestaan as werker belewe” (Kruger, 1986, p. 114). That in turn might have positive implications for the individual and for the organisation.

Clinical psychology has as its basic mission the application of psychological principles to the adjustment of individuals (Phares, 1979). The most desirable characteristic of the clinician - “the capacity to tolerate ambiguity” (p. 20). But as long as 45 years ago Shaffer and Lazarus (1952)

commented that “nowhere is there real agreement over the exact role which should be played by the clinical psychologist” (p. 25). That is still the position today, and it makes it possible to subscribe, within clinical psychology, to many diverse theoretical orientations, of which a phenomenological perspective is one. “The fundamental point of departure of phenomenological praxis from traditional natural scientific research is that priority is given to the phenomenon under investigation rather than being secondary to an already established methodological framework” (Stones, 1986, p. 117). For this study “phenomenology takes 'phenomena' in a strict sense to mean 'how things and events are for the consciousness that beholds them and not how they are in themselves'”(Giorgi, 1986, p. 6).

“Health psychology is the aggregate of the specific educational, scientific, and professional contributions of the discipline of psychology to the promotion and maintenance of health, the prevention and treatment of illness, and the identification of etiologic and diagnostic correlates of health, illness and related dysfunction” (Matarazzo, 1980, p. 815). For this study it means gaining a valid and reliable understanding of the origins of wellness that might also have implications for the treatment and prevention of burnout.

Relevant Paradigms

In this research both the pathogenic and the salutogenic paradigms as conceptualised within health psychology are used (Strümpher, 1990). The pathogenic paradigm focuses on why an individual becomes ill. This knowledge can be utilised to find ways of combating and preventing each of the diseases in turn. At the heart of the pathogenic paradigm is the assumption that diseases are caused by physical, biochemical, microbiological and psychosocial agents.

Unlike the pathogenic paradigm, the salutogenic paradigm does not focus on the identification of stressors because it is accepted that stress is infectious. The focus is on how the individual, despite the omnipotence of stressors, stays healthy. The paradigm also accepts that stressors are neutral in their health consequences for the individual. Furthermore, that the consequences for the individual depend on his or her response to the stressor (Antonovsky, 1979, 1987; Strümpher, 1990).

The Relevant Metatheoretical Views

As relevant concepts in the research, the metatheoretical views on person, illness, health, and reality are presented. 'Meta' in this sense refers to the values and beliefs held by most individuals practicing psychology at the present time (see p. 12, "the intellectual climate").

Person

"'Person' refers to an individual human being who can act independently. Implied in this definition is the idea that a severely mentally retarded individual is a human being but not a person, and that a child is on its way to becoming a person, but is not a complete person. Independence of action implies that a person leads a physical, psychological and spiritual existence" (Meyer, Moore & Viljoen, 1989, p 7). "When we say we know somebody we mean that we actually know at least some of his physical, psychological and spiritual characteristics. The better our knowledge of someone, the broader or more intimate our knowledge of his biological qualities, his psychological dispositions and his spiritual values" (Meyer, Moore & Viljoen, 1989, p. 7). For this study this has the implication that a person, the unit of analysis in this research, is not only an integrated biological-psychological-spiritual and independently functioning human being, but that a person is an active agent in his/her life world who can be known. A person can therefore be phenomenologically described. "Die mens moet dus nie as 'n geïsoleerde of ingekapselde subjektiwiteit beskou word nie, ook nie as objek nie maar eerder as dialogiese wese wat deur die wêreld gekonstitueer word, maar wat op sy beurt ook steeds homself, sy medemens en sy wêreld medekonstitueer" (Kruger, 1986, p. 110).

Illness

Illness is located in the pathogenic orientation. "At the heart of the pathogenic paradigm is the assumption that diseases are caused by physical, biochemical, microbiological and psychosocial agents" (Strümpher, 1990, p. 266). "Illness refers to how the sick person and the members of the

family or wider social network perceive, live with, and respond to symptoms and disability” (Kleinman, 1988, p. 3). Illness-related problems are the principal difficulties that symptoms and disability create in people’s lives, and they come in many forms and intensities. “Illnesses obviously vary in outcome. Some are brief, minimally disruptive of our life activities. Some are more distressing; they take longer to run their course” (Kleinman, 1988, p. 7).

For this study the implication is that illness is the underlying concept to the burnout phenomenon. It is also clear that there is a difference between the physical experience of illness and the individual's experience of the illness. The “sick” role shows that illness in itself is essentially a social phenomenon and that illness is not an absolute term. It is further accepted that the individual is in interaction with his or her environment and that certain personality constructs can moderate the illness-health relationship.

Health

Health is the aggregate of the individual in body, mind and spirit, which can only be understood by referring to the individual's personal experience of health as an expression of his or her nature, being and life (Greef, 1991). Health is not only the absence of illness, although generally it is defined as such. The salutogenic orientation, which focuses on the origins of health, has various explanations of why people are healthy. Matarazzo (1982, p. 12) is of the opinion that we must aggressively investigate and deal “with the role of the individual's behaviour and life-style in health and dysfunction”. As a metatheoretical belief for this study it is sufficient to say that seen on a continuum, health and illness represent different ends of the continuum. Health is also seen not only as not having stress or burnout symptoms, but as an indication of the level of self- fulfillment towards which an individual strives (Friedman, 1990).

Reality

There is a "growing awareness that any so-called reality is - in the most immediate and concrete sense - the 'construction' of those who believe they have discovered and investigated it. In other words, what is supposedly found is an invention whose inventor is unaware of his act of invention, who considers it as something that exists independently of him; the invention then becomes the basis of his world view and actions" (Watzlawick, 1984, p. 10). "We are always part of the systems we are trying to observe, and our participation affects our observations" (De Wet, 1993, p 5). The conclusion that one may come to is that, at best, one should be aware of experimenter bias or the Rosenthal effect. At the other end of the spectrum one might say that our perception of reality is precarious to say the least.

For this research the above observation means that descriptions will be placed in the context of the researcher's interest; "the researcher's request for a description by a subject; the subject as a narrator; the meaning of a description as a text; the researcher as a reader of descriptions and the researcher as author of description" (Van Vuuren, 1989, p. 65). Its relevance to this study is that "the main aim of psychological research should be to explicate the meaning and quality of human psychological life. Our primary source of information will be how self and others experience these phenomena and how we act in them" (Kruger, 1986, p. 115).

The Market of Intellectual Resources

The market of intellectual resources refers to the collection of beliefs which has a direct bearing upon the epistemic status of scientific statements. There are two major types: theoretical and methodological beliefs (Mouton & Marais, 1990, p. 21). The theoretical and methodological beliefs are presented next and are discussed because they are relevant to this research.

Theoretical Beliefs Regarding this Research

All central conceptual descriptions, namely burnout, salutogenesis, and generalised resistance, resources have already been presented as part of the background to the research. These concepts form the main building blocks of this study. In the burnout literature stress is often equated with burnout. Though these two concepts are similar, they are not identical. Burnout is more often the result not of stress per se but of unmediated stress. From a theoretical viewpoint it seems clear that underlying the burnout phenomenon are two models of stress that deserve our attention. These are the systems model of stress and the transactional, also called the interactional, model of stress.

The Systems Model of Stress

“Stress is a state of psychological and physical arousal which comes about as a result of a threat, challenge or change in one's environment. Stress is a normal and natural response that is designed to protect, maintain, and enhance our lives” (Mitchell & Bray, 1990, p. 13). The systems model of stress is an integrated model based on the work of Everly (1989), Lazarus and Folkman (1984), Selye (1956), and Smith and Everly (1992), and it is presented as a model that is fundamental to the burnout concept. It has the following components that follow a logical sequence:

- In the first place there have to be environmental events or stressors. They could be either biogenic stressors or psychosocial stressors. Biogenic stressors cause stress arousal by virtue of the biochemical actions they exert on the human body. Psychosocial stressors do not directly cause stress, but they might initiate stress arousal. Psychosocial events can thus be potentially stressful depending on whether they are appraised or interpreted as being challenging, menacing, or aversive. Only those assessed as such will become psychosocial stressors (Mitchell & Everly, 1993).
- Cognitive interpretation of psychosocial events will not lead to excessive stress unless one or more of them are assessed as being meaningful and potentially challenging or threatening.

“The sheer experience of things around us cannot lead to action unless they are appraised for their effect upon us” (Arnold, 1984, p. 125). Interpretational mechanisms play a very important if not the primary role in occupational stress and illness among accountants (Smith & Everly, 1992). “There are no things good or bad, but thinking makes them so, Horatio”, said Shakespeare's Hamlet. Stress may be bad for you, it may affect your health, and it may lead to burnout if you perceive your work as stressful and beyond your ability to cope with (Muldary, 1983). Different individuals may appraise situations as stressful or nonstressful, and the perceptual and cognitive processes involved - psychological processes - may be the most crucial aspects of the experience of stress. Indeed, there may be no stress response at all unless environmental demands are perceived and judged to tax or exceed the individual's adaptational resources.

- Affective integration is the resultant emotional arousal following the cognitive interpretation of a psychosocial event. Emotions are caused by the interpretation of events rather than the events themselves (Rosenman, 1984). Mason (1975) and Lazarus (1978) maintained that the response of the body to stressors is mediated by emotional arousal and cognitive appraisal. The extensive research conducted by the Lazarus group (Coyne & Lazarus, 1980; Lazarus, Averill & Opton, 1970; Lazarus, Cohen & Folkman, 1980) suggests that the body's response to stress may not be absolutely nonspecific. They suggest that if different response patterns are associated with different stressors, and if those different reactions are associated with various emotional states, then stress reactions may be mediated by the individual's perceptions and may even be specific to particular kinds of appraisals about the nature of different situations.

- The stress response itself consists of three major axes (Mitchell & Everly, 1993, p. 24):
 - a) the endocrine axis
 - b) the neural axis
 - c) the neuroendocrine axis

An understanding of the stress response requires that the biochemical functions of these systems be outlined, for the characteristic reactions of both the autonomic nervous system (ANS) and the endocrine systems are assumed to be at the very heart of one's subjective experience of both stress and burnout:

- a) The endocrine axis consists of the anterior pituitary gland and its effector mechanisms such as the adrenal cortices, which release hormones like cortisol and aldosterone. Similarly, estrogen, progesterone and testosterone can all be altered during stress. It would appear that the stress response is primarily a function of an orchestrated secretion of a family of hormones from the pituitary-adrenal axis. But this is only part of the overall picture.
 - b) The neural stress axis consists of the nerves of the sympathetic nervous system, the parasympathetic nervous system (collectively known as the ANS), and the neuromuscular nervous system (the nerves to the skeletal muscles).
 - c) The neuroendocrine stress axis consists of the sympathetic neural chain and its innervation of the adrenal medullae. Stimulation of this axis results in the release of the hormones epinephrine and norepinephrine from the two adrenal medullae. This axis is responsible for the flight or fight response described by Cannon (1932). These mechanisms are always activated for they represent necessary aspects of normal human physiological functioning. They become of interest in the study of stress and disease when they become over stimulated and sustain their activation at excessively high levels.
- The stress response in general can therefore be understood in the following manner. It begins the instant a stressor is perceived by an individual. Selye (1976) suggested that when stressors are perceived as being stressors, the hypothalamus functions much like a central arousal mechanism and triggers the pituitary gland to secrete adrenocorticotrophic hormone (ACTH). When ACTH reaches the adrenal cortex, a characteristic reaction is set off whereby a host of corticoid hormones are released into the bloodstream. At the same time the

sympathetic nervous system instantly activates the adrenal medulla to release catecholamines. All these substances reach organs and muscles and bring the body to a highly aroused state. As bodily systems are gearing up for fight or flight, it may become more difficult to think clearly because the brain is focused more on the motor aspects of your response. Fortunately the complementary action of the parasympathetic nervous system helps to reduce the levels of various substances in the body. But it takes longer to relax than it does to become aroused. Today the lives of many people consist of repeated demands that stimulate arousal throughout the day, with only infrequent periods of relaxation, and it becomes more and more difficult for the body to repair the effects of the stress response. Selye (1974) hypothesised that individuals use up a special energy source during the stress response. He posited that adaptation energy provides the power to mobilise the body and give it strength for fight or flight. These constant drains on the energy supply eventually deplete it. Selye (1974) maintained that each person has a finite supply of energy for adaptation at the time stressors are encountered. After using all that is available during a stressful experience, the individual is thought to need a period of rest so that this energy supply can be replenished. Because the parasympathetic nervous system is not engaged long enough to counter the effects of arousal, the stress response continues and the energy available for adaptation is expended. This is the point at which exhaustion, one aspect of burnout, sets in (Muldary, 1983).

- Target organ activation can lead to either excessive activation or to coping strategies. According to Mitchell and Everly (1993, p. 26) “target organs” refers to the bodily organs within any given person which become somatic “targets” of the stress response. Given the three stress response axes mentioned above, the potential range of target organs that could be affected by excessive stress is quite wide. An individual could experience excessive activation on a cognitive level, a physical level, an emotional level or a behavioural level. Some of the common signs and symptoms of excessive stress on a cognitive level are: Confusion in thinking; difficulty in making decisions; lowered concentration; memory dysfunction; and a lowering of all higher cognitive functions. Some of the common signs and

symptoms of excessive stress on a physical level are: Excessive sweating; dizzy spells; increased heart rate; elevated blood pressure; and rapid breathing. Some of the common signs and symptoms of excessive stress on an emotional level are: Emotional shock; anger; grief; depression; and feeling overwhelmed. Some of the common signs and symptoms of excessive stress on a behavioural level are: Changes in ordinary behaviour patterns; changes in eating habits; decreased personal hygiene; withdrawal from others; and prolonged silences (Mitchell & Everly, 1993, p. 27).

- At the same point in time an individual can cope and manage stress by avoiding stressors, cognitive reinterpretation, reducing arousal and ventilating the stress response. When coping strategies are successful, pathogenic stress arousal is reduced. But if the coping strategies are unsuccessful, target organ activation will continue at excessively high levels and target organ disease or dysfunction becomes a matter of time. The stress response may therefore be implicated in various physical illnesses. Chronic stress - the continuous, unrelieved level of low-grade arousal - is assumed to play a determinant role in serious health breakdowns. Chronic stress is also assumed to play a direct causal role in the development of the burnout syndrome (Veninga & Spradley, 1981). The process of physical deterioration believed by many to occur within the body under prolonged stress is not completely understood, but there is an abundance of scientific evidence favouring the notion of a causative nonspecific stress response (Muldary, 1983).

In summary, the individual is an active agent in the stress process and it is accepted that self-regulation of cognitive, behavioural and emotional strategies can mediate the potential influence of the stressor and thus prevent burnout. An understanding of how stress affects us physically, mentally and emotionally prepares us for an active emphasis on “eustress” (the positive aspects of stress) and an effective response to the negative aspects of stress (“distress”) in order not to become burned out.

The Transactional Model of Stress

This model elucidates the current attention being given to interactions between individuals and their environments. The central focus is on the nature of interchanges, or transactions, between person and environment and the cognitive processes that intervene in the person-environment relationship. The transactional model is attributed to Lazarus (1967) (Coyne & Lazarus, 1980). Within the model, psychological stress is seen as a product of the way an individual appraises and constructs a relationship with the environment. According to Muldary (1983, pp. 30-31) in this relationship "environmental demands, cognitive appraisals, coping efforts, and emotional responses are interrelated in reciprocal ways so that each affects the others". Stress is not seen as a linear phenomenon but is seen as resulting from the interaction of factors assumed to play causal roles. The model recognises that different people experience stress in different ways because the seemingly identical conditions to which they are exposed are not really the same for each person. The differences are attributed to cognitive appraisal, threat, and coping.

An implication of adopting such a process-orientated perspective is that the etiology of stress and burnout need to be conceptualised in nonlinear terms. Although there appear to be certain environmental conditions that often function as common stressors, they do not function as stressors unless individuals perceive them as such. Some individuals burn out, and others do not.

Methodological Beliefs

Methodological beliefs are beliefs concerning the nature of social science and scientific research. More often than not, methodological beliefs are no more than methodological preferences, assumptions, and presuppositions about what ought to constitute good research (Mouton & Marais, 1990). What follows are the methodological beliefs applicable to this research project.

From a phenomenological point of view, psychology as a human science is a descriptive science. Psychology as a descriptive science and psychology as an exploratory science are two

distinct types of science and should not be viewed as two phases in the same type of science (Van Vuuren, 1989). The very use of the word "phenomenology" raises immediate suspicion in many scientific- psychological circles. Either the term is understood to refer purely to descriptive research as opposed to controlled parametric procedures, or it is thought to be a return to introspective procedures. The scientific psychologist must become aware of the shallowness of such interpretations. "One must abandon the idea that phenomenological psychology has declared war on scientific psychology by virtue of an anachronistic obedience to a historical method of philosophy. A method which is equally rejected today by the great majority of technically minded philosophers" (Thines, 1977, p. 17). What needs to be emphasised is the spirit of renewal that characterises phenomenological psychology in its tentative criticisms of outdated mechanistic causality. This should be done in a convincing and positive manner, or as Thines (1977) puts it, in at least as convincing a way as the classical reductionist procedures used in traditional psychological research. "According to the 'scientists', the object determines the subject's act of knowing, but in the view of 'existentialists' the conscious subject posits a world of objects.....Both views lead to impossible consequences. We want therefore to oppose to these views a position that deviates fundamentally from both and claim that 'the objective' is a discovery made by human subjects and that objectivity is the result of a certain subjective approach" (Strasser, 1963, p. 60).

Kruger (1986) states that he wants to elucidate two misconceptions that generally exist. The first view is that a phenomenological approach is totally subjective because it focuses on the lived experience. This view is not valid because the subject/object duality is exactly overcome in phenomenology ... it is an explicitation of the lived experience intended to expose the world of the specific individual (p. 111). Another misconception is that phenomenological research is only idiographic. This is totally beyond the truth. One naturally always starts with an individual subject, but it does not concern the inner life, but the lived world (p. 112).

The fundamental point of departure of phenomenological praxis from traditional natural scientific research is that priority is given to the phenomenon under investigation rather than this being secondary to an already established methodological framework (Stones, 1986, p. 117). Any

study of concrete human experience requires that the approach, method and content be seriously considered in relation to one another. One's fundamental worldview determines the way in which phenomena are to be understood. This in turn guides the nature of one's methodological unearthing of the phenomenon - which itself is not a given bare fact, but which reveals itself according to one's excavation procedures (Stones, 1986). Similarly, McCracken (1988, p. 17) suggests that "qualitative research does not survey the terrain, it mines it. It is, in other words, much more intensive than extensive in its objectives". The significance for this research is that a broad methodological base is utilised within the overall qualitative paradigm. But the point of view of convergence and complementarity (possible inter-paradigmatic overlap) as described by Mouton and Marais (1990, p. 170) is accepted. The qualitative paradigm is based on induction, holism and subjectivism, which means that it does not assume an absolute understanding of psychological reality, but seeks to describe the life world of the subject. This means that an understanding of the underlying psychological processes of the individual nurse will be achieved with all the interactional complexity in the nurse's life that such an excavation encompasses. The intention is that this will contribute to the theoretical understanding and integration of the stressor (burnout) and resource (salutogenesis) concepts in the nursing profession. A more encompassing debate on the usefulness of the qualitative approach will not be pursued here. Extensive literature on the subject can be found in Cleaver, (1988), Edwards (1991), Fischer and Wertz (1979), Kruger (1986), Kvale (1987; 1990), Stones (1986), Trodes (1986), Van Vuuren (1989; 1991) and Van Vuuren and Ladikos (1991). The phenomenological approach opens up the whole of the science of psychology for human experience and not only those areas operationalised into the empirical-scientific framework (Kruger, 1986).

Central Research Hypothesis

The central hypothesis of this research is that specific salutogenic constructs, as operationalised by the individual nurse, influence the experience of burnout in the nursing profession. It is hypothesised that this influence underlies the health outcome for the individual, which may be either positive or negative.

Research Design

According to Mouton and Marais (1990) a distinction can be made between exploratory, descriptive and explanatory research. The research goals and research strategies of these kinds of research are explained in Figure 1.2 (p. 29).

This research design is partly descriptive and partly explanatory. It is descriptive in the presentation of the burnout and salutogenic constructs and the relevant theoretical models. The important consideration in a descriptive study is to collect accurate information on the domain phenomena which are under investigation.

The present research design is, however, also partly explanatory. Mouton and Marais (1990) postulate that the purpose of explanatory research is the indication of causality between variables or events. There is also the added feature of direction (a one tailed study) and not just causality. The goal of this research is evaluative, to determine if and how the salutogenic variables influence the experience of burnout. From the above it becomes clear that combinations of different research goals and strategies are not only possible, but when utilised innovatively, can be expected to answer the research questions posed in this research.

RESEARCH STRATEGY		
RESEARCH GOAL	Contextual interest (internal validity)	General Interest (Internal and external validity)
Exploratory research	Overview of phenomena by means of case studies and in-depth interviews	Overview of phenomena by means of exploratory surveys
Descriptive research	Case studies, in-depth interviews, participant observation	Sample surveys
Explanatory research	Contextual explanations by means of case studies, historical analysis	Experimental and quasi-experimental studies

Figure 1.2 Research Strategy (Mouton & Marais, 1990, p. 51)

A broad methodological base, was therefore utilised for this research, within the overall qualitative paradigm. The point of view of convergence and complementarity (possible inter-paradigmatic overlap) as described by Mouton and Marais (1990, p. 170) is accepted. With this view of convergence firmly in mind a descriptive-explanatory study was chosen to describe the idiosyncratic experience of individual nurses and their experience of burnout. The focus of these descriptions is on successful coping by the individual. Stated differently, the focus will be on the presentation of the phenomenological perspective of the operationalisation of personality constructs. To this end multiple descriptive-dialogic case studies, using Duquesne phenomenological research method (DPRM) principles for data collection and preliminary analysis, will be utilised. (This method will be discussed in detail in chapter four.) Quantitative data will be presented using the clinical approach (Krisner, 1964).

The research is therefore aimed at gaining an understanding of the underlying psychological processes which will contribute to the theoretical understanding and integration of the burnout and salutogenic concepts in the nursing profession. The potential merits of these findings have particular meaning for nursing practice and research.

Phenomenological Research Design

As discussed under methodological beliefs earlier in this chapter, a phenomenological focus of interest is not concerned with comparing populations of people as a statistical study would. It is concerned with deepening our understanding of a human phenomenon. It was stated that it becomes important to enter the life world of the individual and to somehow gain existential and phenomenological understanding of the individual's experience. To this end, "ten in depth protocols of an experience may tell us more than one hundred superficial ones" (Todres, 1986). The end product of qualitative research is not control and prediction, but the understanding of human experience (Beck, 1990).

A growing disenchantment with the quantitative approach has led, over the past twenty years, to a re-examination of the research process as a whole, and a search for qualitative methodologies that would redress the balance (De Wet, 1985; Edwards, 1991; Kruger, 1986; Stones, 1986). One method has been the re-examination of the case study research method (CSR) in an attempt to re-establish its place as a fundamental tool in social science and psychology (Eckstein, 1975; Edwards, 1991; Bromley, 1986), another has been the Duquesne school's phenomenological research method (DPRM) (Giorgi, 1975; 1985; 1986). These methods and their integration will be discussed in chapter four in order to arrive at the conceptualisation of multiple descriptive-dialogic case studies, using Duquesne phenomenological research method principles for data collection and preliminary analysis.

Quantitative Research Design

Within the social sciences in general, there has for long, been a quantitative hegemony where quantitative analysis of data from a large number of persons has been the criterion for acquiring scientific status. The fact that creative research has often been based on intensive analysis of a few persons' relations to their surroundings has been neglected (Kvale, 1987). In this research the information gathered from the psychometric instruments will only be used to expand on information gathered in the unstructured interviews (Bromley, 1986). It is not the idea to use the quantitative information for extensive interpretation. The information gathered from the psychometric instruments will be used to divide the research participants in high burnout prone individuals and low burnout prone individuals as well as to find out whether each individual scores high on salutogenic properties or low on salutogenic properties. The reason for this is that one would expect, from a quantitative perspective, that an individual who scores high on burnout will score low on salutogenic properties and an individual who scores low on burnout will score high on salutogenic properties. It is expected that the salutogenic properties act as generalised resistance resources and have buffering effects on stress and burnout. The possibility exists, however, that the mere presence or absence of burnout symptoms is not enough to explain the individual's functioning. Entering the life world of the individual might prove more informative.

The information from the psychometric instruments will then be utilised to add to the information gathered by the multiple descriptive-dialogic case studies. This combined information will be used to draw general principles and conclusions.

The clinical approach (Krisner, 1964) to the interpretation of quantitative data is suitable because its use gives the study a comprehensive frame of reference where not only isolated phenomena but the individual in her or his totality will be scrutinised. Within the clinical approach the research participant will be assessed as a unique and authentic person with a specific lifestyle. This point of view stresses the fact that the individual is more than a point of intersection of abstract variables (Wolman, 1965).

Research Method

This research will consist firstly of a literature survey. It will also make use of limited empirical information gathering to assist in the unstructured interviews and in the phenomenological analysis of data. The main thrust of the research and contribution and integration into current psychological knowledge will, however, come from a focus on the interviews and phenomenological analysis of data collected.

The research proposal was submitted to the University of South Africa and to the Departments of Industrial Psychology and Psychology at this University, as well as to Critical Incident Stress Management Services, Medical Services Branch, Health Canada, to assure protection of the research participants. Upon approval by all departments involved, the research continued.

The research method was to consist of two phases, namely a literature survey and empirical and phenomenological research. This research consisted of the following steps:

- **Literature survey**

Step one: The analysis and integration of the existing literature on burnout with a specific focus on the experience of burnout in the nursing profession. The existing literature is presented through the selection of recent literature and archival resources and by means of a predetermined structure.

Step two: The presentation and integration of the existing literature on salutogenesis with a specific focus on the role of salutogenesis and salutogenic constructs in burnout in the nursing profession. The existing literature on salutogenesis is presented through the selection of recent literature and archival resources and by means of a predetermined structure.

Validity and Reliability of the Literature Survey

The aim of the research- design and method is to plan the project according to the stated goals of the research, in order to increase the reliability and validity of the specific research (Mouton & Marais, 1990).

In this research validity is assured through the selection of archival resources which are relevant to the problem statement and aims of this research and by means of comparing different literature resources. The research constructs have already been identified as pertaining to the research questions and to the salutogenic paradigm specifically. The selected constructs are pertinent to the research and have thus not been subjectively selected. In order to increase theoretical validity as evident in scope, clarity and systemacy a detailed literature survey of burnout and salutogenesis will be presented by means of a predetermined structure. The researcher will attempt to order and identify the central essence of the constructs in a logical and systematic way (Mouton & Marais, 1990). This makes it possible to explain the underlying dimensions or meaningful connections of the relevant constructs in a logically correct manner.

As archival resources tend to be difficult to verify, this low reactivity is used to increase the reliability of the research. In this research it has therefore been attempted to select recent archival resources. Reliability is furthermore guaranteed through adherence to the research design and references to similar existing research.

- **Phenomenological and empirical research**

The phenomenological and empirical research consists of ten steps, namely:

- Step 1:** Selection of the applicable phenomenological research method
- Step 2:** Population and sample
- Step 3:** Selection, description and motivation of the measuring battery
 - * The qualitative measuring instrument
 - * The quantitative measuring instruments
- Step 4:** Administration of the qualitative measuring instrument and the quantitative measuring battery
- Step 5:** Qualitative and quantitative data analysis
- Step 6:** Formulation of hypothesis
- Step 7:** Reporting, discussion and integration of results
- Step 8:** Formulation of conclusions
- Step 9:** Formulation of restrictions of the research
- Step 10:** Formulation of recommendations

Validity and Reliability of the Operational Phase

Validity and reliability must be considered in terms of the focus of qualitative research, which is the description of human experience, and not the control and prediction of variables (Sandelowski, 1986). Qualitative research is concerned with rich descriptions of human experience, but it will be judged by two criteria: The soundness of the methodology used; and the usefulness of the research

findings (Polkinghorne, 1994). These two criteria will be largely determined by the role of the researcher and the transparency of the research results. (Ashworth, 1987; Segal, 1996; Sykes, 1991).

The role of the researcher is to function as a "participant observer" (Stones, 1986, p. 118) and to come to an explication of the lived experience of the research subject with the intention of exposing the world of the specific individual (Kruger, 1986). There is a sense of intimacy and intersection between the researcher and the research subject throughout the research process. According to McCracken (1988, p. 22) the qualitative researcher strives for trust and collaboration with the research subject, but there has to be distance so that his or her values and preconceptions do not influence the research process too much. Ashworth (1987, p. 40), referring to Heidegger, states that the researcher always brings "fore-understanding" into the research process. This fore-understanding refers to the researcher's values and expectations, and feelings concerning involvement in the research process. This fore-understanding has to be scrutinised by the researcher through a process of self-awareness and openness, so that the experience of the research subject can reveal itself in an unbiased way (Ashworth, 1987).

According to Sykes (1991) the task of the qualitative researcher is to strive to communicate the whole research process in a transparent manner. This implies that the researcher must constantly be aware of the entire process of arriving at research conclusions and be able to communicate these conclusions in a clear and logical fashion. Transparency is also important to the reader of the research results. The reader should be able to relate to and interact with the research process as outlined by the researcher (Segal, 1996). According to Segal (1996) the foundation of transparency is descriptive adequacy, a term coined by Ashworth (1987). Descriptive adequacy refers to findings which are based on sound and explicit argumentation and forms the basis for reasonable extrapolations concerning the applicability of findings to similar situations. Segal (1996) further states that the findings in qualitative research will be strengthened if the internal validity of the research project is high. Sykes (1991) says that internal validity in qualitative research refers to the fit between the data and the findings. Internal validity has the potential to be high in this type of

research because the researcher is able to be flexible and question and check the emerging data. It is further important for internal validity that the researcher does not select or neglect data just to fit his or her own argument.

The two above-mentioned criteria enhance the "auditability" (Sandelowski, 1986) of the research. Another researcher can follow the process and logic of the research from beginning to end, making sure that the phenomenon under investigation has been accurately described, that the findings can be replicated and that the findings can be confirmed by somebody else.

Designated Chapters

The chapters in this research will be presented as follows:

- Chapter 2 : Burnout
- Chapter 3 : Salutogenesis
- Chapter 4 : Empirical and phenomenological research method
- Chapter 5 : Results
- Chapter 6 : Conclusions, limitations and recommendations

CHAPTER 2

BURNOUT

The aim of this chapter is to present and integrate the existing literature on burnout with a specific focus on the experience of burnout in the nursing profession. The concept of burnout will be discussed together with the antecedents of burnout. Both the consequences of burnout and the different coping strategies utilised to combat burnout will also be examined. The manifestation of the burnout concept in nursing literature will be discussed and the chapter will conclude with a discussion of the restrictions inherent in the burnout concept.

The Concept of Burnout

The origin of "burnout" and the development of the concept can be traced through the literature (Beck & Gargiulo, 1983; Belcastro & Gold, 1983; Burgess, 1980; Cherniss, 1980b; 1995; Cordes & Dougherty, 1993; Freudenberger, 1974; 1975; 1982; 1983; 1985; Freudenberger & Richelson, 1980; Golembiewski & Munzenrider, 1988; Jones, 1981; Maslach, 1976; 1978; Maslach & Jackson, 1977; 1982; Mitchell & Bray, 1990; Muldary, 1983; Pines & Aronson, 1981; 1988). Although burnout is a multidimensional phenomenon that defies simplistic analysis, the validity of the concept is compromised when it is viewed so comprehensively that virtually nothing is excluded as a cause, symptom, or effect. The parameters of burnout need to be clarified and its symptoms viewed in terms of extremes. Etiological explanations must take into account the fact that some people burn out and others do not, even though they are exposed to the same conditions. The individualistic nature of burnout must be recognised as a function of the individual's relationship with the environment - with each individual relating to the environment in unique and qualitatively different ways.

It was Freudenberger, as well as Christina Maslach and Ayala Pines, colleagues at the University of California at Berkeley, who popularised the concept, pioneered its study and legitimised

its status as a critical issue (Farber, 1983). Freudenberger was trained as a psychoanalyst and consequently his model of burnout is based primarily on the psychology of the individual. Maslach and Pines on the other hand are both social psychologists by training who embraced empirical psychology. These two perspectives - the clinical and the empirical - have complemented each other quite well and have generated a wealth of data and insights into the phenomenon of burnout.

What transpires early in the research process is that burnout is not a simple, unidimensional phenomenon with easily grasped causes and solutions. Farber (1983) pointed out that burnout is a complex problem with roots in intrapsychic, interpersonal, social and organisational phenomena with complex conceptual formulations.

Towards a Definition of Burnout

"Burnout is kind of like pornography. I'm not sure I can define it, but I know what it is when I see it" (Forney, Wallace-Schutzman & Wiggers, 1982, p. 436). Freudenberger (1989, p. 3) states that some definitions in the literature are vague, conflicting, or overly inclusive. For instance, some theorists refer to burnout as a loss of will or as an inability to marshal one's forces. Others suggest that burnout is predominantly a pervasive mood. The definitions vary, some are precise, some global, some psychological, some behavioural. Some speak of it as a state, some as a process; some refer to the cause, others only to the outcome. Each definition tries to contribute to the understanding of the phenomenon.

"Even before tackling the issue of definition, I would like to make the point that is a futile question to ask, 'What is burnout?' Because burnout is a construct, residing in the heads of many people (and probably a little differently in each of them), all we can meaningfully ask is, 'How do we want to define burnout?' in order to make it a useful concept" (Burisch, 1993, p. 76).

There is a general agreement that burnout occurs at an individual level, that it is an internal experience that is usually psychological in nature, and that it is perceived by the individual as a

negative experience (Jackson, 1982). This agreement does not exclude Regelson's (1989, p. 39) definition which states that "in essence, burnout reflects dissatisfaction with the workplace, domestic situation and social or political state". Burnout is "someone in a state of fatigue or frustration brought about by devotion to a cause, way of life, or relationship that has failed to produce the expected reward" (Freudenberger & Richelson, 1980, p. 13).

Veninga and Spradley (1981, p. 6-7) defined burnout as "a debilitating psychological condition brought about by unrelieved work stress". They insisted that burnout is a work-related condition that results in "1) depleted energy reserves, 2) lowered resistance to illness, 3) increased dissatisfaction and pessimism, 4) increased absenteeism and inefficiency at work". A further compression of the term burnout was advanced by Edelwich and Brodsky (1980, p. 14), who restricted their use of the term to the helping professions. They acknowledge that burnout can occur in virtually any profession but they maintained that it tends to assume special intensity and character in the human services professions.

In similar vein Maslach and Jackson (1977, p. 3) defined burnout as "the loss of concern for the people with whom one is working (including) physical exhaustion (and) characterised by an emotional exhaustion in which the professional no longer has any positive feelings, sympathy, or respect for clients or patients". In fact Maslach (1976) noted that burned out professionals "lose all concern, all emotional feelings for the persons they work with and come to treat them in detached or even dehumanised ways" (p. 16). These observations lead to the now well accepted definition by Maslach and Jackson (1980) of burnout as a syndrome of emotional exhaustion, depersonalisation and reduced personal accomplishment. Pines and Aronson (1981, p. 15) defined burnout as "the result of constant or repeated emotional pressure associated with intense involvement with people over long periods of time". As an erosion of spirit, burnout affects precisely those professionals who had once been the most idealistic and enthusiastic, the professionals who had at one time been "on fire".

Muldary (1983, p. 12) also leans towards a definition that emphasises burnout as a response

to stress experienced in the context of human services. He defines burnout as the "process by which a once-committed health professional becomes ineffective in managing the stress of frequent emotional contact with others in the helping context, experiences exhaustion, and, as a result, disengages from patients, colleagues, and the organisation".

According to Farber (1983) burnout can be "conceptualised as a function of the stresses engendered by individual, work- related, and societal factors" (Farber, 1983, p. 3). Golembiewski and Munzenrider (1988) state that burnout can be conceptualised as:

- something old, "the concept does double-duty, not only permitting us to link the observed phenomena to established pathways of commentary and research but also raising the challenge of testing for possible theoretical connections" (p. 7)
- phenomenally significant, in the sense that it is not an empty category
- something new, "it reflects a novel and highly-augmented contribution to our understanding of an important social phenomenon" (p. 7)
- a metaphor that captivates our attention. "Burnout appears to be a central topic in the behavioural sciences, ... [this] may stem from the fact that basic problems of modern social life seem to become so troublesome that the guiding metaphors of past decades cannot effectively deal with them" (p. 10).

Hallsten (1993) states that burnout is a chronic, negative, affective response with fatigue and emotional exhaustion as its core aspects. Shirom (1989) concludes that burnout essentially "refers to a combination of physical fatigue, emotional exhaustion and cognitive weariness" (p. 33). Finally, a less well known but rather precise operational definition of burnout was presented by Brill (1984, p.14): "an exceptionally mediated, job- related, dysphoric and dysfunctional state in an individual without major psychopathology who has (1) functioned for a time at adequate performance and affective levels in the same job situation and who (2) will not recover to previous levels without outside help or environmental rearrangement".

What becomes clear in this definitional mixture is that burnout can be defined as purely work related or as a combination of acute, delayed and chronic stressors which have developed in work and nonwork areas. This view of the burnout phenomenon can be referred to as the state conception of burnout, since it identifies burnout with affective states. Researchers within the field may have different opinions regarding antecedents and consequences of the phenomenon, but most of them appear to adhere to this state conception of burnout (Hallsten, 1993).

For this research burnout is seen as a work-related problem that emerges in human and public service provision (Cherniss, 1995; Maslach, 1982; Maslach, 1993; Muldary 1983). The definitions by Pines and Aronson (1988) and Muldary (1983) have been adapted and combined in order to define burnout in the following manner. **Burnout is an array of symptoms (in accordance with the state conception) that include psychological (emotional and mental exhaustion), negative attitudinal (behavioural and work-related) and physical components caused mostly by work- related factors and/or stresses, but also influenced by individual and societal factors.**

Characteristics of Burnout

As mentioned previously, Maslach and Jackson (1982) are of the opinion that burnout is a syndrome of emotional exhaustion, depersonalisation, and reduced personal accomplishment. **Emotional exhaustion** refers to a depletion of one's emotional resources and the feeling that one has nothing left to give to others at a psychological level. The **depersonalisation** phase of burnout is the development of negative and callous attitudes about the people one works with. The depersonalised perception of others can lead one to judge them as somehow deserving of their troubles. A third aspect of burnout is **the perception that one's accomplishments on the job fall short** of personal expectations - a perception which involves a negative self-evaluation.

There is an abundance of evidence to suggest that burnout is especially prevalent among persons working in occupations where intense or emotionally charged face-to face interactions, or "**people work**", go on. This makes "people work" a distinguishing feature of burnout. Cherniss

(1995) describes the experiences of lawyers, nurses, teachers and health service workers. By definition most health careers involve a great deal of contact with people - patients, patients' families or friends, and other medical personnel. Often this interpersonal contact is emotionally charged, with feelings of tension, anxiety, embarrassment, fear, or even hostility underlying the verbal exchange. This source of **chronic emotional stress** can lead to the development of burnout.

Allan Lyall (1989) remarks that there is an **attitude problem** that society has perpetuated, and still helps to foster throughout society and especially in the helping professions, that leads individuals to be proud of the fact that they **strive to meet unrealistic expectations**. If one is a professional athlete, the ability to "play with pain" is a dubious asset. Although players may not be able to deliver the performance normally expected of them, their toughness is exhibited for all to see. But here all that is at stake is a game. In the health care system the stakes are much higher and the attitude much less commendable. Health care providers traditionally put themselves and their patients at unnecessary risk by trying to accomplish too much. They are so proud of their exhaustion that they make no serious effort to remedy the situation. The fearsome image used to justify this attitude is that people will go untreated, or may even die, if health care providers do not "carry on regardless". This of course is seldom true. Ross (1977) calls this the fundamental attribution error.

According to Freudenberger and Richelson (1980) burnout is a problem born of good intentions. It is not a disgrace nor does it get better by ignoring it. The people who fall prey to it are for the most part decent individuals who have striven hard to reach a goal. Their schedules are busy, and whatever the project or job, they can be counted on to do more than their share. **They are burning out because they have pushed themselves too hard for too long**. They started out with very high expectations and refused to compromise along the way. Lynn (1989) reminds us that burnout occurs only in achievers. In one way or the other we have all fashioned wings of feathers and wax and, like Icarus, flown too close to a symbolic sun and then plummeted emotionally. Burnout tends to afflict people who are highly motivated and idealistic when they enter their professions, expecting their work to give their lives a sense of meaning (Cherniss, 1995; Pines & Aronson, 1988). It is a particular hazard in occupations in which professionals tend to experience

their work as a kind of "calling."

Burnout involves **the painful realisation that the service provider has failed** - to make the world a better place, to help the needy, to have real impact on the organisation - **and that the individual has nothing left to give**. Whenever the expectation level is dramatically opposed to reality and the person persists in trying to reach that expectation, trouble is on the way. Deep inside, friction is building up, the inevitable result of which will be a depletion of the individual's resources, an attrition of the individuals' vitality, energy, and ability to function.

Because of prior learning, family background, current life circumstances, job experiences, appraisal skills, coping resources, and various other factors, certain individuals may be more predisposed to burnout than others. The initial position in this study is also that it is not possible actually to identify and distinguish separate personality "types" that are predisposed to burnout. Burnout is too **highly individualised** to accommodate static and rigid categorisation of persons according to degree of susceptibility. With the possible exception of the "obsessive-compulsive personality" and type A personality behaviour, there is much variability among people who experience burnout. The opposite view, namely that individual differences are related to the experience of stress and to coping, has also been studied, however, Cox (1985, 1990), Cox and Ferguson (1991) and Payne (1988) are strong proponents of the belief that individual differences do play a key role in the moderation and mediation of stress.

What can be accepted is that individuals participate in shaping their own environments. **Those who have stereotyped, long-standing patterns of interacting with the world may invariably set themselves up for burnout**. Paul Pruyser (Lynn, 1989) has the following to say about burnout:

Sooner or later, health care professionals who deal with conditions entailing much suffering or pain discover that they have to perform a task for themselves in addition to discharging their helping obligations toward their patients. Prone to becoming overwhelmed by the suffering they see around them and fearful of losing their equilibrium, they must undertake

an arduous balancing act. When the pain of the world is no longer an abstract philosophical idea but knocks daily at one's door in concrete self-presentations of suffering individuals, safeguards are needed for the continuity of at least some vital restorative processes, such as undisturbed sleep, access to new energy supplies, and some measure of good cheer. But securing such psychological provisions for oneself is not easy, for the very fact one feels in dire need of such restorative and equilibrating operations is a sign that one's psychological state has already moved in the other direction, where insomnia, tiredness, weariness, brooding and a wistful or mournful mood threaten (pp. 23-24).

The Collins English Dictionary defines "characteristic" as a distinguishing quality, attribute, feature or trait. From the above the following characteristics of burnout come to the fore: Emotional exhaustion; depersonalisation; reduced personal accomplishment; people work that is a source of chronic emotional stress; an attitude problem consisting of unrealistic expectations; service providers who have pushed themselves too hard for too long; the painful realisation that the service provider has failed to effect change (this is a subjective evaluation) and has nothing left to give; burnout is highly individualised but those who have stereotyped, long-standing patterns of interacting with the world (inflexibility in dealing with the world) may invariably set themselves up for burnout.

This section described the characteristics of burnout. In the next section more conceptual issues of the burnout phenomenon will be explored further.

Conceptual Issues

Burnout is a multidimensional phenomenon that defies simplistic analysis. The validity of the concept, however, is compromised when it is viewed so comprehensively that virtually nothing is excluded as to where and in whom burnout could take place, its causes, symptoms and effects.

Three issues according to Maslach and Schaufeli (1993) therefore need to be addressed. In the first place these authors ask whether burnout is limited to the human and public service

professions, or is it a more general phenomenon that is found in other occupations and even outside the work sphere? This is not simply a scenario issue, but is important in the conceptualisation of burnout in terms of establishing the milieu in which burnout should be considered as a possibility. The second question is whether burnout is a distinctive concept that can be distinguished from other related concepts. The third question is whether there are diagnostic criteria that would allow burnout to be identified in an individual. Again, this is not simply a diagnostic issue, but is important in determining whether burnout as a concept (something existing in the mind), can be pinpointed in an individual.

Burnout and the Public Service Professions

The following is pertinent in a discussion of the range of phenomena that could be classified as burnout. At times, burnout has been used in a very broad sense to describe dysphoric feelings that may occur in almost any setting. At other times it has been used specifically as a work related concept within the human and public service industry. In earlier writings Freudenberger and Richelson (1980) talked of people burning out in relationships whereas Pines and Aronson (1981) preferred to distinguish between burnout, something which happens to human service workers, and tedium, a similar constellation of feelings that affects workers in non-human-service jobs. Restricting the definition of burnout to human service workers acknowledges the unique pressures of utilising oneself as the "tool" in face-to-face work with needy, demanding, and often troubled clients (Farber, 1983). Should this concept then be confined to human services workers, or public service professionals?

This is a valid question if one remembers that burnout has not been restricted to the human services professions in the literature: Burnout appears largely to be specific to the work domain. The idea that its origins lie in the job situation might have given rise to the extension of the burnout concept to other types of occupations. Maslach and Schaufeli (1993) quote Cahoon and Roney (1984), and Etzion, Kafry and Pines (1982) as examples of discussions about burnout in business, and corporate and managerial burnout. Following the literature trail, Caccese and Mayerberg (1984),

Capel, Sisley and Desertrain (1987), Fender (1989) and Smith (1986) discuss burnout in terms of coaches and athletes in the sports world. To add insult to injury, or rather, confusion to Nero's burning city, burnout has also been discussed as extending into nonoccupational domains such as political activism (Gomes & Maslach, 1991), family life and parental burnout (Pelsma, Roland, Tollefson & Wigington, 1989) and marital burnout (Pines, 1988).

Maslach and Schaufeli (1993) discuss this issue in detail and state that the strong possibility exists that the burnout definition has been transplanted uncritically to other fields and is being used in ways that are not meaningful or relevant. Their concerns are echoed by other critics who state that changes made to the population under study, meaning the human service profession, transform the basic concept of the meaning of components like personal accomplishment and depersonalisation, rather than simply translating and transporting them to different occupations (Garden, 1987; Schaufeli & Peeters, 1990). In the same vein it can be argued that the term "burnout" takes on a different meaning when it is being applied to marriage or parenting, as opposed to a job in the human services. "If burnout is being used in these contexts as simply a synonym for unhappiness, or frustration, or dissatisfaction with one's child or spouse, then it is a superfluous addition that is not adding any new insights to these issues" (Maslach & Schaufeli, 1993).

In conclusion, it is accepted that burnout is found in possibly all professions that include people work (Cordes & Dougherty, 1993). Such a perspective is accepted for the purposes of this research. The extension of the concept to other work domains and to nonoccupational domains has been mentioned and cautioned against. This research leans towards a focus of the health care service provider's experience of burnout and in seeing burnout as a phenomenon that is best explained within the confines of the human services professions.

Burnout as a Distinctive Concept

According to Maslach and Schaufeli (1993), the diversity of burnout causes, symptoms, definitions, and consequences has contributed much to the confusion about the specificity of burnout.

Burnout can only be distinguished in a relative way from other related concepts. It should be mentioned that concepts such as stress, depression and job dissatisfaction are plagued with the same sort of definitional ambiguity as burnout. It should further be noted that there are no sharp boundaries between burnout and these other concepts. According to Maslach and Schaufeli (1993), there is a relative distinction between burnout and stress, with regard to the time they take to develop. Furthermore, there is a distinction between burnout and both depression and job dissatisfaction with respect to domain. Attention will now be given to these two issues.

Burnout as a type of stress: The theoretical view of stress as accepted for this research was presented in chapter 1. In the burnout literature stress is often equated with burnout. Though these two concepts are similar, they are not identical. So where does stress fit in with burnout? Or more accurately, where does burnout fit in with stress? Cordes and Dougherty (1993) say that despite the growing consensus surrounding the burnout concept, the distinction between burnout and stress has not been clearly delineated. Most people associate stress with a response to a major event. What is not so well understood is the enormous toll in physical, mental and emotional resources demanded by longer-term frequently low level stress (Mitchell & Bray, 1990). Stress of this type has been called chronic stress or cumulative stress. In this research cumulative stress is viewed as burnout. It is made up of a collection of stressful events, such as critical incidents, combined with work-related, home-related or family-related stressors. They may also be mixed with organisational stressors, routine job stressors, and leftover stressors from one's early childhood development. In similar vein Ganster and Schaubroeck (1991) have argued that burnout is in fact a type of stress - specifically, a chronic affective response pattern to stressful work conditions that features high levels of interpersonal contact. Burnout is a distinctive aspect of stress in that it has been defined and studied primarily, but not exclusively, as a pattern of responses to stressors at work (Pines & Aronson, 1988; Shirom, 1989). The burnout response syndrome is largely initiated by external demands and circumstances, including interpersonal stressors. The notion that one's psychosocial environment, life style, and attitudes are linked to disease is by no means a new idea. In a meta-analysis Tower (1984) reviewed 523 published reports investigating the relationship between psychosocial factors and disease. The results supported the conclusion that a strong relationship exists between

psychosocial factors and illness.

Cordes and Dougherty (1993) say that burnout represents a particular type of job stress in which a pattern of emotional exhaustion, depersonalisation and diminished personal accomplishment (strains) result from a variety of work demands (stressors), especially those of an interpersonal nature. For them the three component model that burnout represents is a definite indicator that burnout is a type of stress phenomenon. They argue that at its core is emotional exhaustion, which is a traditional stress variable. Depersonalisation is a new construct not formally appearing in the stress literature. Finally they state that feelings of personal accomplishment (related to such concepts as self-efficacy) are familiar to the stress literature. Cordes and Dougherty (1993) further argue that this third component of burnout, or a diminished level of this variable, adds to the assertion that self-evaluations are central to the stress experience.

Pines (1993) argues that while everyone can experience stress, burnout can only be experienced by people who entered their careers with high goals, expectations, and motivation. In other words, people who expected to derive a sense of significance from their work. A person who has no such initial motivation can experience job stress but not burnout.

Everly (1989) states that science traditionally classified diseases on the basis of their cause or their end-organ symptoms. Regarding classification by 'cause', for example, adjustment disorders are 'caused' by the inability to adjust to new situations; viral disorders are caused by viruses. Regarding classification by symptoms, on the other hand, mood disorders are characterised by affective symptom complexes, and anxiety disorders are characterised by anxious symptomatology. The post traumatic stress disorder is classified by both its cause (trauma) and its symptoms (stress). In an attempt to break from this traditional classification Everly (1989) proposes that various anxiety-related and stress-related diseases be viewed in the light of a new taxonomic perspective, namely as disorders of arousal. "Despite a wide variety of etiologic stimuli, and an even wider variety of symptom complexes, these disorders are best seen as but variations on a theme or a pathognomonic hypersensitivity for, or an overall characteristic of, arousal" (p. 150). More specifically, the disorders

of arousal concept is based on an integration of work done by Selye (1976), Gellhorn (1967), Gray (1982) and Post (Post & Ballenger, 1981).

This corpus of evidence indicates that a major homogenising phenomenological constituent of these stress disorders is a limbic-system based neurologic hypersensitivity that is capable of giving rise to a host of psychological and stress-related somatic disorders (Everly 1989). These disorders are referred to collectively as disorders of arousal and Everly (1989) states that stress-related syndromes seem to be characterised by what appears to be an increased vulnerability to frustrating and challenging stimuli.

In conclusion, it seems safe to say that burnout is a unique type of stress phenomenon which, with other stress-related diseases, can be viewed as a disorder of arousal. Some of the stress-related diseases which should be considered in the differential diagnosis of burnout are discussed.

Burnout as a type of depression or job dissatisfaction: Various theoretical perspectives would seem to predict that burnout is related to such concepts as depression and job dissatisfaction. A relevant question that Maslach and Schaufeli (1993) ask is, at what point does a relationship become so strong that both concepts are reinterpreted as indices of the same underlying construct? In other words, being different from something and being related to something are not mutually exclusive. They argue that the distinction becomes even harder to make when measurement and methodological problems are taken into account. "A high correlation between two concepts can be due to several artifacts, whereas a poor correlation might be caused by unidentified confounding variables" (p. 10). It is therefore a legitimate question to ask whether burnout can be differentiated conceptually as well as empirically from such affective states as depression and job dissatisfaction.

It has often been noted that the symptoms of burnout, in many ways, mirror those of depression: feelings of hopelessness; helplessness; emptiness; sadness; psychosomatic complaints; and neurovegetative signs. Warr (1987) distinguished between two types of affective well-being:

depression is considered to be context-free, whereas burnout is regarded as job-related. Oswin (1978) described a syndrome of professional depression among nurses that bears close resemblance to burnout, including being overtired, becoming hardened and accepting one's ineffectuality at the job. Freudenberger (1981) says that reactive depression is most often accompanied by guilt, whereas burnout generally occurs in the context of anger that is job-related and situation specific rather than pervasive. On a conceptual level it seems as if burnout is a job-related syndrome, which is characterised by dysphoric symptoms that are similar to those of depression.

According to Pines and Aronson (1981) burnout is a socio-psychological concept and thus different from a concept such as clinical depression. In depression the individual and the individual's personal history are the source of symptoms and the focus of therapy. In burnout the search for the antecedents of symptoms and modes of coping is located in the environment. Later Pines (1993) describes the unique characteristic of burnout, the one that best differentiates it from other concepts, including depression and job dissatisfaction, as being the fact that burnout is always the end result of a gradual process of disillusionment in the quest to derive a sense of existential significance from work. He says that "while it may be true that in a discussion of depression, for example, there is an implicit assumption that the depressed individual may not have always been depressed, the state of depression and not the sinking down to it is the crucial element in both its conceptualization and its treatment" (p. 40). Pines (1993) further says that burnout is a much more specific phenomenon than these other concepts. While stress, depression and job dissatisfaction can happen to everyone, burnout only happens in people who entered their professions with the expectation of deriving from a sense of existential significance from their professions. Similarly, while depression is a total and general experience that has an impact on all aspects of a person's life, burnout is a specific experience that characterises people who work over long periods of time in situations that are emotionally demanding, the kind of situations that occur frequently at work.

In conclusion, Maslach and Schaufeli (1993) state that given the current state of knowledge on these issues, the most conclusive statement to make is that the distinctiveness of the burnout concept pertains to both its process (time) and to its multidimensionality (domain).

The Diagnostic Criteria that would Allow Burnout to be Identified in an Individual

As was pointed out in the discussion on the definitional ambiguity surrounding burnout, most of the definitions regarding the phenomenon can be referred to as "state" conceptualisations of burnout. These conceptualisations identify burnout with affective states. Although these "state" definitions of burnout differ in scope and precision, they share, according to Maslach and Schaufeli (1993), they share at least five common elements:

- There is a predominance of dysphoric symptoms such as mental or emotional exhaustion, fatigue, and depression.
- The accent is on mental and behavioural symptoms rather than on physical symptoms, although some authors mention atypical physical complaints as well.
- Burnout symptoms are work-related.
- The symptoms manifest themselves in "normal" persons who did not suffer from psychopathology before.
- Decreased effectiveness and work performance occur because of negative attitudes and behaviours (p. 15).

Grounded in a similar analysis of definitions, Bibeau et. al. (1989) suggest subjective and objective diagnostic criteria for burnout as well as four criteria of exclusion that allow a differential diagnosis.

- The main subjective indicator is a general state of severe fatigue accompanied by (1) loss of self-esteem resulting from a feeling of professional incompetence and job dissatisfaction; (2) multiple physical symptoms of distress without an identifiable organic illness; and (3) problems in concentration, irritability, and negativism.
- The main objective indicator of burnout is a significant decrease in work performance over a period of several months, which has to be observable in relation to (1) recipients (who receive services of lesser quality); (2) supervisors (who observe a decreasing effectiveness,

absenteeism, etc.); and (3) colleagues (who observe a general loss of interest in work-related issues).

- These subjective and objective indicators of burnout should not result from (1) sheer incompetence (the person has to have performed well in the job for a significant period); (2) major psychopathology, or (3) family related problems. (4) Severe fatigue resulting from monotonous work or a big workload is excluded when not accompanied by feelings of incompetence or lowered productivity.

Judging from the above, it seems clear that burnout can be assessed in psychiatric terms. The description of burnout in psychiatric terms might detract from the burnout concept's popularity as a socially accepted label that carries minimal stigma. The positive side to it is that a clinical psychological and psychiatric diagnosis of burnout would provide official recognition of a legitimate personal problem.

Models of Burnout

Models of burnout that attribute its occurrence solely to work-related stresses are still common in the popular press, with the resultant failure to acknowledge the role of personality variables, mediational processes or socio-historical factors. The professional literature has, however, offered increasingly complex models of burnout, often emphasising the interaction of individual, organisational, and societal factors (Farber, 1983). Harrison (1983), for instance, proposes a social competence model of burnout, focusing on the fundamental need of workers to perceive themselves as competent in their roles. Fischer (1983) employs a psycho-dynamic perspective to explain the burnout syndrome, pointing out specific characterological structures, tendencies, and resistances of burned out workers. Heifetz and Bersani (1983) suggest that burnout among human service workers is best conceptualised within a cybernetic model, emphasising the critical role of feedback in professionals' pursuit of client growth and their own professional development. Several writers have advanced the "deficit model" of burnout (Farber, 1983) which suggests that burnout is caused not by the presence of job stressors but rather by the absence of job motivators.

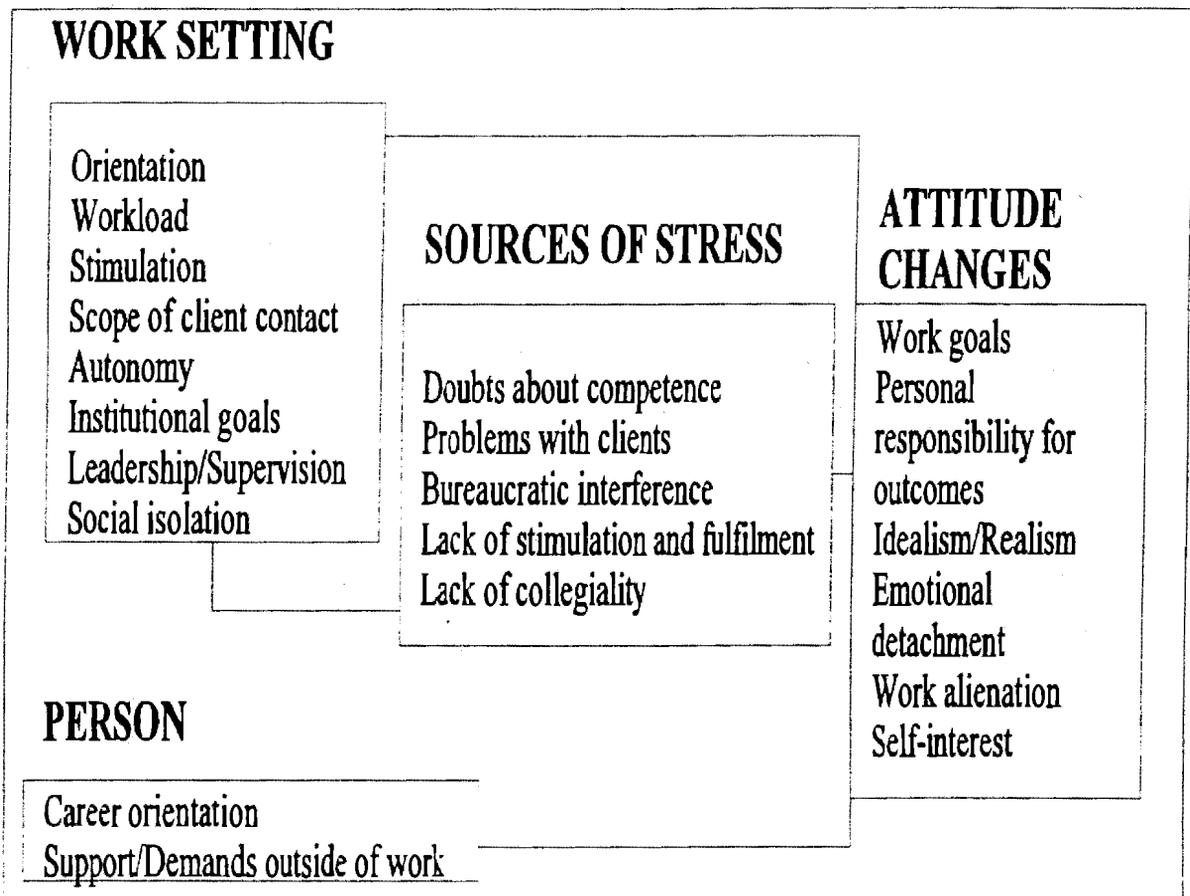


Figure 2.1 The Cherniss process model of burnout (Cherniss, 1980b)

According to Burke (1987), Cherniss proposed perhaps the only comprehensive model of burnout (see Figure 2.1). This process model will be discussed briefly in the next paragraph. Two other models of burnout will also be discussed. These are the multidimensional model of burnout (Maslach & Jackson, 1981), and the existential model of burnout (Pines, 1993).

The Cherniss process model (Cherniss, 1980b, ref. Figure 3.2) suggests that individuals have particular career orientations, extra work support, and demands, that interact with particular work-setting characteristics. The coming together of these factors results in the experience of particular sources of stress. Some individuals employ techniques and strategies that might be termed active problem solving, while others cope by exhibiting negative attitude changes. Burnout for Cherniss occurs over time, it is a process, and represents one way of adapting to, or coping with, particular stress (Burke, 1987).

The operational definition and the corresponding measure that is most widely used in burnout research is the three-component model developed by Maslach and Jackson (1981, 1982a, 1982b, 1984). The multidimensional model is not at odds with simpler conceptions of burnout as a single, unidimensional phenomenon, rather, it both incorporates the single dimension (exhaustion) and extends it by adding two other dimensions: response to others (depersonalisation) and response to self (reduced personal accomplishment). It is interesting to note that these three components do actually appear in most of the various definitions of burnout, even if they are not being considered within a multidimensional framework (Maslach, 1993). Jackson et al. (1986) argued that significant progress in understanding burnout is the product of the development of new (meaning multidimensional model) theoretical perspectives. It is true that there are various problems in the articulation of the interrelationships among the three components, but despite that, this model has by far the most popular appeal. Maslach (1993) argues that of the three burnout components, emotional exhaustion is closest to an orthodox stress variable. Although this similarity validates the location of the burnout phenomenon within the stress domain, it is also the cause for some scepticism (Jackson, Schwab & Schuler, 1986). If emotional exhaustion is simply a synonym for stress, then nothing new has been learned from the burnout research. Thus, Maslach (1993) argues, to limit the

concept of burnout to just the component of emotional exhaustion is to define it simply as experienced stress and nothing more. This ignores the two latter components of self-evaluation and relation to others. In the three-component model of burnout, reduced personal accomplishment reflects a dimension of self-evaluation, and depersonalisation tries to capture a dimension of interpersonal relations. According to Maslach "both these components add something over and above the notion of stress"(1993, p. 28).

From a clinical point of view the existential model of burnout presented by Pines (1993) remains very relevant. For Pines "the root cause of burnout lies in our need to believe that our lives are meaningful, that the things we do - and consequently we ourselves - are useful and important" (1993, p. 33). Its underlying assumption is that only highly motivated individuals can burn out. A person with no such initial motivation can experience stress, alienation, depression, an existential crisis, or fatigue, but not burnout. Success provides a sense of existential significance that in turn reinforces these individuals' original motivation for the work. This positive loop can be sustained indefinitely, as long as the individual feels challenged, supported, and successful at work. From an existential point of view, people need meaning in their lives, and the failure to find such meaning will cause burnout. Long term confrontation with negative work features provides a subjective experience of deficiency and an existential experience of failure. The result is a negative loop that with time and with growing levels of burnout, can turn an individual into a very unhappy person. The crucial factor in determining whether highly motivated individuals will achieve a sense of success and significance or whether they will experience failure and burnout is the perceived work environment. It is also important to remember that the existential model of burnout is an abstraction. Real-life work environments are never all-supportive or all-stressful; rather they consist of a complex combination of supportive and stressful features. The likelihood of burnout occurring depends on the key factors in the balance between the supportive and stressful elements in the environment.

Burnout and its Sequelae as Developing Stages or as a Random
Occurrence

Having dealt with the general characteristics of burnout, the conceptual issues surrounding the concept, and models of burnout, the next question is whether burnout occurs in set stages. Freudenberger (1974) seems to have settled this issue a long time ago. "Since there are various stages of burn-out, any one of the preventive measures I mentioned may also be used to help the person who is in the process of burning out and who has not yet quite burned out completely" (p. 165). At least for Freudenberger it seems as if progressive burnout is a reality within considerable individual variability to work and nonwork stressors.

Several other authors have suggested that burnout progresses through identifiable stages. The most notable, of course, is Maslach (1982) who originally suggested that emotional exhaustion appears first. As excessive work demands interfere with and drain an individual's emotional resources the results is a distancing by the individual from his or her involvement and psychological availability. This depersonalisation provides an emotional buffer between the worker and the demands. Subsequently, as the worker realises his or her emotional exhaustion and depersonalisation he or she might feel inadequacy in terms of his or her potential contributions to society, work, and self.

This processional view of burnout is echoed by numerous writers in the field. Veninga and Spradley (1981) state that burnout progresses through five stages, namely, honeymoon, fuel shortage, chronic symptoms, crisis and hitting the wall. Cherniss (1980b) states that burnout occurs in three stages, which he calls impinging job stress, emotional response and psychological accommodation. Edelwich and Brodsky (1980) hypothesised that burnout occurs in four sequential stages which they call enthusiasm, stagnation, frustration and apathy. Mitchell and Brady (1990) are of the opinion that cumulative stress reactions can be experienced in four relatively distinct phases, the warning phase, the mild symptom phase, the entrenched phase and the severe/debilitating phase. No discussion of this issue would be complete without acknowledging Golembiewski and Munzenrider's (1988) book, *'Phases of burnout'*, which is in essence a discussion of an extension of Maslach's work discussed

above. The phase model of burnout sees the sequence of changes described above as fixed. This is regarded as an attempt to identify critical happenings at different points in time. According to Muldary (1983, pp. 45-46) it would be premature to conclude that burnout does in fact progress through an orderly sequence of events and stages or phases. What would be closer to the truth is that burnout appears to reflect a process that takes place in a variety of ways, proceeds at different rates, and depends on the nature of each person's relationship with his or her total experiential world. It should be expected that there will be considerable individual variability in response to work and nonwork stressors and in the appearance of the burnout syndrome

A study by Lee and Ashforth (1993) found only partial support for this processional view of burnout. Others have argued that there is no fixed sequence. No symptom is inevitably followed by another set symptom. One component is not an inevitable consequence of another (Schwab & Iwanicki, 1982). This makes intuitive sense despite the numerous contradictory conceptions in the literature. It makes clinical sense because individuals do present with burnout without necessarily having moved through a discernable sequence of different stages of burnout. The author hopes that this idea of a non-fixed sequence will be proved by this study. But as far as the literature is concerned the overwhelming impression seems to be that burnout develops over time and through orderly stages or phases.

Differential Diagnosis

Because there are quite a few stress-related syndromes it might be a good idea to differentiate between them. From a clinical psychological perspective a major consideration in the diagnosis of burnout is the possibility that the patient is suffering from acute stress or delayed stress disorder. Other considerations that can both cause and exacerbate the symptoms are generalised anxiety disorder and post traumatic stress disorder. The psychiatric differential diagnosis should include generalised anxiety disorder, acute stress disorder, delayed stress disorder and post traumatic stress disorder. They will be discussed briefly in order to differentiate between them and burnout. In other words, to indicate what burnout is not.

Anxiety

Anxiety is a diffuse, highly unpleasant, often vague feeling of apprehension, accompanied by one or more bodily sensations. These sensations may include restlessness, an empty feeling in the pit of the stomach, tightness in the chest, a pounding heart, perspiration, or a headache. Some argue that panic attacks and associated severe anxiety are unpredictable and come from out of the blue (Barlow & Craske, 1989; Clum, 1990). This is confirmed by Kaplan and Sadock (1991) who state that anxiety is a response to a threat that is unknown, internal, vague, or conflictory in origin. It should also be taken into consideration that just as burnout symptoms are a warning to the individual that something needs to be done to protect himself or herself, anxiety is an alerting signal. It warns of an external or internal threat, and it, therefore, has lifesaving qualities. Seligman (1993) says that anxiety warns us that danger lurks. It fuels planning and re-planning, searching for alternative ways out, rehearsing action.

Individual patterns of anxiety vary widely and whether an event is perceived as anxiety provoking depends on the nature of the event and on the resources, the defenses and the coping mechanisms of the person. The experience of anxiety has two components: the awareness of the physiological sensations (such as palpitations, sweating, butterflies in the stomach, tightness in the chest, shaking knees, and quavering voice) and the awareness of being nervous and frightened. In addition to the motor and visceral effects on thinking, perception, and learning should not be overlooked (Kaplan & Sadock, 1991). Anxiety tends to produce confusion and distortions of perception, not only of time and space but of people and the meaning of events.

In the *Diagnostic and statistical manual of mental disorders* (4th ed., 1994) anxiety disorders include panic disorder, phobias, obsessive-compulsive disorder, post-traumatic stress disorder and generalised anxiety disorder. Disorders are classified together because anxiety is considered to be the fundamental symptom in all those syndromes (Kaplan & Sadock, 1991). In a previous section it was concluded that burnout is a unique type of stress phenomenon which, with other stress-related diseases, can be viewed as a disorder of arousal. It is also postulated that anxiety, in much the same

way as it is regarded as the fundamental symptom of all the above-mentioned stress-related diseases, can also be regarded as the fundamental symptom of a unique type of stress phenomenon, namely burnout.

Acute stress

Acute stress reactions are dramatic, overwhelmingly powerful experiences following one or more critical incidents. Although the signs and symptoms of panic attacks and acute stress reactions correspond, the two are not the same thing. Panic attacks or a panic disorder is the fear of fear within oneself (Swede & Jaffe, 1987). Acute stress reactions differ from panic attacks in that they are always associated with critical incidents. The term "critical incidents" refers to incidents that are so powerful that they can easily overcome a person's normal ability to cope with the stress of the job. Critical incidents are extraordinary events that cause extraordinary stress reactions. Any event can be considered a critical incident if it has the ability to distress by overwhelming the person's usual coping ability. Some critical incidents may affect only one or two people who are involved with them, others are so extensive that almost every service provider involved will be strongly affected by the incident (Mitchell & Bray, 1990).

According to Mitchell (1985) more than 85 percent of emergency personnel have experienced acute stress reactions after working at one or more critical incidents. The majority of service providers experience only temporary stress reactions and recover within a few weeks. But there is a percentage who take months to overcome the effects of critical incidents and between two and four percent of service providers may experience such significant effects that their jobs, health and happiness are permanently impaired. For this reason it is suggested that all individuals involved in an incident be defused (De Wet, 1987). The idea behind this reasoning is that the individuals free up emotional energy that would otherwise be used to deal with the traumatic event. The defusing/debriefing frees up this energy for other use by the individual and will prevent this incident from contributing to the individual's burning out.

The intensity of the critical incident will mostly determine the severity of the stress reaction and this will determine the level of individual distress. Mild stressful events produce a mild stress reaction with barely noticeable distress signals. The more intense the stressful situation, the more intense the stress signals that are experienced. All people are susceptible to stress reactions, and anybody, including service providers, can present with stress symptoms. (A complete list of stress signs and symptoms would be burdensome to read and would not serve any useful purpose here. They are listed in Mitchell & Bray, 1990, pp. 42-43. Most acute stress reactions begin either at the scene of the critical incident or shortly thereafter, usually within the first 24 hours after the incident (Mitchell & Bray, 1990). This is also what differentiates acute stress from burnout. Burnout is a much more insidious process that might flare up during an acute stress reaction. It is recommended that one first deals with the acute stress-reaction that presents itself. A thorough history taking will, however, reveal the more cumbersome burnout underlying the acute stress reaction (Mitchell & Bray, 1990).

The signs and symptoms of an acute stress reaction do not usually indicate mental illness (Mitchell & Bray, 1990), but pre-existing emotional problems, or emotional baggage, will be made worse by such a stressful event and will affect the stress reaction (De Wet, 1987). A few symptoms would be sufficient to indicate that an individual is experiencing an acute stress reaction. To ignore these warning signals would be the worst thing to do. At best they indicate a need for some corrective action to limit the impact of a stressful event or to begin the recovery process. Dealing with an acute stress reaction will also limit the possibility of this reaction adding to the already overburdened individual's tendency to burnout (Mitchell & Bray, 1990).

Delayed Stress

Delayed stress responses are like acute stress-reactions in that they are a direct result of a critical incident (Mitchell & Bray, 1990). It is not uncommon for an individual who experienced a critical incident to feel the effects only days, weeks or sometimes even years after the event. The reactions and emotions to a specific incident can be suppressed at the time, only to come back at a

later stage, usually following a new critical incident. The reactions experienced then are not the result of the latest incident, but of an older suppressed incident that becomes conscious. This makes delayed stress much more difficult to diagnose than acute stress (Mitchell & Bray, 1990).

According to Mitchell (1986) the time factor is crucial. So much time has passed that the individual experiencing the delayed stress is unlikely to associate the signs and symptoms with the original critical incident. The individual thinks that she or he has put the incident behind herself or himself. This inability to see the connection between past events and current reactions lies at the heart of the problem. The passage of time has a way of distorting, covering, or exaggerating the typical symptoms, which makes it harder to recognise the stress symptoms for what they are. De Wet (1987) mentioned that it is as if the individual becomes lost to him or herself. An added problem is that delayed stress is more tenacious than acute stress. The suppressed stress has been around for a long time and has had time to establish roots. It is thus much harder to resolve.

Delayed stress reactions are often recognised by persistent intrusive images (Mitchell & Bray, 1990, p. 44). These images may appear in the form of annoying thoughts that relate to the distressing incident. These thoughts which have a tendency to come into a person's mind when they are not invited in and usually at an inappropriate time, cause the individual to experience difficulties with attention, concentration, and focus. When the intrusive thoughts are present, the individual may feel the same anxiety and discomfort that were present at the scene during the event. Intrusive thoughts are also likely to show up in nightmares or during daydreams. The visual images can be graphic representations of the critical incident or incidents, or they may be distortions of reality. Individuals often complain that they see the same horrific sequence over and over again. Needless to say these images are emotionally distressing, they might also produce physiological responses. Independently of or in conjunction with these intrusive visual images, there may also be auditory or olfactory impulses. These sights, sounds and smells associated with a critical incident, which occur later when the individual is away from the scene and awake, are called flashbacks. Flashbacks have this dreamlike quality except that they happen when the individual is fully awake.

Other physical signs of delayed stress are sleep disturbances, lowered sexual drive or aversion to physical contact, and a myriad of somatic symptoms like nausea, breaking out in cold sweats, muscle tremors and startle responses. Unexpected loud noises, odours and certain sights may cause dramatic reactions in individuals suffering from delayed stress reactions. There might also be a heightened susceptibility to a wide spectrum of diseases like ulcers, diabetes, cancer, and coronary artery disease (Mitchell & Bray, 1990).

The most common emotional signs of delayed stress reactions are feelings of intense grief and depression (Mitchell, 1986). These usually go hand in hand with a general feeling of malaise and a loss of emotional control. This can happen at any time after the event, but usually this happens without warning, which makes it even more disturbing. Or there is the perception that: "I have experienced worse incidents in the past, why do I feel this way now?" The individual may not realise that the current incident might have been just the trigger mechanism that brought to consciousness old suppressed incidents. When emotionalism increases the typical reaction is withdrawal and isolation. This is especially true for health service providers. Once this process is in progress the individual may lash out with anger and outbursts of rage, feel irritable, and lonely and experience self-doubt or guilt. Other emotions that come to the surface long after a traumatic event, are a sense of hopelessness and helplessness. If these emotional symptoms continue unchecked they might produce suicidal thinking (Mitchell, 1986).

The cognitive signs of this form of stress experience manifest themselves as intense distractibility and a lowered attention span (Mitchell & Brady, 1990). It is as if the individual loses the ability to filter out unnecessary stimuli, and because of the lowered concentration span, the individual can no longer sort out things as in the past (Cooper, 1981). Repetitive obsessive thinking about specific elements of the traumatic incident which can be so marked that it screens out other areas of life have also been reported. It follows from there that the emotions stirred by the constant reminders may contribute to changes in a person's behaviour. But as noted above, the experience of emotional isolation and withdrawal cuts the individual off from support systems. Some individuals may become extremely talkative or make jokes about almost everything. There may also be some

destructive behaviour, such as increased use of alcohol or tobacco. Mitchell and Brady (1990) state that "the important point to note is that current behaviour is changed substantially from previous behaviour" (p. 49).

To summarise, when experiencing the repercussions of delayed stress, the inability to see a correlation between past events and current responses, often makes individuals increasingly susceptible to more significant risks to their health, happiness and to their ordinary level of functioning. Delayed stress and burnout have many symptoms in common. In fact, delayed stress disorder may be one of the reasons an individual presents for help. Careful consideration, however, has to be paid to the cause, scope and extent of the problem. Delayed stress reaction is the direct result of a critical incident, most likely in the not too distant past, whereas burnout is caused by numerous individual, societal and work-related factors.

Post-Traumatic Stress Disorder

Post-traumatic stress is the term used to denote the stress response syndrome which follows exposure to some traumatic event. A traumatic event is defined as a psychologically distressing event that is outside the usual range of human experience (APA, 1987). The three major features of post-traumatic stress disorder are: 1) the re-experiencing of the trauma through dreams and waking thoughts, commonly known as "intrusive thinking" or "intrusive thoughts", 2) emotional numbing to and withdrawal from other life experiences and relationships, and 3) symptoms of autonomic instability, depression, and cognitive difficulties (such as poor concentration). These symptoms are also called persistent symptoms of increased arousal (Kaplan & Sadock, 1991).

According to Mitchell and Everly (1993) "Post-traumatic Stress Disorder (PTSD) represents the single most severe and incapacitating variation of human stress (Everly, 1989; Everly & Lating, 1994). Contrary to historic opinion, PTSD may be engendered by events other than combat and contrary to popular opinion, PTSD may occur at a shockingly high prevalence. For example, Norman and Getek (1988) have estimated that one-half of all patients admitted to urban trauma centres are

likely to suffer from PTSD in addition to their physical trauma, while another 31% may suffer from a milder variant of post-traumatic stress. Similarly, Herman and Van der Kolk (1987) have noted that the borderline personality disorder may be a post-traumatic syndrome. It may be that the borderline personality and "multiple" personality disorders may simply be characterological manifestations of PTSD.

Phenomenologically, the intrusive memories of the trauma combined with excessive chronic and intense levels of arousal constitute the key elements of this disorder. The withdrawal symptoms are seen as being secondary and reactive to the intrusive memories and arousal and, therefore, contingent upon the severity of the interaction between the intrusive recollections and the symptoms of arousal (Mitchell & Everly, 1993, p. 36). PTSD is not something to be taken lightly. It is a serious condition that can lead to personality changes, illness, and if it is ignored, may end with the person's suicide (Mitchell & Bray, 1990). It has the potential to literally consume an individual's life. The reiterative nature of the disorder is nothing less than a potentially never ending effort to make sense out of the world in the face of traumatic evidence that one's worldview is inadequate and therefore no longer protective.

With regard to the serious but often misunderstood nature of this stress disorder, it is accepted that PTSD is commonly misdiagnosed as alcohol and drug dependencies, factitious disorder, malingering, adjustment reaction, borderline personality disorder, schizophrenia, depression, panic disorder and generalised anxiety disorder, resulting in the inappropriate treatment of the condition (Kaplan & Sadock, 1991). Needless to say, early diagnosis and treatment of PTSD is a desirable goal since the proper treatment depends largely on a precise diagnosis of the condition.

In conclusion, it must be said that PTSD is not the only psychiatric manifestation of post-traumatic stress. There are many individuals who have suffered and will suffer the ill effects of post-traumatic stress yet will not meet all the diagnostic criteria for PTSD. Some of the other potential post-traumatic stress syndromes are: depression, self-medication and substance abuse, personality disorders, panic syndromes, erratic work-related behaviour, burnout, memory dysfunction

and amnesic syndromes regarding traumatisation. When a critical incident is extremely powerful and when it is well outside the usual range of human experience, it may cause PTSD to develop in a small number of people who experienced the event (Mitchell & Bray, 1990). Burnout on the other hand, occurs as the result of prolonged exposure to a great many stressors over a long period of time. The stressors do not have to be as severe as in the case of acute or critical incident stress. It is of course possible that an individual can suffer from PTSD symptoms and be diagnosed as being burned out. The distinction is that burnout is usually caused by a combination of a wide range of work and nonwork stressors (Mitchell & Bray, 1990, p. 52).

Antecedents of Burnout

The stress that causes burnout is engendered by individual factors, societal factors and work-related factors (Cherniss, 1980a; 1980b; Farber, 1983) and they will be discussed in this section. Individual factors include individual personality variables, mediational processes such as cognitive appraisal, and current life stresses and supports. Societal factors include the relationship between the individual and the work environment. Societal factors also refer to broader social concerns, as well as to community and caring relationships. Work-related factors refer to the central role of work-related stresses, to the nature of the work role and the nature of the work setting (Farber, 1983, pp. 4-11). Cordes and Dougherty (1993) state that the antecedents of burnout can be grouped into three broad categories: Job and role characteristics, organisational characteristics and personal characteristics. The first two will be discussed under the previously mentioned work-related factors in burnout, and the last one under intrapsychic and individual factors in burnout.

In assessing the causes of burnout one can easily focus exclusively on the individual characteristics of burnout (Cox & Ferguson, 1991). This may be too narrow a view. Therefore, Pines and Aronson (1988, p. 51) state that their analysis of the causes of burnout has focused on the environment, not because individual differences are unimportant, but because almost all individuals can be affected by environmental changes, regardless of their personality characteristics or cognitive styles. For them, looking toward the environment, which consists of all the settings in which the

individual functions, including the occupational, organisational, social, home and recreational environments, rather than at the individuals' intrapsychic experience for solutions has more practical utility for understanding burnout.

One of the problems of looking for the causes of burnout is that "anything can be a precursor of strain for somebody at some time" (Golembiewski, Munzenridder & Stevenson, 1986, p. 4). "What is emotionally painful for one staff person may not pose any special problem for the next" (Maslach, 1978, p. 115). The most general burnout conceptions are found in the model presented in Figure 2.2, which is, in essence, the differentiation between unpleasant or harmful stress, called distress (from the Latin *dis* = bad), and stimulating or vitalising stress, called eustress (from the Greek *eu* = good). The available literature is clear only about the precursors or causes of burnout. The fixation on the view that any stimulus can be a stressor for someone at some time has its inadequacies, even though it may be true. It also encourages an emphasis on heightening stress-coping capabilities by individuals, rather than on reducing stress-inducing potential in, for instance, work environments.

According to Golembiewski and Munzenridder (1988), "the emphasis on burnout viewed in terms of progressive phases provides a potential way out of this conceptual cul de sac. In a manner of speaking, burnout phases deal with the bottom line of an individual's balance of eustress over distress, whatever the ranges and magnitudes of stressors to which individuals are exposed, and whatever their coping skills ... [this] approach does not seek to finesse forever the study of precursors - absent or present - but it does assign them a distinctly secondary priority" (pp. 14-15). This focus, as like the Pines and Aronson (1988) focus, is again on the work environment rather than the individuals' intrapsychic experience.

Intrapsychic and Individual Factors in Burnout

Five possible antecedents of burnout within the intrapsychic and individual fields will be discussed. Personal characteristics as an antecedent of burnout, personality as an antecedent of burnout, the public service domain as an antecedent of burnout, lack of control as an antecedent of burnout and certain existential issues as antecedents of burnout are presented.

Personal Characteristics as an Antecedent of Burnout

According to Cordes and Dougherty (1993) certain demographic characteristics have been shown to contribute to an explanation of why some individuals experience burnout while others remain virtually unaffected by it. Men and women often report differences in levels of the three burnout components, but there is mixed evidence concerning the pattern and complexity of the relationships (Cordes & Dougherty, 1993). Younger individuals consistently report higher levels of the burnout components (Maslach & Jackson, 1981; Russell et al., 1987), but one study found that more experienced employees reported lower levels of emotional exhaustion and depersonalisation (Anderson & Iwanicki, 1984). There is some evidence that married individuals report lower levels of the burnout components and individuals with children consistently report lower levels of the burnout components (Maslach & Jackson, 1985).

Personality as an Antecedent of Burnout

There is general agreement that burnout prone individuals are empathic, sensitive, idealistic and people oriented (Farber, 1983). Individuals who suffer from burnout share certain personality characteristics that make them choose human services as a career. In the main people who choose helping professions are individuals who are particularly sensitive to the needs of others, who have especially great empathy for the suffering of others. Most human service professionals are "feeling types" as opposed to "thinking types". The premise of the Jungian theory of psychological types distinguishes between these two types (Jung, 1960). People who are oriented to life primarily

through thinking typically develop strong powers of analysis, objectivity in weighing events with regard to logical outcomes, and a tough-minded scepticism. People whose orientation is primarily feeling, typically develop a sensitivity to other people's feelings and needs. They have a need for affiliation, a capacity for warmth, and a desire for harmony. Pines and Aronson (1988) state that the distinction between feeling and thinking types also reflects the differences in the experience of burnout in corporate management and in the human services.

The research done on type A and type B personality types and their reaction to burnout strengthens the premise that individual personality type plays a distinct role in the reaction to burnout. According to Edwards (1991), the type A behaviour pattern has maintained a central position in research into individual differences and stress. Hallsten (1993) states that the comparison between type A behaviour pattern and burnout is that the latter has less the character of a trait or a typology, although it bears some resemblance to the interpretation of type A behaviour as presented by Matthews (1982). She emphasised the importance of uncontrollability, self-involvement, and ambiguous standards for the occurrence of type A behaviour.

Human and Public Service as an Antecedent of Burnout

Public service professionals suffering from burnout perform emotionally taxing work. A job in which a person helps others involves a certain degree of stress. The specific degree and kind of stress depends on the particular demands of that job and on the resources available to the professional. Each occupation has its unique pressures, anxieties and conflicts inherent in the work itself and in the context in which the work is done. According to Lief and Fox (1963), health professionals repeatedly encounter highly emotional situations in their daily work. These situations involve "exploring, examining, and cutting into the human body; dealing with fears, anger, sense of helplessness, and despair of patients; meeting emergency situations; accepting the limitations of medical science in dealing with chronic or incurable disease; being confronted with death itself" (p. 13). Doctors, nurses and psychological care providers are also exposed to the most personal intimacies and conflicts and are frequently the focus of intense, primitive transference reactions, both

affectionate and hostile, to which they do not dare respond in kind (Oken, 1978). From personal experience this writer agrees with Kadushin (1974), who states that the danger of burnout and emotional exhaustion results from the constant demand to give emotional energy to others. From the existential perspective the most important tool for public service professionals who provide psychological help to other individuals is the professionals themselves. Workers may feel that failure with a patient reflects both on their competence as technicians and on their competence as people (Pines & Aronson, 1988).

Lack of Control as an Antecedent of Burnout

The importance of experiencing a sense of control over various aspects of one's environment and the resultant benefit to the organism's general physical and emotional health are well documented (Ormel & Sanderman, 1989; Steptoe & Appels, 1989). Indeed, it has been argued that control and lack of control are important in mediating emotions not only within the range of normal day-to-day fluctuations of mood states, but also in the expression of more pathological forms of emotions such as those that occur in clinical disorders (Mineka & Kelly, 1989). Lang (1984, 1985) sees control as one of the three fundamental dimensions of human emotion, whereas other theorists focus on the role of lack or loss of control in the origins and maintenance of clinical anxiety and depression (Abrahamson et al., 1978; Barlow, 1988; Garber et al., 1980; Mineka, 1985; Seligman, 1975). In a study on the relationship between anxiety, lack of control and loss of control, Mineka and Kelly (1989) discussed the importance of control and lack of control during exposure to aversive or stressful experiences in determining the consequences of those stressors. They found that having a prior history of control over important life events is thought frequently to often protect the organism from the negative consequences of later experience with environmental stressors. They also found that having control (actual, perceived or potential) over aversive events substantially reduces the amount of fear/anxiety produced by those events, as evidenced by cognitive, behavioural and physiological response measures. The relevance of this research for the burnout construct is almost self-explanatory. It is argued that experiencing a lack or loss of control (actual, perceived or potential) over the physical, psychological and attitudinal components will cause the individual an

increased amount of burnout symptomology. The opposite, namely, having control (actual, perceived or potential) over the physical, psychological and attitudinal components and subsequent behaviour might produce a buffer against burnout or decrease the intensity of the experience of burnout symptoms.

According to Syme (1989, p. 3) the concept of control is of interest and importance to researchers in the health field for at least three reasons. First, it seems to provide a parsimonious integration that incorporates into one thought a variety of lesser and apparently unconnected ideas that up to now have been only of moderate interest. Second, the concept seems to have broad applicability. Third, the concept deals with behaviour that may be amenable to intervention; it involves behaviours which, hopefully, something can be done about.

Existential Issues as Antecedents of Burnout

According to Pines and Aronson (1988), the root cause of burnout lies in the existential need to believe that life is meaningful, that the things that are done are useful, important, and even heroic. The same cause can be found in Freudenberger's (1980) view of the subject. Adopting a different approach Wessells (1989) states that the root cause of burnout is that professionals define job success and responsibility unrealistically. Their own definitions of professional responsibility and professional success serve to negate whatever valuable services they are rendering and leaves them feeling that they are failing professionally, since they cannot attain their goals. This reasoning also has a distinct existential tone to it. But while burnout may be the result of failure in the existential quest for meaning, it is experienced by most people as a far more mundane process.

In general people experience burnout as a gradual erosion of their spirit and zest as a result of the daily struggles and chronic stresses that are typical of everyday life. Their lot involves too many pressures, conflicts and demands, and too few emotional rewards, acknowledgments, and successes. Stress in and of itself does not cause burnout. The cognitive interpretation and affective integration determine that. "This process of disillusionment highlights, once again, the root cause of

burnout - a sense of failure in the existential quest for meaning" (Pines, 1993, p. 36). Cordes and Dougherty (1993) discuss various aspects of personal expectations as antecedents to burnout. Employees' expectations about their profession, the organisation, and their own personal efficacy may make a significant contribution to burnout. Another aspect discussed by Cordes and Dougherty (1993) that adds to the understanding of how this may contribute to burnout include the individual's expectations - high, unmet with shifts in expectations.

Although Pines and Aronson (1988) are of the opinion that people burn out when their work has no meaning and stress continuously outweighs support and rewards, that is, they supply an existential answer to the problem, this might not be the only possible answer. From a clinical and practice perspective it does, however, clarify the problem and gives one a clear perspective on this problem.

Interpersonal and Social Factors in Burnout

Three possible antecedents of burnout within the interpersonal and social fields will be discussed. These are social support, asymmetry of the helping relationship and the lack of a sense of community.

Social Support as an Antecedent of Burnout

The effects of social support on stress and burnout have received extensive attention in the literature (Buunk & Schaufeli, 1993; Cherniss, 1980a; Cohen & Wills, 1985; Constable & Russell, 1986, Hallsten, 1993; Maslach & Jackson, 1984). Social support appears to have a positive effect on individuals' well-being through two different processes. In the first place, support has been identified as a buffer between job-related stress and the pathogenic influences of stressful events. This may occur in one of two ways. Support can help individuals to redefine the potential harm in the situation, or it can enhance their belief that they can cope with the situation by increasing their perception that others will provide the necessary resources. In the second place, social support can

have a major effect on experienced stress. Social support is positively related to psychological and physical health, irrespective of the presence or absence of life or work stressors. The accumulated evidence supports both the buffering model and the direct model of social support. Both models seem to be correct in certain situations, but each represents a different process through which social support affects well-being (Cordes & Dougherty, 1993).

In a study of workers in a mental health organisation, Leiter and Maslach (1988) examined the effects of different sources and types of interpersonal contact. They looked at contact with co-workers and supervisors, and distinguished between pleasant and unpleasant co-worker and supervisor contacts. Among the group of nurses, unpleasant supervisor contact was positively related to emotional exhaustion, whereas pleasant supervisor contact was negatively related to depersonalisation and pleasant co-worker contact was positively related to personal accomplishment.

In a series of studies, Leiter (1988, 1990, 1991) explored the direct effect of several facets of social support. According to Cordes and Dougherty (1993), "this line of research highlights the distinct pattern of relationships among variables and the three burnout components, and it also points out the complicated nature of support and the role it plays in burnout. Not only are sources of support differentially effective on the burnout components, they may also have negative effects" (p. 635). This is in line with findings by Buunk and Schaufeli (1993), who say that burned-out nurses, particularly when they are under stress, do not affiliate with their colleagues. Instead they tend to withdraw and avoid their presence.

It would seem as if the literature has much to say about this topic, although it does not supply any concise answers to complex questions. As Cordes and Dougherty (1993) say, "the research suggests that professional and personal sources of support are largely independent of one another" (p. 635).

Asymmetry of the Helping Relationship as an Antecedent of Burnout

In most public service positions the focus is on the people who receive the service. The professionals' role of helping, understanding, and support is defined by the clients' needs. Pines and Aronson (1988) say that from the client's perspective, the professional is there only to serve and the professionals' presence is justified only as long as they continue to serve. Feelings are legitimate only when expressed by the client. What becomes clear is that, unlike most human relationships which are more or less symmetrical, the therapeutic relationship is not, it is complementary. The professionals give and the clients receive. Needless to say, this type of relationship can become extremely stressful for the professional providing help. Its effects are doubled when combined with the emotional intensity characterising most human service work and with the selective sample of people who choose to work in the human services.

In a study Van Yperen et al. (1992) found that nurses' perceived imbalance in their relationships with patients was associated with higher levels of burnout. That is, nurses who believed they invested more in their patients than they received in return, in the form of positive feedback, health improvements, appreciation, and gratitude, also reported higher levels of emotional exhaustion, depersonalisation, and diminished personal accomplishment. This is echoed by Buunk and Schaufeli (1993) who discuss the imbalance between investments and outcomes in relationships between nurses and patients.

The best example of the absurdity of an orientation that is exclusively client-centred comes from Pines and Aronson (1981, p. 54) who quote this story by Martin Lipp in *The wounded healer*:

“It was the case of a psychiatrist who committed suicide, which according to Dr. Lipp, a psychiatrist himself, is not that unusual; many psychiatrists commit suicide. But it nevertheless was a shock to all his friends and especially to his colleagues who, despite their expertise in recognising depression, did not notice anything unusual about his behaviour prior to the suicide. He was young, at the prime of his life. Even though he went through a painful

divorce, he seemed to be doing well. He was very successful professionally, and a brilliant future lay ahead of him. No one suspected he was as depressed as his suicide note indicated. The only people who seemed to have any indication of what he was going through were his patients. One patient said she had noticed that he was upset and sensed that something was very wrong. So she asked him about it. The psychiatrist's response was to smile at her gently and say that her job was to look after herself, not after him. Even at his most desperate hour he could not break the client- doctor relationship and take the hand that was offered to rescue him."

The Lack of a Sense of Community as an Antecedent of Burnout

Farber (1983) along with Cherniss (1980a; 1980b), theorises that the kind of systematic frustration and disenchantment that many workers, both professional and non-professional, report with reference to their jobs suggests that burnout may also be a symptom of broader social concerns. There is a small, but consistent, body of research findings that suggest that high levels of job satisfaction can, and do, co-exist with high levels of stress and burnout (Farber, 1983). Being excellent at one's work is both gratifying and demanding and this, of course, a precarious balance at the best of times a precarious balance at the best of times. Burnout often affects the most caring and most involved workers; they are the ones for whom a discrepancy between effort and results matters the most. As Sarason says: "After a person becomes aware that he cannot continue to make a strong commitment to work, that an impersonal society has rendered him impotent and dependent and has frustrated the desire for personal growth, the resulting alienation and loneliness bring to the fore the absence and need for a sense of community" (1977, p. 287).

The need for a "psychological sense of community is central to the positive experience of work" (Sarason, 1977, p. 283). What becomes obvious is that burnout becomes more prevalent as patient - professional relationships become increasingly encumbered by institutional constraints or confounded by unrealistic expectations (Farber, 1983, p. 12). Cherniss (1980a; 1980b) has examined the interaction of individual helpers' expectations and their goals, the institutional

constraints of working in and for large bureaucracies, and the public's perceptions of the nature of such work. He discusses something he calls the "professional mystique" that surrounds the public service professional. According to Farber (1983), this professional mystique involves the public's belief that professionals experience a high level of autonomy and job satisfaction and are highly competent and professional. This mystique is initially accepted by the incoming professionals and serves to reinforce their unrealistically high expectations of themselves. Invariably this mystique clashes with the reality of bureaucratic constraints and work-related stresses, ultimately culminating in disillusionment and burnout.

Organisational Factors in Burnout

"The search for causes [of burnout] is better directed away from identifying the bad people and toward uncovering the characteristics of the bad situations where many good people function" (Maslach, 1978, p. 114). Two possible antecedents of burnout within the organisational field will be discussed, namely job and role characteristics as an antecedent of burnout and organisational characteristics as an antecedent of burnout.

Job and Role Characteristics as an Antecedent of Burnout

The role of the client in service-provision interactions, and the expectations of the service providers themselves, have been shown to help to explain the experience of burnout. Client interactions that are more direct, frequent, of longer duration, or chronic, are associated with higher levels of burnout (Cordes & Dougherty, 1993). Most of the systematic research on the concept of burnout has focused on individuals in the helping professions, specifically in health services, religious and social services, teaching and public law (Muldary, 1983; Payne & Firth-Cozens, 1987; Welsh et al., 1982). In these professions burnout is believed to be most frequently and intensely experienced because of the high level of arousal from direct, frequent, and mostly intense interactions with clients. Maslach (1978) said that the potential for emotional strain is greatest for workers in the helping professions because they are constantly dealing with other people and their problems. According to

Farber (1983, p. 5) virtually all human service professionals complain of "long hours, isolation, lack of autonomy, client neediness, public misunderstanding of the nature of their work, insufficient resources, lack of criteria to measure accomplishments, excessive demands for productivity, inadequate job training and administrative indifference to or interference with their work".

A further factor in most instances is an excessively heavy client load. Jackson et al. (1986) divided caseload into quantitative and qualitative dimensions. The quantitative dimensions include frequency of contact, duration of contact, number of interactions and percentage of time spent with clients. Qualitative dimensions of client caseload involve interpersonal distance (phone contact versus face-to-face contact) and client characteristics (chronic versus acute, child, adult or family interactions). Both these qualitative dimensions represent a kind of psychological intensity of contacts with clients, which in turn affect the overall stress associated with the interaction.

Role conflict, role ambiguity, and role overload have been shown to be associated with burnout to varying degrees. Individuals who report higher levels of these role variables also report higher levels of burnout. Role conflict occurs as a result of incongruity or incompatibility of expectations communicated to a role incumbent by his or her role senders. Role ambiguity is associated with one's need for certainty and predictability, especially one's goals and means of accomplishing them. Role overload was originally conceptualised as a qualitative and quantitative experience. Individuals experiencing qualitative overload feel they lack the basic skills or talents necessary to complete the task effectively. Quantitative overload refers to the individual's perception that the work cannot be done in the allotted time (Cordes & Dougherty, 1993).

Schwab and Iwanicki (1982) found that role conflict and role ambiguity accounted for a significant amount of variance in the emotional exhaustion and depersonalisation dimensions for a sample of 469 teachers. Brookings et al. (1985) reported statistically significant relationships between perceived role conflict and role ambiguity and all three burnout components for 135 female human service professionals. According to Cordes and Dougherty (1993) the findings of the studies that look at the effects of role conflict and role ambiguity in the burnout literature, although limited,

are very consistent. In the same manner empirical investigations on the effects of quantitative overload on individuals' burnout scores reported very consistent findings (Cordes & Dougherty, 1993).

Organisational Characteristics as an Antecedent of Burnout

Bureaucratic organisations in general can promote three causes of burnout, namely overload (already discussed in the previous section), lack of autonomy and lack of rewards. All three are tied to the failure of work to provide a sense of meaning to life (Pines & Aronson, 1988, p. 101). "The common element to most work-related stresses is that each promotes a feeling of inconsequentiality, a feeling on the part of professionals that no matter how hard they work, the payoffs in terms of accomplishment, recognition, advancement, or appreciation, are not there" (Farber, 1983, p. 6). What transpires is that burnout is caused by individuals' perception of the discrepancy between their input and expected output. Pines and Aronson (1988, p. 59) state that managers burn out for the same reason that other professionals burn out: their work experience does not match their ideal, they cannot achieve in their work what they expected to achieve.

Lack of autonomy in an organisational setting can be a highly stressful experience. Pines and Aronson (1981) say that they found that burnout increased as autonomy, sense of control and discretionary time decreased. They also mention that lack of autonomy in bureaucracies is apparent in administrative pressures on the individual worker, unnecessary rules, and lack of voice in decisions that affect one's job and life. In this writer's experience in dealing with nurses and their employment complaints, a major issue continued to be problems related to the bureaucratic allocation of shiftwork and the assignment of co-workers during a particular shift. The fact that they had no say in the matter contributed to the experience of stress and feelings of loss of individuality.

Organisations are notoriously inefficient distributors of rewards, appreciation and recognition. According to Pines and Aronson (1981) this contributes to discouragement and demoralisation and eventually to burnout. Lachman (1983) says that feeling appreciated by those you work for and

with makes it inviting to come to work. "When work is a place to get recognised and rewarded you do not want to take days off or leave your workplace" (p. 150). Unfortunately, both verbal and non-verbal recognition continue, in many instances, to be lacking in public service organisations.

Consequences of Burnout

The significance of burnout as a practical concern is highlighted by its association with negative organisational outcomes and various types of personal dysfunction. Although many of the consequences discussed here are not unique to burnout, they illustrate how potentially costly and damaging burnout can be and accentuate the importance of better management in dealing with the problem. Figure 2.3 contains a comprehensive list of symptoms of burnout as found in the literature. Certain features of burnout are manifested more frequently than others, with the presenting pattern made unique by each individual. People approach the inevitable stresses of life and work in different ways. In the same manner the experience of burnout is uniquely individual. The process involved in this experience is individual cognitive appraisal (Pines & Aronson, 1988).

The consequences of burnout will be discussed briefly. They include (a) physical consequences, (b) emotional consequences, (c) interpersonal consequences, (d) attitudinal consequences and (e) behavioural consequences.

Physical Consequences

As discussed previously (The Diagnostic Criteria that would Allow Burnout to be Identified Within an Individual), it was indicated that in burnout the accent is on mental and behavioural symptoms rather than on physical symptoms. It was pointed out, however, that some authors do mention atypical physical complaints as well. Physical symptoms are characterised by low energy, chronic fatigue, and weakness. There may be an increased susceptibility to illness and psychosomatic complaints. Changes in eating habits may also occur, either in the form of eating too much or as eating too little. An increase in the use of alcohol, cigarettes or other substances has also been

reported (Pines & Aronson, 1988). Kahill (1988) reported symptoms like fatigue, insomnia, headaches, and gastrointestinal disturbances.

Emotional Consequences

PHYSICAL	PSYCHOLOGICAL	WORK BEHAVIOUR
Fatigue Sleep disturbances Difficulty sleeping Difficulty getting up Stomach ailments Tension headaches Migraine headaches Gastrointestinal problems Frequent colds Lingering colds Frequent bouts of flu Backaches Nausea Muscle tension Shortness of breath Malaise Frequent injuries Weight loss Weight gain Stooped shoulders Weakness Change of eating habits	Feelings: Anger Frustration Depression Boredom Discouragement Disillusionment Despair Apathy Guilt Anxiety Suspicion Paranoia Helplessness Hopelessness Pessimism Immobility Resentment Moodiness Attitudes: Cynism Indifference Resignation Self-doubt Other: Loss of empathy Difficulty concentrating Difficulty attending Low morale Decreased sense of self-worth	Dehumanisation of patients Victimisation of patients Fault finding Blaming other Defensiveness Impersonal, stereotyped communication with patients Applying derogatory labels to patients Physical distancing from patients and others Withdrawal Isolation Stereotyping patients Postponing patient contact Going by the book Clock watching Living for breaks Absenteeism Making little mistakes Unnecessary risk taking Use of drugs and alcohol Marital and family conflict Conflict with co-workers Decreased job efficiency Overcommitment or undercommitment

Figure 2.3 The signs and symptoms of burnout identified in Aronson (1988)

Two types of exhaustion are discussed under this heading. Emotional exhaustion involves primarily feelings of helplessness, hopelessness, and entrapment (Pines & Aronson, 1988). Under the heading of emotional exhaustion Muldary (1983) mentions apathy and helplessness, accompanied by

a free-floating anxiety which manifests as worry, apprehension and nervousness. A pervasive sense of discouragement and emptiness is also reported. People who burn out feel they need all of the little emotional energy they have left to keep going through the motions of daily life and that they have nothing left to give to anyone. Mental exhaustion associated with burnout has various dimensions (Muldary, 1983). At one level mental exhaustion is evidenced by difficulty in paying attention and concentrating. At another level it involves an impaired ability to solve problems and make decisions. At still another level mental exhaustion is characterised by the development of negative attitudes toward patients, colleagues, the work environment, and toward oneself.

Maslach and Jackson (1982) state that a hallmark of the burnout syndrome, across a wide range of helping professions, is a shift from a positive and humanised orientation in the perception of recipients to a negative and depersonalised or dehumanised one. Pines and Aronson (1988) define dehumanisation as a decreased awareness of the human attributes of others and a loss of humanity in interpersonal interactions. Clients, employees, patients, or students are viewed in more cynical and derogatory terms, and the practitioner begins to develop a lower opinion of their capabilities and their worth as human beings.

Interpersonal Consequences

The harmful effects of job-related activities on the individuals' relationships with family and friends and on their personal lives have gained increasing recognition as researchers have become aware of the link between work and nonwork domains (Cordes & Dougherty, 1993). In particular, the links between burnout and the deterioration of social and family relationships and the links between burnout and work-nonwork conflict have received empirical support (Jackson & Maslach, 1982). Interpersonal consequences also include changes in the nature of frequency of interactions with clients and co-workers (Jackson & Schuler, 1983).

Attitudinal Consequences

Attitudinal behavioural effects involve the development of negative attitudes towards clients, the job, the organisation or oneself (Kahill, 1988). Communication problems in the helping professions may manifest themselves through the avoidance of clients, a change in tone and manner of interaction, not responding to clients or not listening to them. There may also be the open expression of anger and hostility towards clients. On a more personal level a withdrawal from colleagues, social contacts and family may occur. Negative attitudes and dissatisfaction with the organisation may become so bad that even the spouses of the workers developed negative attitudes toward the organisation (Jackson & Maslach, 1982).

Behavioural Consequences

Behavioural consequences of burnout entail organisation-related behaviours as well as consumption behaviours (Cordes & Dougherty, 1993). In general the performance efficiency of the individual goes down. Pines and Aronson (1988) report that the correlation between the self-diagnoses and the burnout assessed by close colleagues was highly significant. In other words, if people are burning out, whether they know it or not, others around them are quite aware of it. Other organisation-related behaviours mentioned by Cordes and Dougherty (1993) include job turnover, absenteeism, and decreases in the quality and quantity of job performance. Consumptive behaviours such as smoking and the increased use of alcohol and drugs by the individual have also been reported. Muldary (1983) identifies some of the frequently cited behavioural effects of burnout. (See Table 2.1.)

As the scant, but growing, body of evidence illustrates, the consequences of burnout have some very real physical, emotional, interpersonal, attitudinal, and behavioural implications (Cordes & Dougherty, 1993). Not only does the individual suffer, but the worker's family and friends, the organisation, and the people with whom the worker interacts during the work day all pay the price for this problem.

Spending less time with patients	Reducing physical contact with patients
Taking excessive and unnecessary risks	Excessive use of humour about work
Expression of anger toward patients	Avoiding other staff persons
Excessive blaming of patients or staff	Frequent complaining about the job
Ignoring patient complaints	Tardiness at work
Absenteeism	Increased alcohol consumption
Increased smoking	Increased use of patent or prescription drugs
Medication errors	Increased difficulty in following orders
Poorly charted notes and observations	Sudden changes of expression and mood
Taking fewer breaks or more breaks from work	Nonverbal anger (e.g., slamming, tossing)
Clock watching	Describing patients in derogatory terms
Fault finding	Impersonal, stereotyped communication with patients
Performing duties strictly by the book	Inefficient patient care
Search for transfer or relocation	Reduction in overall performance efficiency
Decreased cooperativeness	

Table 2.1 Common behavioural manifestations of burnout, proposed by Muldary (1983)

Coping Strategies

Many front line people in the health care professions, those closest to the problem of burnout, suggest that the main focus of intervention must be on the individual worker since organisations are probably destined to continue functioning as they are. The assumption is that individuals must do what they can within the parameters and constraints of their employing organisations (Muldary, 1983). Whereas this might be true to an extent, it is also true that many presumed 'givens' of an organisation are changeable. Just as there are limits to what organisations can do to change, so too are there limits to what individuals can do to adapt. What individuals and organisations need to do is to determine what can and what cannot be changed within the system. Once the realities of the organisation are accepted, the individual needs to determine what he or she can do to cope with them.

One of the most crucial steps in managing burnout is for the individual to recognise its signs and symptoms. Unfortunately many persons experiencing burnout are not aware that there is a

problem, or at least they are not aware that their distress involves burnout (Muldary, 1983; Pines, 1993). Before any intervention can be effectively implemented, one must become aware of the problem. Once individuals become aware that a problem does exist, they must commit themselves to doing something about it. This section focuses on a consideration of various strategies for direct and indirect coping that individuals use with varying degrees of success.

Intrapersonal Coping Strategies

Coping is defined by Lazarus and Launier (1978) as "efforts, both action-oriented and intrapsychic, to manage (that is, to master, tolerate, reduce, minimise) environmental and internal demands and conflicts among them which tax or exceed a person's resource" (p. 311).

The four major strategies proposed for dealing with burnout on an individual level are:

- being aware of the problem
- taking responsibility for doing something about it
- achieving some degree of cognitive clarity
- developing new tools for coping and improving the range and quality of old tools (Pines & Aronson, 1981)

These are, of course, generalised recommendations. People vary in their individual coping styles, and coping styles differ in effectiveness. Coping refers to efforts to master conditions of harm, threat or challenge when an automatic response is not readily available. Coping in itself does not imply success, but effort. The study of burnout as a dependent variable is exactly the study of the effort of life. The chronic nature of the stresses and their mundane meaningless character make them so difficult to endure.

As a form of life crisis, burnout is an experience that presents the individual with two possibilities: an opportunity for personal growth and the risk of further disorganisation and distress.

Caplan (1964) suggested that coping strategies are effective to the extent that they meet certain criteria. He identified seven characteristics of effective coping behaviour that apply to different kinds of life crises:

- There is an active exploration of reality issues and a search for information.
- There is a free expression of positive and negative feelings and a tolerance of frustration.
- There is an active effort to engage the help of others.
- Problems are broken down into manageable bits and worked through one at a time.
- There is an awareness of fatigue and disorganisation, a pacing of oneself, and the maintenance of control in as many areas of functioning as possible.
- Feelings are mastered where possible, and where mastery is not possible, the inevitable is accepted.
- There is a fundamental trust in oneself and others and a sense of optimism that something can be done to bring about a positive outcome.

Lazarus (1974) suggested two general strategies for coping: (1) Direct action, in which the person tries to master the stressful transaction with the environment; and (2) palliation, in which the person attempts to reduce the disturbance when unable to manage the environment or when action is too costly for the individual. Direct coping, or direct action, is a strategy applied externally to the environmental source of stress, and indirect coping, or palliation, is a strategy applied internally to one's behaviours and emotions.

Pines and Aronson (1988, p. 144) state that in addition to the direct/indirect dimensions of coping, they found an inactive/active dimension. Active coping strategy involves confronting or attempting to change the source of stress or oneself, whereas inactive coping strategy involves avoidance or denial of the stress by cognitive or physical means. These two dimensions, direct/indirect and active/inactive, generate four types of coping strategies, each of them represented by certain behaviour. Those mentioned below are, of course, not the whole spectrum of behaviour, but an indication of the type of coping behaviour observed by Pines and Aronson (1988, p. 145):

- Direct-active: changing the source of stress, confronting the source of stress, finding positive aspects in the situation, etcetera.
- Direct-inactive: ignoring the source of stress, avoiding the source of stress, leaving the stressful situation, etcetera.
- Indirect-active: talking about the stress, changing oneself to adapt to the source of stress, getting involved in other activities, exercise, etcetera.
- Indirect-inactive: drinking or using drugs, getting ill, collapsing, etcetera.

From the above it becomes clear that the interaction of individuals with their unique situations is the ultimate measure of appropriate coping behaviour because each one deals with stressful situations in his or her own way. Support was found in the literature for a relationship between burnout and personality variances in nurses (Eastburg et al., 1994). The theoretical attempt to systemise and prescribe strategies for coping should be recognised as such, and is not a denial of the reality of the unique individual experience of life and stress.

Managing stress and burnout is contingent upon the individual's belief that something can be done to effect positive change and a commitment to implementing the changes that are within the individual's power. Having confidence in one's ability to get control of burnout may well be the most important factor in realising the outcome. The belief that something can be done is the belief that pushes one forward toward doing it. But often the very nature of the syndrome precludes this belief and magnifies the erosion of the self-confidence necessary to deal with burnout.

Interpersonal Coping Strategies

Social systems do not exist solely to make demands on the individual. Social systems can also be a source of some of the very important rewards that individuals need. One of the main rewards provided by people is social support. Social support is defined by Morano (1993, p. 396) as "networks of occupational relationships, which shall comprise one or more of the following: affect or emotional support (admiration, respect, liking), affirmation or appraisal (acknowledgment of the

appropriate behaviour of another), and aid (direct giving of materials, information or service)". Social support is not only found in occupational relationships. Muldary (1983, p. 169) states that most people have at least one support group, and often that group is the person's family.

According to Pines and Aronson (1988, pp. 160-165), social support systems serve a multitude of functions which can be organised into six basic categories: (1) Everyone has occasions when he or she needs one or more people who will actively listen to him or her, without giving advice or making judgments. (2) All individuals need technical appreciation for the work they do; when they do a good piece of work, they need to have it acknowledged. (3) It is comforting to be in an environment where you are the expert and no one challenges that expertise, but if individuals are not technically challenged they run the risk of stagnation and boredom. Technical challenge forces individuals to develop new ways of doing the job and that enhances growth. (4) Another important function of an effective support system is emotional support or appreciation, even if the supporters are not in total agreement with the person getting the support. The supporters care about the individual as a human being, win or lose. (5) Emotional challenge is different from technical challenge. Friends do not have to be experts in your field, they merely have to say, "Are you sure you are doing enough?" Needless to say, trust is a prerequisite for this function. (6) The sixth function is that of social reality testing and sharing, or a social reality touchstone. Social reality is vague, a friend can help the individual interpret this reality and decide on reasonable action.

When individuals encounter people in their environment who fulfil all these functions they are well protected against burnout and go a long way toward reducing stress in life and work. It is important to distinguish one function from another. Social support is not a global thing, but rather a number of separate functions. The fact that one human being recognises the other person's identity, values that person, and sometimes actually helps him or her constitutes social support (Winnubst, 1993).

Eastburg et al. (1994) found that in the relationship between work-related social support and burnout in nurses, higher levels of supervisor support and peer cohesion were strongly associated

with lower levels of all dimensions of burnout. Furthermore, as supervisor support and peer cohesion levels increased over a period of one month, burnout levels decreased significantly. This clearly supports the theoretical discussion by Pines and Aronson (1988) mentioned above and also supports the notion that social support can be considered an interpersonal coping strategy.

One rather interesting coping strategy that warrants special mention is detached concern. Detached concern, a term coined by Lief and Fox (1963) is the healthy balance between overidentification and underinvolvement. The health professional must maintain empathy, concern and caring while balancing them with professional objectivity. The role of humanist must balance the role of scientist. Health professionals accomplish this balancing through intentional and regulated physical, emotional or mental distancing from the health care environment.

It is interesting that one way for practitioners to achieve detached concern is to use the defense mechanism of intellectualisation. It is clear that a certain measure of this defense is essential for effective and competent health care delivery (Muldary, 1983), for it can serve as a buffer against the threat of extreme anxiety caused by repeated contact with people who are suffering. It becomes a problem when used excessively or to the point of moving the provider to the opposite extreme, underinvolvement with health care recipients.

Organisational Coping Strategies

According to Schaufeli et al. (1993) the organisational environment is essential in understanding and coping with burnout because burnout is defined as a negative, work-related psychological phenomenon. There are several avenues open for organisations committed to the improvement of the quality of the work experience for workers.

KUK *Coping Health and ORGANIZATIONS*
Cox, Kuk and Leiter (1993) say that it is generally assumed that the quality of the organisation, of the work environment, and of work itself can affect the experience of stress and employee health and work performance. That is, the healthiness of the organisation may affect the

(1993)

health and performance of its employees. It is the study of this interaction between the healthiness of the organisation and health within the organisation that Cox termed "organisational health" (Cox, 1988). The fact of this interaction offers a chance of promoting occupational health through organisational development, which is discussed in the next paragraph.

The most common of these are interventions done by industrial psychologists in organisational development programmes. "The approach of organisational development aims at changing properties of the organisational environment or climate that are believed to be major influences on the workers' overall satisfaction and performance" (Muldary, 1983, p. 183). According to Pines and Aronson (1988), preventing burnout in organisations can include any of the following interventions: reducing staff-client ratios, making "time out" available, limiting hours of stressful work, increasing organisational flexibility, staff training, and the general improvement of work conditions. Organisational development programmes differ greatly in scope and depth of intervention and are a specialty area in psychology. Other programmes mentioned in the literature are interpersonal conflict resolution programmes, job enrichment programmes, positive reinforcement programmes and burnout workshops (Gibson, Ivancevich & Donnelly, 1991; Muldary, 1983; Pines & Aronson, 1988).

Manifestations of the Burnout Concept in the Nursing Literature

A number of references to burnout and the burnout concept relevant to this research are to be found in nursing literature. As mentioned previously, the precise manner in which burnout is experienced and manifested is clearly an individual matter and depends on each person's relationship with the environment. It is also true that within the public service professions there are some people who burn out faster than others. In a broadly based study by The National Commission for the Study of Nursing and Nursing Education it was reported that 70 percent of staff nurses in American hospitals resigned from their jobs during a typical year (Lysaught 1970). Kempe (1978) says that the turnover of staff in child protection services in some departments reaches over 50% to 100%. It is surmised that in many human services professions where turnover is extraordinarily high, burnout may

be involved (Breed, 1988; Maslach & Jackson, 1982; Mitchell & Bray, 1990; Muldary, 1983; Pines & Aronson, 1988), and when it is, burnout may claim human service professionals within one to ten years after they begin their jobs.

Stress activators have been studied as determinants of turnover among staff nurses and the findings revealed a direct effect of job satisfaction on intent to leave the job (Hinshaw, Smeltzer & Atwood, 1987). The relationship of stress to illness and injury has been studied in occupations other than nursing, but the few studies in nursing have consistently reported positive correlation (Antoni, 1985; Belcastro & Hayes, 1983; Weiman, 1977). Pettegrew et al. (1980) reported positive relationships between psychosomatic illness symptoms and stress in nurses. Bedian, Armenakis and Curran (1981) examined the relationship between job-related interpersonal and organisational climate factors and experienced role stress. Role ambiguity and role conflict as stressors were found to be significantly related to a number of job-related factors. Using a sample of 180 critical care nurses, Norbeck (1985) researched perceived job stress, job satisfaction and psychological symptoms and found that higher levels of perceived job stress are related to lower levels of job satisfaction and higher levels of psychological symptoms. McGrath, Reid, and Boore (1989) studied the effects of personal as well as occupational stress on nurses. The greatest source of stress in their personal lives was adult relatives within the immediate family (17%) and financial difficulties (13%). The greatest source of occupational stress was lack of time to perform duties to the person's satisfaction (67%). Hayes (1988) studied factors causing stress among operating room nurses and also determined the extent of the stress experienced. Findings revealed higher stress levels among younger nurses with education qualifications level of a bachelor's degree and five or fewer years' experience than among older, better experienced and better educated nurses. Ceslowitz (1989) examined burnout and coping strategies used by hospital staff nurses. The research question was whether a significant relationship existed between the use of coping strategies and the presence of emotional exhaustion, depersonalisation, and reduced personal accomplishment. Increased burnout was associated with the use of the coping strategies of escape/avoidance, self-controlling and confront behaviour. Decreased burnout was associated with the use of the coping strategies of well-planned problem-solving, positive reappraisal, the seeking of social support and self-controlling behaviour. Self-controlling was

present in both variate sets, but was used to a lesser extent by nurses with decreased burnout. This is an interesting finding in the sense that self-controlling behaviour can be somewhat negative when it leans towards suppression, and more positive when it leans towards personal control or taking control. This is consistent with the point made previously that managing burnout is contingent upon the individual's belief that something can be done to effect positive change. A person may thus be self-controlling as a "believer", which will have a positive outcome, or as a "non-believer", which will have a negative outcome.

In scientific literature and course material relevant to human service fields, little attention is given to the emotional stresses experienced by the professionals. Instead the focus is almost exclusively on the recipients of services and their problems. In the course of their training, therefore students learn the implicit lesson that it is illegitimate for them to have needs while in the professional role. In her book, *Reality Shock*, Marlene Kramer (1974), a nursing professor, writes about the devastating impact work has on unprepared novice nurses. The reality shock often results in an induction crisis, and turnover is particularly high in the first few months spent working. In similar vein Morano (1993, p. 400) says that "exploring ways to support newly-employed and newly-graduated staff nurses in the occupational setting may be beneficial. Because staff turnover and poor work performance may be among the negative outcomes of occupational stress".

In another interesting study in the stress literature regarding nurses, Handy (1990) challenges the assumption that we do not need a detailed analysis of social structures in order to understand individual experience. She demonstrates that the problems of burnout and other occupational stress in psychiatric nursing cannot be fully understood through "either a theoretical stance which isolates individual experience from the structural context in which it takes place, or a theoretical approach which regards people as mere puppets of inexorable structural forces which operate without their involvement" (p. 197). The approach of this research fully supports this notion; although the focus tends to be more on the individual, the structural context within which the individual functions, is acknowledged.

In her doctoral dissertation entitled "*Psychological stress reaction, coping strategies and health promotion lifestyles among hospital nurses*", Vines (1991) recommends that more research is needed to define coping and coping methods that are effective in controlling psychological stress reactions. She also recommends that further examination of mediating variables such as self-esteem, motivation and personality is needed. And it is just such personality variables that salutogenesis addresses.

From the above it is becoming clear that occupational stress and burnout are well represented in literature on the nursing profession. The question that needs to be answered in chapter three and also in the research is whether salutogenesis can provide an answer to the burnout phenomenon.

Limitations of the Burnout Concept

As in all conceptualisations it should be clear that there are certain restrictions that apply. Cherniss (1993) mentions how extensive and varied the research literature on burnout has become in the last fifteen years. Within this diversity certain limitations within the conceptual framework become apparent. These will be discussed in this section, in addition to the restrictions that apply to this study.

Limitations in the Conceptual Framework

There is a perception among some health care providers that burnout is a vague and non-distinctive concept loaded with diverse meanings; that over-usage and over-extension tend to make the term meaningless, that it is a trendy catchword that is used indiscriminately as a "diagnosis" for almost any problem of living that is experienced. This view is not without merit because burnout is a popular term. As far as this research is concerned, there are five critical shortfalls that hinder a clear conceptualisation of burnout:

- Although the main body of work on burnout has involved people in the helping professions,

there has been a tendency to look for burnout everywhere, at all levels of life and in all occupations (Golembiewski, Munzenrider & Stevenson, 1986). This move away from burnout to job burnout is not an insignificant one (Maslach, 1993). It may have "shifted the focus away from the interpersonal, relational roots of burnout to the view that burnout is just another job-phenomenon" (p. 31).

- This job-framework has led some researchers to extend the concept of burnout to many other occupations in which there is not an equivalent to a caregiving relationship or an ongoing interaction between people. Here one might question whether burnout is actually the same phenomenon when it is transferred to these other occupations. Maslach (1993) asks: "Does it really make sense in those instances to continue to use the concept of burnout, or would it be better to conceive of those particular job-issues in terms of some other, more appropriate construct?"(p. 31).
- To the first two critical shortcomings one could add the following. With burnout meaning "almost anything and everything to various observers", research and experience are not likely to generate theoretical formulations of increasing power (Cherniss, 1980a, p. 16). For both Maslach (1993) and Cherniss (1995) the burnout concept belongs in a social context. Questions that need to be addressed in relational terms include questions about social power (and its imbalance in most helping relationships), interpersonal communication, attributions and self-presentations (Maslach, 1993).
- What is required is a shift needed from focussing on the antecedents of burnout to focussing on the moderator variables in the burnout concept. "What is most emotionally painful for one staff person may not pose any special problems for the next"(Maslach, 1978, p. 115). The available literature is clear only about the precursors of burnout. The fixation on the view that any stimulus can be a stressor for someone at some time has its inadequacies, and is deemed to be a shortfall in this research, basically because there is no limit to the possible precursors or features that may cause distress and burnout. According to Golembiewski and

Munzenrider (1988) the focus should be on an individual's balance of eustress over distress. The moderating role of personality characteristics should be investigated more thoroughly because past research did not investigate such moderator effects on burnout at all (Buunk & Schaufeli, 1993).

- In the last instance, the state conceptions of burnout are over-inclusive. According to Burisch (1993), too many symptoms are associated with burnout, so that burnout can only be discriminated from other mental states such as stress, depression and anxiety disorders with great difficulty. The focus should be on burnout as a process, rather than as a state (Burisch, 1993; Hallsten, 1993; Leiter, 1993).

Limitations for this Research

The single most problematic aspect of the burnout construct for this research is the focus on the individual and the possible exclusion of the impact of the organisation on the individual. To focus exclusively on the individual might mean that we neglect the relationship between higher order organisational and societal issues on the one hand and the subjective experiences of the individual nurse on the other hand.

A second restriction is the old debate on burnout literature and stress literature. Is burnout not simply an inferior and sensationalised version of the stress literature which is rediscovering the same concepts and perpetuating weakly designed empirical research?

The third restriction is the fact that burnout is generally seen from the pathogenic point of view. Although the term burnout is commonly used in the care-giving professions this construct and its conceptualisation have mainly been studied from a pathogenic paradigm. It might prove a difficult task to re-conceptualise this construct into the salutogenic paradigm.

Applicability of the Burnout Concept

Despite the restrictions in the conceptualisation of this concept. Muldary (1983) says that those closest to the problem are not willing to dismiss the concept simply because it has become popular. There are legitimate definition problems but they do not preclude the use of the term since burnout is a causal term rather than a technical one. This prevalent and potentially devastating phenomenon remains a noteworthy and emerging field of study (Entin, 1989). The broad range of the concept of burnout clearly causes difficulty from a heuristic standpoint. This range incorporates those on the left, who consider burnout a popular fiction; those on the right, who consider it a concrete reality; and those in the middle, who consider it a syndrome of varied etiology, symptomatology, management and outcome (Muldary, 1983). In an overview of the burnout literature Freudenberger (1989) says that researchers need to be careful that they do not classify so many concepts under burnout that the term becomes meaningless. They also need to prevent premature closure in their thinking which might serve as a defense against felt anxieties or felt lack of knowledge. They further need to be careful not to exclude those thoughts that do not agree with their preconceived notions or seek to incorporate more than is possible.

Burnout is a process. Stress and burnout are often dealt with through unhealthy behaviours - smoking, overeating, lack of exercise, and abuse of drugs and alcohol. Preventing burnout implies altering work habits and lifestyles so that healing and personal affirmation take place (McCarthy, 1989, p. 71). If passion is the experience of feeling alive and engaged at the moment and that sense of life is characterised by commitment to a vision, then burnout is the absence of passion, commitment, and vision. In caring for others, passion would be the joy of discovering. Confronting uncertainty within the context of passion yields a sense of spontaneity. Confronting uncertainty within the context of ideals can cause burnout (Selder & Paustian, 1989, pp.76, 82). Yarborough (1989, pp. 109, 113) says that "too few of us in the human service field take enough time to pause to think about how we are living and whether our lives are really good. You can't take care of someone else unless you also take very good care of yourself". How each individual deals with stressful situations in his or her own way is up to the individual. The understanding of burnout

relevant to individual differences remains a pertinent area of study.

The frame of reference presented in this chapter was developed to present a more sophisticated conceptual analysis of the inter-relationships between the individual, interpersonal and work-related aspects of the concept from the literature. It is felt that a critical and comprehensive perspective on the phenomenon of burnout has been presented. Burnout is a highly useful concept that describes a specific stress-related outcome.

The only question that remains to be answered is whether this useful concept answers the research questions asked in chapter one? The causes of burnout, the symptoms experienced by the individual and how nurses generally cope with burnout were all discussed. One of the questions that remains to be answered is what the consequences of the symptoms are for the individual. Other than in a generic form no specifics were given. Hopefully this question will be answered in the chapter on results and in the discussion and conclusion in chapter six. The further question of how the individual experiences burnout was also answered only in generic form. How individual nurses cope with burnout is a question that will have to be answered in the results chapter.

Chapter Summary

Burnout is not a simple, unidimensional problem with easily grasped causes and solutions, but rather a complex issue with roots in intrapsychic, interpersonal, historical, social, occupational and organisational phenomena with complex conceptual formulations. The burnout construct was conceptualised by looking at the definition problems surrounding the construct. The working definition of burnout for the purposes of this research was formulated as follows: Burnout is seen as a work-related problem that emerges in human and public service provision and can be defined as an array of symptoms that include psychological (emotional and mental exhaustion), negative attitudinal (behavioural and work-related) and physical components caused mostly by work-related factors and/or stresses, but burnout is also influenced by individual and societal factors differentiating between stress, related-stress features and burnout. The characteristics of burnout were presented

and some conceptual issues were discussed. It was propagated that:

- Burnout should be considered to be a phenomenon that is best explained within the confines of the human services professions.
- Burnout is a unique type of stress-phenomenon that can be viewed as a disorder of arousal.
- Burnout, as opposed to depression and job-dissatisfaction, is always the end-result of a gradual process of disillusionment in the quest to derive a sense of existential significance from work.
- It was further propositioned that burnout does have diagnostic criteria and can be assessed from a clinical psychological perspective.

Some of the models of burnout were discussed without committing to a single one as being more important than the others. It was argued, however, that contrary to the literature, it is hoped that this study will support the notion that there is no fixed sequence in the development of burnout in the individual. The stress-related syndromes that should be differentiated from burnout were also discussed in some detail.

The antecedents of burnout were discussed as a uniquely personal perception. The intrapsychic, interpersonal and organisational factors, each with separate sub-headings, were also discussed under this caption. A myriad of factors can be considered antecedents of burnout. Each one contributes to making burnout a fuzzy concept (Burisch, 1993) or a concept in which membership is a matter of opinion.

The consequences of burnout were highlighted in terms of their association with negative organisational outcomes and various types of personal dysfunction. Five types of consequences of burnout were discussed, namely physical, emotional, interpersonal, attitudinal and behavioural consequences.

Just like the antecedents of burnout, coping strategies were discussed within an intrapsychic,

CHAPTER 3

SALUTOGENESIS

The aim of this chapter is to present and integrate the existing literature on salutogenesis with a specific focus on the role of salutogenesis and salutogenic constructs in burnout in the nursing profession.

The Concept of Salutogenesis

Salutogenesis as a concept developed from a number of independent constructs (as discussed in chapter one) that can be traced through the literature. Allport (1955) has, for example, studied the concept "proprie striving"; Antonovsky (1979, 1987) has studied the concept "sense of coherence"; Bandura (1982; 1989) and O'Leary (1985), among others, have studied "self-efficacy"; Bauman and Udry (1972) "powerlessness"; Ben-Sira (1985) "potency"; Boyce, Shaefer and Uitti (1985) "sense of permanence"; Cohen (1980) "predictability"; Colerick (1985) "stamina"; de Charms (1968) "personal causation"; Frankl (1959) "freedom of will, will to meaning, and meaning of life"; Fromm (1947) "productive orientation"; James (1911) "strenuousness"; Kobasa (1982) "hardiness"; Kohn and Schooler (1983) "self-directedness"; Libassi and Maluccio (1986) and White (1959) earlier, "competence"; Moos (1984) "domains of social climate"; Pearlin and his colleagues (1981) "mastery"; Rosenbaum (1988) "learned resourcefulness"; Rotter (1975) and Wallston and Wallston (1982) have studied "locus of control"; Seligman (1975) "learned helplessness"; and later, "learned optimism", Seligman (1990); Senge (1990) "personal mastery"; Thomas (1981) "stamina"; and Werner and Smith, (1982) "invincibility".

The term salutogenesis was coined by Antonovsky (1979) who argued that at any time, at least one third or more of the population of any industrial society is characterised by some morbid pathological condition. For Antonovsky (1979, p. 77) this pathological condition is the "unbelievable hell on earth of so large a part of the world's population". He states further that illness is not a rare deviance but is the normal state of the human condition. "Given the

ubiquity of pathogens - microbiological, chemical, physical, psychological, social, and cultural - it seems to me self-evident that everyone should succumb to this bombardment and constantly be dying (1979, p. 13). Since this is clearly not the case the salutogenic concept "poses a radically different question, which is: why are people located toward the positive end of the health ease/dis-ease continuum, or why do they move toward this end whatever their location at any given time?" (Antonovsky, 1987, p. xii). Stated differently, the salutogenic concept focuses on the unraveling of the mystery of health and is an attempt to address how people manage stress and stay well.

From Concept to Paradigm

The reason for the conceptualisation of salutogenesis was to counterbalance **the pathogenic orientation**. It is difficult to discuss the concept salutogenesis without mentioning pathogenesis as salutogenesis was conceptualised to counterbalance the concept pathogenesis. "Conventional models of medicine concentrate on individual pathology and generally operate through individually focused methods of prevention and treatment" (Handy, 1990, p. 17). In the same manner psychology (Strümpher 1990), has been functioning mainly in a paradigm of pathogenic thinking. "The pathogenic orientation is directed, generally, at finding out why people fall ill and, in the specific, at why they develop particular disease entities. Such understanding is then used to find ways of combating and preventing each of the diseases in turn" (p. 266).

At the heart of the pathogenic paradigm are one assumption and a concept. In the first place there is the assumption that diseases are caused by physical, biochemical, micro-biological and psychosocial agents, and here the emphasis is on multifactorial determination, usually in terms of risk factors. In the second place, there is Cannon's concept of homeostasis, which implies that the normal state of the human organism is a relatively constant condition. Homeostasis may, however, be disrupted by pathogens and stressors and if the regulatory mechanisms do not function adequately, disease sets in (Strümpher, 1990). The pathogenic concept, of which the salutogenic concept is the opposite, is therefore in general a positivist theoretical paradigm that provides few insights into the experiential world of those it studies (Handy, 1990).

According to Strümpher (1995) the main thrust of salutogenesis and Antonovsky's writings concern sources of health. The salutogenic paradigm, and one can speak of the total concept/thought/idea of salutogenesis, as a paradigm (Breed, 1998), thus moves away from the positivist theoretical paradigm, that permeates the rest of psychology, in three areas: Firstly, unlike the mechanistic model of human behaviour where human beings are dealt with as unconscious and reactive objects operating within a mechanistic and unchanging environment, human beings are regarded as proactive, self-aware subjects, intentionally intervening within a socially constructed world. Secondly, salutogenesis assumes that society is mutable and that human subjectivity and action may alter concomitantly, in contrast to the universal laws of the natural sciences. Thirdly, importance is placed on the social context within which an individual functions. This means that human behaviour is predominantly governed by the social rules which people generate to understand their world instead of being an oversimplification of a limited range of proximal variables which are easier to measure and control (Handy, 1990).

The pathogenic and salutogenic paradigms have different assumptions and in many respects complement each other. But the "salutogenic paradigm is vitally important to new insights and new growth in the social sciences; it holds promise for integration of knowledge at a new, higher level" (Strümpher, 1990, p. 268). As an encore to the above the pathogenic and salutogenic perspectives are best illustrated by Table 3.1.

The focus of this chapter is on the right side of this figure, whereas the focus of traditional psychology is on the left side of the figure. The balance ought to be a movement from left to right, with both orientations being considered, or as Strümpher (1990) states: "the two ought to enrich and stimulate growth in each other" (p. 268). This research is an attempt towards such a movement from left to right, with a strong focus on the why and the how of individual experience of health. A further focus of this research is on optimal functioning by each individual and also on the individual's actual experience of coping.

PATHOGENESIS	SALUTOGENESIS
Why do people fall ill?	Whence the strength?
Abnormal functioning	Optimal functioning
Focus on illness and pathology	Focus on coping
Multifactorial determinism/resistance deficits	Generalised resistance resources

Table 3.1 The pathogenic/salutogenic ways of thinking

Towards a Definition of Salutogenesis

Antonovsky (1987) (quoting Galdston 1954, p. 13 and himself, Antonovsky, 1985, p. 275) uses a metaphor to convey the flavour of the salutogenic image of life: "... a man walking a tightrope from one end to the other, balancing himself even while he changes clothes and takes on and discards a variety of other objects" (p. 89). "We begin to lose our balance and recover it; or slip, catch the rope, and return to a standing position; or fall into a net and again regain the rope; or fall, hurt ourselves acutely or are damaged chronically; or we are destroyed. Some complete the course, with ups and downs, but successfully - and what a glorious, exhilarating experience it has been, whatever the sadness that it has ended" (p. 89).

According to Onega (1991) Antonovsky says that salutogenesis is defined as the study of why and how people stay well. Staying well has to do with how individuals manage tension. Tension is defined as an individual's response to stressors. If tension is managed appropriately, salutogenesis is enhanced. Antonovsky (1995) states that the salutogenic paradigm enjoins people to confront the question of the origins of health, the movements toward the health end of what he calls the health ease/dis-ease continuum. "Salutogenesis focuses on strengths, on the mystery of the movement toward health" (p. 6). For Strümpher (1995) the term fortigenesis (from Latin: fortis = strong and Greek: genesis = origins) seems to be more descriptive of the field of study than the term salutogenesis. Strümpher (1995) is of the opinion that introducing this construct is not a denial of the need to search for the origins of health; he argues that salutogenesis would be better served if called fortigenesis because the focus is more on the enhancement of strength in the individual in general than in the why's and how's of staying well.

Taking all of the above into consideration, the following definition of salutogenesis is adopted for this research: **Salutogenesis refers to the study of the strength individuals exhibit in order to manage the tension and stress in their lives and not succumb to illness.** The argument following from this is that salutogenesis remains a field of study, and cannot be defined as a single concept.

Stress and the Stress Response - Pathogenesis or Salutogenesis?

From the definition of salutogenesis which was adopted, it becomes clear that the term "stress" forms an integral part of the salutogenic concept. In both lay and professional terminology (Muldary, 1983) there has been a tendency to use the word stress in two different ways. As a stimulus, stress is seen as something to which people are exposed from outside of their bodies. Stress is considered to be external to the individual. This makes stress a problematic environmental condition or force that compels the individual to adapt. As opposed to this view, when stress is viewed as a response, it is presumed to be within the individual. As a response stress refers to an internal reaction to demanding environmental conditions. Everly (1989) calls this a personologic predisposition to stress. According to Muldary (1983) there is not only disagreement over the issue of stress as a stimulus or response, there are also different levels of analysis from which the concept has been approached. For instance, at the psychological level, stress is seen in terms of disruptions of thinking, emotions, and behaviour. At the physiological level, stress is viewed in terms of disruptions of bodily functions. At the social level, stress is hypothesised in terms of disturbances in a larger system.

The word stress means different things to different people. That is what makes the definition of stress so troublesome. Muldary (1983) states that Lazarus proposed in 1966 that the term stress be used as a generic term for a whole area of problems that includes the stimuli that produce stress reactions, the reactions themselves, and various intervening processes. This approach created a broad field in which stress could be studied, including physiological, psychological and sociological phenomena. Lazarus defined this broad area of stress in terms of "any event in which environmental demands, internal demands, (or both) tax or exceed the adaptive resources of an individual, social system, or tissue system" (Monat & Lazarus, 1977).

Rather than discuss the myriad of alternative definitions available for the elucidation of the stress concept, the Selyean notion (Selye, 1936, 1950, 1956, 1974, 1976) of the nature of stress is accepted for this research. Hans Selye, borrowing the term from the physical sciences, defined stress as the nonspecific response of the body to any demand made upon it. The stress-producing factors may vary, but they all elicit essentially the same biological stress response (Selye, 1974). It is immaterial whether the agent or situation that is faced is pleasant or unpleasant, all that counts is the intensity of the demand for readjustment or adaptation. It is difficult to see how such essentially different things as cold, heat, drugs, hormones, sorrow, and joy could provoke an identical biochemical reaction in the body. But that is the case. Selye (1974) states that certain reactions are totally nonspecific, and common to all types of exposure.

If stress is the response of the body to a demand, a stressor is the term used to describe this demand or stimulus. The distinction between stressor and stress was perhaps the first significant step in the scientific analysis of that most common biological phenomenon that is known to most individuals from personal experience.

The general adaptation syndrome or stress response is based on Selye's hypothesis that the body's response to stressors typically occurs in three major phases. This is consistent with and an elaboration of Cannon's (1932) fundamental premise that the body possesses a built-in reaction to a wide variety of demanding situations, namely the fight or flight response. Selye (1976) states that the first phase is alarm; it represents an emergency reaction involving the activation of the body's defensive forces. During this reaction a perceived stressor elicits an immediate "call to arms" within the body. The second phase is resistance, in which physiological adaptation is at a maximum level of operation in terms of the bodily resources used. The third and final phase is exhaustion, in which bodily resources are depleted and the individual loses the ability to resist continued exposure to the stressors. It is hypothesised that this is the stage at which coping patterns fail.

Stress, therefore, describes the nonspecific responses of the body to any demand made on it and is a normal and natural response that is designed to protect, maintain and enhance the organism. However, as stress continues to increase beyond tolerable limits, dysfunctional

consequences appear. Stressors represent environmental events which either cause or set the stage for the stress response. It is, however, important to note that the cognitive-affective interpretation is crucial to most stress reactions and that one's interpretation of events as stressful causes emotional upheaval which results in a physiological stress response. The physical stress response results from overstimulation of three axes (see chapter 1). Sustained activation of these axes may eventually result in target organ symptoms of ill-health should individual coping mechanisms fail.

What should be stated with great clarity and what is of great relevance for salutogenesis, is the notion that not all stress is unwanted or undesirable. In fact some stress is actually essential for a full and productive life. It helps the individual to be energetic, constructive, effective and to lead a productive, progressive and happy life. Positive stress is referred to as "eustress", while stress that leads to dysfunction or disease is referred to as "distress" (Selye, 1974). Unfortunately the focus tends to be only on the negative aspects of stress, that hurtful condition which is also known as distress, the damaging force - pathogenesis - that has a negative impact on health, personality, work, and family. The salutogenic perspective accepts stress as omnipresent in human existence, but where the individual finds himself on the health ease/dis-ease continuum will determine how the individual deals with stress.

Characteristics of Salutogenesis

General to the salutogenic field of study is the assumption that people manage stress and stay well (Antonovsky, 1987). Specific to the salutogenic field of study is the assumption that there are individual differences in response to stress. Being male or female, black or white, upper or lower class, Canadian or South African, Cuban or Costa Rican - with all that these social categories imply - is decisive in determining the particular patterns of life experiences that beget the place on the ease/disease continuum (Antonovsky, 1987).

The salutogenic field of study assumes "heterostasis, disorder, and pressure toward increasing entropy as the prototypical characteristic of the living organism" (Antonovsky, 1987, p.2). "Stressors are omnipresent in human existence" and "the human condition is stressful"

(Antonovsky, 1979, p. 9). Whether the source of the stressors is the internal or external environment, whether they are daily hassles, acute or chronic and endemic, whether they are imposed or freely chosen, people's lives are replete with stimuli to which they have no automatic, adequate response but in the face of which they must respond. Stress is not equated with unusual and extreme circumstances; many of the difficult problems with which people cope are not unusual problems impinging on exceptional people in rare situations, but are persistent hardships experienced by those engaged in mainstream activities within major institutions (Pearlin & Schooler, 1978).

Given the omnipresence of stressors it seems self-evident that everyone should succumb to the stresses in their lives. Since this is not the case, the question then follows, "how anyone ever stays alive" (Antonovsky, 1987, p. 14); or even more importantly: "Whence the strength?" (p. 7). The salutogenic question in essence, therefore, concerns itself with how and why individuals stay healthy, but also with where they get their strength from. Kobasa (1982, p. 4) states that "persons create as well as react to the stressful life events in their lives and thrive on as well as tolerate stressful situations". This thriving on or toleration of stressful situations can be linked to coping and as Antonovsky (1987, p. 13) states, the most important consequence of the salutogenic orientation is that it not only opens the way for, but compels us to devote our energies to, the formulation and advancement of a theory of coping.

Coping includes mediators and moderators of stress and can also be seen as being part of individual personality repertoires (Rosenbaum, 1988). Manning, Williams and Wolfe (1988, p. 205) states that potential moderators of stress "are commonly grouped into four categories: (1) social resources, (2) constitutional predispositions, (3) personality traits, and (4) others, such as economic status". It should be obvious that a combination of these factors may work in harmony to manage or exacerbate an individual's tensions when confronted with stressors. As far as this research is concerned the focus is on answering the salutogenic question from the perspective of seeing the individual as functioning from an intrapsychic perspective, or constitutional predisposition, within a social and interpersonal framework and in an occupational setting.

If the salutogenic question is: whence the strength?, the answer as far as this research is

concerned comes from the sense of coherence concept (Antonovsky, 1987), the hardiness concept (Kobasa, 1982) and the learned resourcefulness personality repertoire (Rosenbaum, 1988). These concepts will later be discussed from the perspective of how the individual stays healthy intrapsychically, interpersonally and occupationally.

General Resistance Resources (GRRs) within Salutogenesis

Many persons do not become ill despite quite stressful lives on all levels of functioning (Kobasa, 1979). Confronting a stressor results in a state of tension with which one must deal. Whether the outcome will be pathological, neutral or salutary depends on the adequacy of tension management. Cobb (1976) reviewed an extensive body of literature documenting that supportive interactions among people effectively immunise them against the detrimental health consequences of life-stress. The study of the factors that determine tension management brings us to the concept of generalised resistance deficits - resistance resources (GRD - RRs).

There can be no overall conclusion that stressful life events on a personal level on a social level or at work will lead to debilitating effects. Rabkin and Struening (1976) state that the correlation between stressful events and illness is typically 0.30 and the standard deviation of both distributions is often eight times the mean. This consistent but merely modest relationship between stressful life-events and illness symptoms has prompted investigators (Antonovsky, 1979; 1987; Kobasa, 1982; Kobasa, Maddi & Kahn, 1982; Lefcourt, 1980; Pines, 1983) to conceive of how mediating variables might buffer the debilitating effect of stress on the organism.

Antonovsky (1972) first introduced the concept of generalised resistance resources (GRRs) that can neutralise the otherwise debilitating effects of stressful life events. A range of GRRs would include (Antonovsky, 1979, p. 119):

- physical and biochemical GRRs, like immunosuppressors and immunopotentiators
- artefactual-material GRRs, particularly wealth, that can buy food and clothing, but also bring power, status and a wide array of services
- cognitive GRRs, particularly knowledge-intelligence, contingent on education, which

include skills, but also knowledge, for example, one's legal rights, or about avoiding STDs or carcinogens

- the emotional GRR of ego identity
- coping strategies, as overall plans of action for overcoming stressors
- interpersonal-relational GRRs, like social support and commitment
- and, lastly, the macrosociocultural GRRs of "ready answers provided by one's culture and its social structure", which include religion

According to Kobasa, Maddi and Kahn (1982) a plausible list of resistance resources includes constitutional strengths (e.g., little history of family illness), social supports (e.g., social contacts and status centrality), health practices (e.g., jogging), coping strategies and personality characteristics. In Antonovsky's (1979, p. 121) view, all GRRs have in common that they facilitate "making sense out of countless stressors with which we are constantly bombarded". But then Antonovsky added a further idea to the concept. If a GRR by definition creates life experiences characterised by consistency, participation in shaping outcome, and an underload-overload balance, this can also be applied to stressors, but towards the other end of the continuum. He proposed that we speak of "major psychological generalised resistance resources - resistance deficits" (GRR - RDs) as one unified concept (Antonovsky, 1987, p. 28). In each case - wealth, ego strength, cultural stability and so on - a person can be ranked on a continuum. Put differently this means that an individual can have GRRs (resources) or GRDs (stressors) that are built into the life situation of the person and are generalised and long-lasting. For the purpose of this research and to be consistent in the presentation of information (see also Figure 3.1) this researcher speaks of the unified concept as generalised resistance deficits - resistance resources, a general movement from left (negative) to right (positive). The GRDs - GRRs will determine how an individual deals with or copes in a given situation. Suffice it to say that stressors and resources, are conceptually and operationally distinguished, as appropriate to an approach that is generally called the buffering hypothesis. Commonly, both the stressors and the resources have direct (negative and positive, respectively) effects on personal functioning (Antonovsky, 1987, p. 31).

The question that follows from the above is how these resistance resources might operate

to keep the person healthy during the encounter with stress. Alternatively, what are the underlying processes utilised in the solicitation of GRRs? The same question is asked by Wheaton (1985, p. 352): "How do coping resources act to buffer the impact of social stressors?"

Wheaton (1985) argues that the stress-buffering issue is formulated as one involving an interaction between some potential source of stress and some factor in coping, so as to define the circumstances under which stress does and does not have an impact. The prediction is that the effect of stress on illness responses should be significantly different in high as opposed to low coping resource groups, or that this stress effect should decrease as access to important coping resources increases. The issue here is how to interpret changes in the estimated effect of stress before and after coping is controlled. Wheaton (1985) argues that stress buffering used to be demonstrated when the estimated effect of stress decreases when coping is controlled, but that this prediction was only concerned with the net direct effect of stress and not with the total causal effect. The total causal effect is the sum of direct and indirect effects of stress through intervening coping resource variables. He argues that "stress-buffering is suggested when an indirect effect (through a coping resource) operates in a direction opposite to the overall (total) causal effect" (p. 353).

Wheaton (1985, pp. 361-362) further suggests three criteria that collectively express the notion of stress-buffering:

- Stress-buffering implies mostly straightforwardly the mitigation of the impact of exposure to stress.
- The effect of the resource should either be activated by, or specific to, the presence of stress.
- The stress-buffering effect should occur prior to the impact of stress on the health outcome, and either simultaneously with, or consequent to, increases in stress.

Other explanations of how these resistance resources might operate to keep the person healthy during the encounter with stress are discussed briefly in the following four sections. These discussions are brief to limit overlap with the coping strategies already discussed in chapter two.

Health Practices

Oettgen (1977) discusses the immunological approach of how physical and biological agents might function as stress-resistance resources. Immunopotentiating and immunosuppressing mechanisms constitute inherent strength and weakness, respectively, that underlie individual differences in the body's response to various noxious agents. The physiological or biological approach to stress resistance includes health practices that might be successful in protecting and strengthening organs and bodily systems. The best known and most utilized health practice is exercise. Apparently the beneficial effect of exercise is not restricted to sports like jogging or tennis, but includes physical labor as well (Kobasa et al. 1982). Exercise seems a promising enough buffer to justify additional attempts to determine its role with other possible mediators in protecting health.

Social Support

On the psychological level social support has been cited as an important mitigating factor in times of stress (Antonovsky, 1979; Cobb, 1976; Kobasa, Maddi & Kahn, 1982; Pines, 1983). Social support has been defined as information that leads individuals to believe that they are cared for and loved, esteemed, and valued, and that they participate in a network of communication and mutual obligation. Although social support systems serve a multitude of functions, the buffering effects of social support can be condensed into six basic support functions: "listening; technical support; technical challenge; emotional support; emotional challenge; and the sharing of social reality" (Pines & Aronson, 1988, p. 160).

Personality Characteristics

Operating at a psychological level as well is the individual's personality disposition that has both cognitive appraisal and action aspects. What is stated quite clearly is that personality dispositions can also influence coping processes and that this may be the mechanism whereby personality exercises a buffering effect on stressful events. The issue regarding the particular personality dispositions that mitigate the otherwise negative effects of stressful life events have

been addressed in chapter 1 and will be discussed further on in this chapter (sense of coherence, hardiness and learned resourcefulness). How these particular personality dispositions mediate is that they have a cognitive appraisal effect of representing events as less meaningless, or not totally overwhelming, or not so undesirable. They also have the action effect of instigating coping activities that involve interacting with and thereby transforming the events into a less stressful form rather than avoiding them.

Personal Coping Techniques

Kaplan (1985) pointed out that there are scores of psychosocial variables that seem to be linked to health maintenance and disease etiology. Progress in this area will depend on individual ability to convert long lists of variables into coherent theories or models. That is exactly what Antonovsky (1979) and others proposed to do in formulating the salutogenic paradigm. Within this paradigm there are GRDs and GRRs that promote and/or vitiate a positive health outcome. Successful coping by the individual, which would ultimately lead to more positive health outcomes, is closely linked to the extent to which one is capable of cognitively and emotionally ordering one's perception of the stressor and accepting a willingness to confront it. In other words, the individual's construction of reality following a stimulus will determine the action or non-action taken to deal with the stimulus. What is shared by most researchers, (and this includes the studies mentioned in the beginning of this section) and what appears to be a cornerstone in the salutogenic paradigm, is the individual's construction of reality. How each individual construes his or her reality is a decisive factor in coping and health outcome. This aspect has been extensively studied by Watzlawick (1984) from the constructivism paradigm.

With regard to personal coping techniques, it is important to note that it is not the type of coping strategy that an individual uses that is important, but rather the number of coping techniques he or she has in his or her repertoire or how flexible he or she is in employing different coping strategies (Cohen, 1984). The emphasis is on flexibility and on having a repertoire of GRR's, not on a specific coping style. This leads to the interesting paradox that coping strategies may be both adaptationally sound or capable of eliciting a heavy price, depending on the individual using them and the circumstances. This does not imply that anything works well, but Antonovsky

(1987) is under the impression that to search for a personality type or coping strategy that is universally effective in successfully dealing with stressors is useless and self-defeating. One can, however, generalise about the character or the personality characteristics of the person who has many alternative coping strategies as potentials and uses them flexibly and appropriately. In the next three sections this will be discussed in detail. For Antonovsky (1979) this is an individual with a strong sense of coherence, for Kobasa (1982) it is the person with the hardy personality, for Rosenbaum (1988) the individual who has learned resourcefulness.

Three Answers to the Salutogenic Question: Whence the Strength?

What transpires from the above is that salutogenesis opens up the vista to a reality where the question that is being asked is the most important. For Antonovsky (1987, p. 14) the question is always more important than any given answer. He states that "if we keep our eyes wide open to reality, the way is open to increasing our understanding of coping". The answers that individuals have to the salutogenic question (whence the strength?) have roots in intrapsychic, interpersonal, social and occupational functioning. It is the belief of this researcher that different answers to the question have merit, and that there is not necessarily a single correct answer to the complex salutogenic question.

In an important paper on salutogenesis Strümpher (1990) reviewed five constructs from different theoretical perspectives to illustrate the potential of salutogenic thinking in explaining the concurrence of high stressor loads with survival and healthy functioning. He reviewed Antonovsky's "sense of coherence", Kobasa's "hardiness", Ben Sira's "potency", Thomas and Colerick's "stamina" and Rosenbaum's "learned resourcefulness". In a different study, Parkes (1994), chose five dimensions of personality as moderators of relations between work stress and health outcomes, namely Rotter's "locus of control", Kobasa's "hardiness", Matthews and Haynes' "type A behaviour", Eysenck and Eysenck's "neuroticism" and Scheier and Carver's "dispositional optimism". Antonovsky (1987) himself reviewed constructs related to the sense of coherence. Add to these the constructs that were mentioned at the beginning of this chapter and it becomes clear that there are a number of constructs that may be used to explore the salutogenic field of study.

The answer to the above question, whence the strength, will depend on the theoretical orientation of whoever answers the question. As discussed in chapter one (see pp. 8 and 9), it also seems as if the study of resistance resource constructs found in the literature greatly overlap. Therefore ..., for Antonovsky (1979), the answer to the question: "Why and how people stay well" can be found in "sense of coherence", for Kobasa (1982) it is "hardiness" and for Rosenbaum (1988) "learned resourcefulness". A discussion of each of these three orientations follows next.

Sense of Coherence

A discussion of the historical background, the definition of a sense of coherence, and the subcomponents of the manifestation of a sense of coherence in the individual's personal and social life follows. This section will be concluded with a discussion of a sense of coherence and work.

Historical Background

After 1970 Antonovsky (1979) became aware of and formulated the salutogenic question. The development of his thoughts on salutogenesis was discussed in chapter 1. In answer to the salutogenic question Antonovsky (1987) developed the sense of coherence concept and he states that he is "quite persuaded, until data compel me to modify or change my position, that the sense of coherence is a very major determinant of maintaining one's position on the health ease/ disease continuum and of movement toward the healthy end" (p. 15). Up to the time of his death in 1994 Antonovsky was never persuaded to alter his position on this concept drastically.

The sense of coherence (SOC) is seen as a major determinant of maintaining one's position on the health ease/disease continuum. Antonovsky (1987) sees comprehensibility, manageability, and meaningfulness as the three core components of the SOC. When individuals rate high on these components, they can be identified as having a strong SOC, and when they rate low on these three components they can be identified as having a weak SOC. Antonovsky is very adamant about the fact that a strong SOC is not a particular coping style. The stresses encountered in life are many and varied, and there are many possible coping procedures. To

consistently adopt only one pattern of coping is to fail to respond to the nature of the stressor and therefore to decrease the chances of successful coping. What the person with a strong SOC does, is to select the particular coping strategy that seems most appropriate to deal with the stressor being confronted.

Definition

The sense of coherence is defined by Antonovsky as "... a global orientation that expresses the extent to which one has a pervasive, enduring though dynamic feeling of confidence that 1) the stimuli deriving from one's internal and external environments in the course of living are structured, predictable, and explicable; 2) the resources are available to one to meet the demands posed by these stimuli; and 3) these demands are challenges, worthy of investment and engagement" (Antonovsky, 1987, p. 19).

The Subcomponents

- **Comprehensibility**

Consistent experiences provide the basis for the comprehensibility component. Comprehensibility refers to the extent to which one perceives the stimuli that confront one, deriving from the internal and external environments, as making cognitive sense - as information that is ordered, consistent, clear and structured - rather than as nonsense or as information that is chaotic, disordered, accidental, inexplicable and random (Antonovsky, 1987; Strümpher, 1990). It also implies that on the basis of past experience stimuli will in future also be ordered and even be predictable. It means that perceptions make cognitive sense (Strümpher, 1990). The person high on the sense of comprehensibility expects that stimuli encountered in future will be more or less predictable, and even if they are not, that they will be orderable and explicable. Nothing is implied about the desirability of stimuli. Accidents happen and terrible things can happen, but a person high on comprehensibility can make sense of them (Antonovsky, 1979). The distinction between scoring low and high on comprehensibility is that in the case of the former the individual believes that things happen, invariably unfortunate things, and that this will probably continue to happen for the rest of the individual's life. In the latter instance, events in life are seen as

experiences that can be coped with, challenges that can be met. At worst the event or its consequences are bearable.

- **Manageability**

A good load balance, that is an underload-overload balance in life experience, provides the manageability component. Underload refers to when there is not enough direction, or when the individual is seldom called on to exercise his or her abilities or to actualise his or her potential. Overload refers to the individual setting a pace too rapid for demanded development, or never having enough time and energy to do everything, or not having enough resources to do something. Manageability refers to the extent to which one perceives that the resources at one's disposal are adequate to meet the demands posed by the stimuli that bombard one. In other words, there is a load balance, and no underload or overload. According to Antonovsky (1987) "at one's disposal" may refer to resources under one's own control or to resources controlled by legitimate others, like friends, one's spouse, God, a political party, a doctor. Anybody one feels one can count on and trust. A person who has a high sense of manageability will not feel victimised by events or feel that life is treating her or him unfairly. Bad things do happen in life, but when they do occur, the individual will be able to cope without endless complaints.

Strümpher (1990, p. 269) says that at this point the SOC construct interacts with the literature on social integration into various networks as reviewed by Cohen (1988). A notable point made by the latter is that the mere perception that help is available may make things manageable, without actual help or support being provided.

- **Meaningfulness**

Meaningfulness is the component that for Antonovsky (1979) guards against too great an emphasis being placed on the cognitive aspect of the sense of coherence. It also refers to the importance for the individual of being involved in the process of shaping not only his or her destiny, but also his or her daily experience. This component, therefore, refers to the extent to which one feels that life makes sense emotionally. This means that at least some of the problems and demands posed by living are worth investing energy in or are worthy of commitment and engagement. This also means that some challenges are seen as welcome rather than new burdens

that one would much rather do without (Antonovsky, 1987). For any life experience one can ask whether the individual has had a say in choosing to undergo that experience, in judging whether the rules of the game are legitimate, and in solving the problems and tasks posed by the experience. When others make decisions on behalf of the individual and he or she has no say in the matter, he or she is reduced to being an object. A world thus experienced as being indifferent to what the individual does comes to be seen as a world devoid of meaning. It is important to stress that the dimension is not control, but participation in shaping outcome, participation in decision making, taking responsibility.

Manifestation in the Individual's Personal and Social Life

The question that needs to be answered is how a strong SOC manifests itself in the individual's life? What is becoming clear is that the SOC refers to a generalised, long-lasting way of seeing the world and the individual's life in it. A strong SOC does not mean that the person views his or her entire world as comprehensible, manageable and meaningful. The individual sets boundaries, some wide, some narrow, and what happens outside these does not bother him or her. A strong SOC does not mean the whole world has to be coherent, but even with narrow boundaries, the real world will still influence the individual. There are four spheres that cannot be excluded if a person is to maintain a strong SOC, namely, the individual's feelings, immediate interpersonal relations, the major sphere of activity and the existential issues of death, inevitable failures, shortcomings, conflict and isolation (Strümpher, 1990). It may also well be that one of the most effective ways a person with a strong SOC maintains his or her view of the world as coherent is to be flexible about the life areas included within the boundaries considered significant and of course to be able to shift these boundaries as needed over time. In other words, a strong SOC does not imply a rigid SOC. "The strong-SOC person seeks a balance between rules and strategies, between stored and potential information. There is confidence that sense can be made of the new information. There is little felt danger in seeing the world as a challenge and in being open to feedback" (Antonovsky, 1978, p. 27). This has implications for the intrapsychic and personal dimensions of an individual's life, as well as for the social and interpersonal aspects of his or her life.

Antonovsky (1987) is of the opinion that the failure to extend the definition of stressors to all stimuli that are taxing, whether or not they are appraised as endangering, underlies the widespread failure to distinguish between tension and stress and derives from a pathogenic orientation. In all cases the stimulus that reaches the brain is indeed defined initially as a stressor or nonstressor. Antonovsky calls this primary appraisal-I. "By and large, I hypothesise, the person with a strong sense of coherence is more likely to define stimuli as nonstressors, to assume that he or she can adapt automatically to the demand, than one with a weak sense of coherence. In this way the former will not experience tension, with the potential of its transformation into stress" (1987, p. 132). The next step is primary appraisal-II; this is when the evaluation of the nature of the stimulus as endangering one's well-being is seen as, positive, benign, or irrelevant. To perceive a stressor as benign or irrelevant is to define it as of little consequence for one's life, to be able to assume that whether one mobilises the resources to deal with the demand matters little, the tension will soon evaporate. It is in essence a cognitive re-framing of the stressor as a nonstressor.

Antonovsky (1978) states that this reframing is possible because the individual has confidence that, as in the past, by and large things will work out, that what seems to be a problem will turn out not to be much of a problem and to be reasonably soluble, that the dissonance is only seeming. This is in line with Bandura's (1982) self-efficacy theory. What is argued within this paradigm is that successful coping which would ultimately lead to a more positive health outcome, is closely linked to the extent to which one is capable of cognitively and emotionally ordering one's perception of the stressor and accepting a willingness to confront it. In other words, one's construction of reality following a stimulus will determine the action or non-action taken to deal with the stimulus.

In the last place Antonovsky (1987) states that the social category that an individual finds himself or herself in is decisive in determining the particular patterns of life experiences that engender a stronger or weaker SOC. Although culture, class, and history offer no ironclad guarantees of a pattern of life experiences of consistency, load balance and participation in decision making, they do allow for statistical prediction.

Sense of Coherence and Work

In a discussion of work experiences as a specific form of life experience, Sorokin (1959) proposed the premise that all psychological processes of any member of an occupation undergo modification, especially when one stays in the same occupation for a long time. Even greater is the occupational influence on the processes and on the character of one's evaluations, beliefs, practical judgements, opinions, ethics, and whole ideology. Antonovsky (1987) says that this is too general to produce a detailed understanding of how one's job shapes one's SOC or a positive health outcome. What is important is the question of the social valuation of the enterprise (the occupation) in which one is engaged. Such valuation is expressed in the resources (power, rewards, prestige) allocated by society to the collectivity. This is also valid for the individual worker. The more one perceives the social valuation of one's work as meeting one's criteria of equity, the more one is likely to feel that "this is mine". Kohn (1985) states that there is accumulating evidence that job conditions affect adult personality mainly through a direct process of learning and generalisation. In other words, that the lessons of the work are directly carried over to nonoccupational realms. The above does not mean a generalisation to everybody. Individuals live in a given sociophysical environment. Each of these implies a set of life experiences relevant to the health outcome of the individual.

Strümpher (1990) states that it seems evident that the SOC not only refers to how people stay healthy, but that it must impact on how work is approached and performed. It is hypothesised that a strong SOC would thus result in the person:

- making cognitive sense of the workplace, perceiving its stimulation as clear, ordered, structured, consistent and predictable information
- perceiving work as consisting of experiences that are bearable, with challenges that can be met by availing oneself of personal resources or resources under the control of legitimate others
- making emotional and motivational sense of work demands, as welcome challenges, worthy of engaging in and investing energies in (p. 270).

An individual with a strong SOC seems to be an asset to any organisation. If a person has an orientation such as the one outlined above, then it tends to lead to productive performance, recognition, reward and promotion.

Hardiness

A discussion of the historical background, the definition of hardiness, its subcomponents and the manifestation of hardiness in the individual's personal and social life follows. This section will be concluded with a discussion of hardiness and work.

Historical Background

Kobasa (1982, p. 5) began a series of studies in the mid-1970's in response to previous stress research and "in the hope of advancing a personality and social psychology with both disciplinary and social relevance". Integrating an existential theory of personality (Kobasa & Maddi, 1977) with different empirical leads from social, developmental and personality research, Kobasa (1979) proposed the hardy personality style as a source of positive resistance to the debilitating effects of stressful life events on health. As a constellation of three crucial personality characteristics hardiness was presented as facilitating not only survival in the face of stress, but also the enrichment of life (Kobasa, Maddi & Puccetti, 1982).

Definition

Hardiness is defined as a constellation of interlocking personality characteristics that function as a resistance resource in the encounter with stress. (Kobasa, 1982; Manning et al., 1988). The personality dispositions of hardiness are commitment, control, and challenge.

Subcomponents

- **Commitment**

This refers to the ability to believe in the truth, importance, and interest value of who one

is and what one is doing (Kobasa, 1982). The commitment quality can be seen as a tendency to involve oneself in whatever one is doing or what the individual is encountering, instead of experiencing alienation from it. Relevant to cognitive appraisal, a committed person has a generalised sense of purpose that allows him/her to identify with and find the events, things, and persons in the environment meaningful. Relevant to action, the committed individual is sufficiently empowered in himself/herself and his/her relationship to the social context for such a person not to give up easily under pressure (Kobasa, Maddi & Kahn, 1982).

What this boils down to is that a committed person's relationship to the self and to the environment involves activeness and approach rather than passivity and avoidance. Commitment to self provides an overall sense of purpose that mitigates the perceived threat of any given stressful life-event in a specific life-area. The committed person knows not only what he or she is involved in but also why the involvement was chosen.

There is also another feature of commitment, (Kobasa, 1982) namely, that it is based on a sense of community, coming from the existential theory, being-with-others in the world. The committed person benefits from both the knowledge that he or she can turn to others in stressful times and that others are counting on him or her not giving up in times of great pressure. Commitment corresponds with what Antonovsky (1979) calls sense of community or accountability to others. For Antonovsky it is the most fundamental interpersonal resource for successful coping with stress.

- **Control**

The control disposition is expressed as a proclivity to make the individual feel and act as if he or she is influential in the face of the varied contingencies of life, rather than being helpless (Averill, 1973; Seligman, 1975; Syme, 1989). In other words, that the individual can influence the course of events and seek explanations for why something is happening not simply in terms of others' actions or fate, but also with an emphasis on his or her own responsibility. Kobasa (1982) states that control allows a person to perceive many stressful life-events as predictable consequences of his or her own activity and, thereby, as subject to his or her own direction and manipulation. This does not imply the naive expectation of complete determination of events and

outcomes, but rather implies the perception of oneself as having a definite influence through the exercise of imagination, knowledge, skill and choice.

According to Enevoldsen Bowsher and Keep (1995), control is incorporated into the hardiness construct utilising Rotter's construct of internal versus external locus of control of reinforcements. Syme (1989) is of the opinion that control is an integrating concept in the social sciences and that it can act as a transcendent concept for interdisciplinary research. According to Kobasa et al. (1982), control enhances stress resistance perceptually by increasing the likelihood that events will be experienced as a natural outgrowth of one's actions and, therefore, not as foreign, unexpected and overwhelming experiences. In terms of general coping with life, control leads to actions aimed at transforming events into something consistent with an ongoing life plan and, therefore, renders ongoing life events less disturbing.

- **Challenge**

This disposition is based on the belief that change, rather than stability, is the normative mode of life and the anticipation of changes as interesting incentives to growth rather than threats to security (Kobasa, 1982). Challenge mitigates the stressfulness of events on the perceptual side by colouring events as stimulating rather than threatening, specifically because they are changes requiring readjustment. In coping behaviours, challenge will lead to attempts to transform oneself and thereby grow rather than conserve and protect what one can of one's former existence (Kobasa et al., 1982).

Because of their search for new and interesting experiences, an individuals who welcome challenge have explored their surroundings and know where to turn for resources to aid them to cope with stress. In a personal correspondence to Antonovsky, Kobasa states that what she is trying to measure is not simply adventurousness or eagerness for chaos. Crucial for her is "the person's ability to view change, the unexpected, the unpredictable as opportunities ... and turn them into something 'coherent'" (Antonovsky, 1987, p. 51).

Manifestation in the Individual's Personal and Social Life

From the above it follows that the personal coping resources of commitment, challenge and control should keep a person healthy despite encounters with events generally regarded as stressful. They can be viewed as interlocking parts of an overall orientation or personality style of stress resistance. A style that Kobasa (1982) terms hardiness. When life is stressful, hardiness decreases the number and severity of illness reports. The person's basic constitution acts like a filter that shapes both the initial organismic response to stress and the eventual degree of physical effects in the aftermath of stress.

Kobasa (1982, p. 11) states that discriminant function analysis established a significant difference in hardiness between the high stress/low illness executives in her study and the high stress /high illness subjects. She found hardiness to be important in the stress resistance of other groups as well (p. 12). Literature indicates that hardiness is seen as a personality stress resistance resource or personal coping resource (Wheaton, 1985) that might have a certain constitutional predisposition as per individual, but is seen as a legitimate stress buffering resource by its proponents.

The hardiness personality orientation is mostly a cognitive appraisal of events and the appraisal will determine the subsequent actions directed towards those events (Manning et al., 1988). What becomes apparent is that the hardy individual appraises events from an optimistic point of view and is rarely overwhelmed by stressful events. A further point of note is that the hardy individual engages in decisive interactions with intrapsychic, interpersonal and social situations in order to resolve these situations or to transform them into a less stressful form. "This dual process of cognition and action is labeled 'transformational coping' and tends to protect health" (Manning et al., 1988, p. 206). Therefore, hardiness is conceptualised as contributory to positive perception, evaluation and action that reduces an individual's personal and social life-stress and leads to a more healthy adjustment.

Hardiness and Work

Kobasa (1982) is adamant that "looking at how personality interacts with characteristics of professions to keep persons healthy, promises to do more than just provide a better understanding of stress and its consequences. It suggests how personality based stress resistance may be developed in different work contexts" (p. 28). These work-based differences in stress resistance have caused Kobasa (1982, p. 26) to examine the diverse occupational and cultural contexts of each of the professional groups that she studied. Further, it might point to possible intervention attempts by which the exercise of hardiness and, thereby, the enjoyment of health, might be facilitated. An existential context seeks to improve persons' perceptions and understanding of themselves and their complex environments. It certainly seems to confirm the pre-scientific idea that the work context in which the individual finds himself or herself will determine what personality-based resistance resources are utilised.

Learned Resourcefulness

A discussion of the historical background, the definition of learned resourcefulness, its subcomponents and the manifestation of learned resourcefulness in the individual's personal and social life follows. This section will be concluded with a discussion of learned resourcefulness and work.

Historical Background

The concept learned resourcefulness developed from behaviour therapy. The term learned resourcefulness was first used by Meichenbaum (1977) in association with his stress inoculation programme. In stress inoculation training individuals are trained in cognitive and behavioural skills that will enable them to cope effectively with stressful events. The major components of the stress inoculation program are:

- self-monitoring of maladaptive thoughts, images, feelings, and behaviours
- problem-solving skills

- emotion regulation and other self-control skills

Meichenbaum (1977) found that people who have acquired these skills develop a sense of learned resourcefulness. For instance, they acquire the belief that they can effectively deal with a manageable level of stress.

Rosenbaum (1983) suggested that individuals may differ in the extent to which they are able and willing to self-regulate internal responses. "The personality repertoire that I have labeled learned resourcefulness consists not just of a set of beliefs, but also of skills and self-control behaviours which are taught in a typical stress inoculation training program. Research on learned resourcefulness is guided by the underlying assumption that these behaviours are acquired in different degrees by most people without any formal training" (Rosenbaum, 1988, p. 483).

Definition

Learned resourcefulness refers to a personality repertoire which has been defined as a set of behaviours and mostly cognitive self-control skills by which the individual self-regulates "internal responses that interfere with the smooth execution of an ongoing behaviour" (Rosenbaum, 1983, p. 483). Learned resourcefulness describes "an acquired repertoire of behaviours and skills (mostly cognitive) by which a person self-regulates internal responses (such as emotions, cognitions, or pain) that interfere with the smooth execution of a desired behaviour" (Rosenbaum & Ben-Ari, 1985, p. 200).

It is assumed that learned resourcefulness is a basic behavioural repertoire that is learned from the moment of birth and serves as a basis for coping with stressful situations (Rosenbaum & Palmon, 1984). The concept of personality repertoires was introduced by Staats (1975), who used it interchangeably with the term "basic behavioural repertoires". "Personality repertoires are not personality traits, but rather a set of behaviours, cognitions and affects that are in constant interaction with the social and physical environment of the person" (Rosenbaum, 1988, p. 484).

The Subcomponents

The specific behavioural skills that constitute learned resourcefulness are:

- the ability to choose and implement effective problem solving skills
- the ability to use cognitive skills such as self talk to control internal processes
- the ability to delay the gratification of needs
- the tendency to evaluate the self as efficient and effective in situations

These specific skills are employed when the individual is confronted with stressful events as all coping with stressful events calls for attempts at self-regulation, or self-control. The conditions that activate the self-regulatory process are similar to those that have been recognised by stress researchers as conditions of stress (Rosenbaum, 1988). The process of self-regulation consists of three phases (Strümpher, 1990):

- **representation**, during which the individual experiences without any conscious effort, a cognitive and/or emotional reaction to changes within the individual or the environment. These reactions occur more or less automatically and these automatic thoughts are assumed to originate from deeply rooted cognitive self-schemata and should not be confused with conscious and deliberate attempts to appraise the situation at hand.
- **evaluation of the changes**, first, as desirable or threatening, then, if threat is appraised, evaluation whether anything can be done about it. The initial automatic reaction to a disruption is followed by a conscious evaluation of its meaning for the individual.
- **action (or coping)** to minimise negative effects of the internal or external changes. Learned resourcefulness has its main impact on the action phase (p. 273).

"Thus any effective coping with a stressor involves the three phases of the self-regulatory process. The first is an emotional or a cognitive reaction which we have called the representational phase of the process. This is followed by a conscious evaluation of the stressor, that is the evaluation phase disruption, which is the action phase of the self-regulatory process" (Rosenbaum, 1988, p. 486).

The individual who is high on learned resourcefulness is thus able to deal with stressors by means of problem focused strategies. Negative thoughts and emotions are minimised during the coping process. This enables the individual to focus on dealing with the specific stressor and to persist as gratification of personal needs is delayed. The perception of the self as effective and efficient furthermore aids the individual in persisting with the task (Rosenbaum, 1983).

In contrast, the individual who does not demonstrate learned resourcefulness is not goal oriented and focused on problem-solving when dealing with a stressor. Negative internal responses are not checked and contained, which hinders persistence in dealing with the external demands. This ineffectivity leads to evaluations of inefficiency and helplessness.

Manifestation in the Individual's Personal and Social Life

Individual differences in learned resourcefulness are likely to have little impact on the representational phases of the self-regulatory process. The differences between the high resourceful and low resourceful subject are mainly in how they cope with their emotional and cognitive reactions to stressors. In other words on the action phase of the self-regulatory process. How a person evaluates a stressful encounter will determine whether or not he or she will attempt to cope with the stressor. However, without the appropriate repertoire of self-control skills coping will be ineffective (Rosenbaum, 1988, p. 487).

Rosenbaum (1988) is of the opinion that hardiness, sense of coherence (SOC), and learned resourcefulness are all personality repertoires which may have stress buffering effects. But where hardiness and SOC influence a person's evaluation of the stressful disruption, learned resourcefulness influences the person's actions toward reducing the interfering effects of the reactions to a stressor, and not the primary appraisal of the stressor. In other words, learned resourcefulness is postulated to have no influence on the individual's initial emotional and cognitive reactions to a stressor nor on the primary appraisal of the stressor.

Learned resourcefulness as a personality repertoire is postulated to have its greatest impact on the person's attempts during the action phase to self-regulate internal responses that

interfere with the smooth execution of a desired behaviour (1988, p. 487). It, therefore, makes not only for a handy addition to the personality repertoires of hardiness and SOC, but also represents an extremely useful shift in focus.

Learned resourcefulness is acquired mostly by cognitive-behavioural programmes such as those suggested by Meichenbaum (1985), but Rosenbaum (1988) states that he believes that resourcefulness is acquired during childhood through informal training. In fact Rosenbaum (1988) feels that learned resourcefulness could be conceived as a stable personality trait, like intelligence. This caused Rosenbaum (1988) to advocate the development of effective methods for assessing a person's self-regulatory skills and the individual's ability to cope with stressful events.

The learned resourcefulness model suggests that high resourceful subjects use more self-control methods during a stressful encounter and use them more frequently and more effectively than low resourceful subjects. The manifestation of learned resourcefulness in the individual's personal and social life is best described by the impressive amount of empirical evidence that Rosenbaum (1988) collected to show the difference between the way high resourceful individuals deal with various issues and the methods low resourceful individuals adopt:

- High resourceful individuals tolerated laboratory-induced pain longer and used self-control methods more frequently and more effectively in doing so than low resourceful individuals.
- As migraine sufferers, high resourceful individuals reported lower pain intensity, focused less on the sensory aspects of their pain, and used prophylactic medication more than low resourceful individuals.
- As diabetics, high resourceful individuals were more successful in controlling sugar intake than low resourceful individuals.
- After natural childbirth, high resourceful individuals reported that they had engaged more often in breathing-relaxation exercises, used more self-encouraging statements during delivery, and felt more control over the process than low resourceful individuals.

- As smokers high resourceful individuals were more successful in giving up cigarette smoking on their own.
- High resourceful individuals used self-control methods more effectively to cope with seasickness on missile boats in a stormy sea and showed fewer performance deficits, notwithstanding seasickness than low resourceful individuals.
- in experimentally induced experiences of uncontrollability or failure, high resourceful individuals reported more positive self-evaluations, fewer negative self-evaluations and more task-oriented thoughts than low resourceful individuals (Strümpher, 1990, pp. 273-274).

Regarding social support, Rosenbaum (1988, p. 491) postulates that "those who are able to help themselves (i.e., high resourceful persons) will be most helped by others. Yet those who are unable to help themselves (i.e., low resourceful persons) are likely to deplete their social resources by their highly socially dependent behaviour". In conclusion it can be said that the three stage model of self-regulation presented provides the theoretical framework by which the differential role of various personality and social resources in coping with stress can be elucidated.

Learned Resourcefulness and Work

The present data suggest that there are substantial and reliable differences between high resourceful and low resourceful subjects in the way they cope with noncontingent events. The meaning of this in the work situation is obvious. With the passage of time, people who have succeeded in the past in self-regulating (controlling) their internal responses acquire skill in doing so. They also expect to be able to do so in future. The learned resourcefulness thus provides a basis for further learning. It is suggested by Rosenbaum and Ben-Ari (1985) that low resourceful persons judge themselves inefficacious in coping with emotional strains and difficult tasks whereas high resourceful persons judge themselves more efficacious in dealing with emotional and task demands and are as a consequence more likely to continue with self-control behaviour. Thus, high resourceful persons, when challenged by an insoluble task, are more likely to be spurred into action. They are also more likely to be oriented towards maximising their chances of success whereas low resourceful individuals will be more inclined toward avoiding failure. This has clear

implications for differentiating between individuals in the work force and for predicting their chances of success in an organisation.

Manifestations of the Salutogenic Concept in the Nursing Literature

There are a number of references to salutogenesis and salutogenic principles relevant to this research to be found in nursing literature. In an evaluation of the salutogenic model for its adaptability to nursing, Sullivan (1989) determined that salutogenesis is explicit, comprehensible, logically congruent, and has social significance, congruence and utility. She concluded that salutogenesis is suitable for adaptation to the nursing milieu and for use as a nursing paradigm.

The use of personal, organisational, and coping resources in the prevention of staff nurse burnout was studied by Rich (1991). The dissertation revealed that burnout is prevented through the social resources of the organisation, the personal resources of the nurses and the use of appropriate coping resources when stress was encountered. In another study on job satisfaction among critical care nurses, Stechmiller and Yarandi (1992) revealed that thirteen variables had a significant effect on job satisfaction and explained 63% of the variance. The four most significant effects on job satisfaction were opportunities for advancement, meaningfulness of work, pay and supervision. Commitment to career, task identity and job security had a modest effect on job satisfaction.

- **Sense of coherence (SOC)**

In research on work stress, burnout and sense of coherence among dialysis nurses Lewis et al. (1992) stated that the results indicated that work-load was the major contributing factor to both overall stress and burnout. A strong SOC was a major factor in mediating the effect of work-related stress on burnout. High levels of burnout were significantly associated with higher levels of perceived job stress and a weak SOC. They also found that an understanding of the stressors that affect responses to the work environment allowed for successful interventions to alter the risk of exhaustion and burnout.

The concept of sense of coherence has been examined in the context of perceived burden in caring for chronically ill older persons (Coe, Miller & Flaherty, 1991). The predicted inverse relationship between the SOC and perceived caregiver burden was statistically significant for all conditions except urinary incontinence.

In a study by Jones (1991) she reviews the development of stress, adaptation, and coping theory and also examines the theory's appropriateness for nursing science. She states that adaptability may be viewed as a complex phenomenon encompassing biological, psychological, social, cultural, and spiritual components and is related to resilience, hardiness and sense of coherence.

In another study by Ryland and Greenfeld (1991) on work stress and wellbeing, they state that their study supports to the SOC as a valid coping construct in an organisational setting. Kalimo and Vuori (1991) conducted a follow-up study after 25 years on how childhood home conditions, individual factors in youth, and sense of coherence affected the relationship between self-reported job factors and stress reactions. For all educated groups, a good SOC explained having influence at work and perceptions of assistance from others. Poor task control among uneducated participants was associated with the prevalence of subjective stress symptoms. Weak intellectual qualifications, poor self-esteem, and deficient social conditions in childhood set constraints on the development of psychic resources.

Hart et al. (1991) attempted to provide validity evidence linking sense of coherence and anxiety among undergraduates. They found that individuals scoring high on SOC enjoyed better mental health than individuals with lower scores. In a study by Flannery and Flannery (1990) they found that SOC correlated negatively with life-stress and symptoms and appeared to mitigate the impact of life stress. SOC was not a buffer variable for life-stress.

The results therefore indicate that sense of coherence does influence the experience of burnout in the nursing profession. It seems as if a high sense of coherence has an effect on the perceived manageability of the care giving burden and the comprehensibility component of sense of coherence aids the individual in adapting to the external demands. The presented research did

not deal with the unique idiosyncratic experience of the nurse and the individual operationalisation of the sense of coherence construct is only implied.

- **Hardiness**

Lambert and Lambert (1987) discuss the concept of hardiness as an inherent health promoting factor. They contend that hardiness has a direct relevance to nursing practice and suggest that hardiness can be taught. They postulate that it can be used to help nurses increase their tolerance to stress, to screen nurses who might be exposed to high stress in the work environment, and to aid in preventing stress-related illnesses. In giving the profile of the hardy NICU nurse Consolvo, Brownell and Distefano (1989) state that interviews with their long-term nurses correlated with Kobasa's hardiness research. The nurses saw themselves as being in control of their patients who are entrusted to the nurses by the parents. The nurses are committed to their work, which they view as essential. They are constantly challenged by the technological improvements, and demands of their work and, to add a fourth personality characteristic to Kobasa's work, they see companions as an integral part of their ability to cope with stress.

Consolvo et al. (1989) state that a large body of previous research on stress, burnout and the nursing profession has focused on external factors and their effects on nurse retention. They postulate that through the utilisation of Kobasa's and others' work on hardiness they can hope to learn more about the introspective factors and their relationship to the success of long-term NICU nurses.

Rummel (1991) in a study on the relationship of health value and hardiness to health-promoting behaviour in nurses, concluded that individuals who scored high on hardiness were married, perceived their health status as excellent, and engaged in a greater number of health-promoting behaviours than their peers. Hardiness emerged as the strongest predictor of health-promoting behaviour.

In research by Taylor and Cooper (1989) the evidence suggests that personality is a predictor of health and that the notion of control is a key factor in understanding the

relationships among personality, stress and health. Manning, Williams and Wolfe (1988) in an interesting study with 468 participants, argued that the results indicated that hardiness did not moderate the relationship between stressors and outcomes as reported by others, such as Kobasa. "However, hardiness did have significant direct effects on emotional and psychological factors thought to be related to personal well-being and work performance. Hardy individuals reported higher levels of job satisfaction and fewer tensions at work than did the less hardy. In general, hardy individuals experienced a higher quality of life and a more positive affect while being more energised and less negative about life. Hardy individuals also reported fewer somatic complaints and tended to be less depressed and anxious than individuals low in hardiness. In addition, hardiness was negatively related to all four measures of life and work stress implying that hardiness may not be independent of life demands" (p. 205).

Predictors of healthy lifestyles among professional nurses were found to be hardiness, self-efficacy and self-motivation and in a study by Rosenburg (1990) these predictors explained 34% of the variance in lifestyle. Commitment, a hardiness subscale, and years employed had the largest beta weights and were the most predictive of a healthy lifestyle.

Gillmore (1990) conducted a study on workplace variables and experienced occupational hazards as predictors of health of specialty nurses. The purpose of the study was to describe the relationship which exists among the hospital work environment, individual nurse characteristics and nurses' health. It was found that individual moderating variables thought to influence the relationships between workplace environment and nurses' health were age, nursing experience, hardiness and social support. In a similar study on personality hardiness, ways of coping, social support and burnout in critical care nurses, Boyle et al. (1991) found that after controlling for nurses working nights, social support, hardiness, emotion-focused coping and problem-focused coping accounted for 44% of the variance in burnout scores.

In a study on hardiness in nurses and its relation to stress, social support, coping and illness, Dermatis (1989) found that individual components of hardiness that were found to exert positive main effects on health included commitment and an internal locus of control - an effect which was significant even after controlling for social desirability. Commitment was found to

exert a positive effect on health through coping.

But it is not all plain sailing for the hardiness construct. Personality hardiness, occupational stress and burnout were investigated in 100 critical care nurses. Topf (1989) found that although hardiness was predictive of occupational stress and burnout, the study did not provide support for the stress buffering effect of hardiness. In a study by McCranie et al. (1987), they found that although hardiness was a significant additive rather than interactive predictor of burnout, hardiness at best had a beneficial main effect on reducing burnout, but did not appear to prevent high levels of job stress from leading to high levels of burnout.

Funk (1992) cautions that in their effort to test the hardiness theory, researchers should adopt a standard hardiness measure because the use of nonstandard scales has created a body of research that is difficult to recreate and thus to compare in order to validate results.

Research has thus indicated that hardiness has a moderating effect on the health and well-being of nurses and is a relevant construct when examining burnout in the nursing profession. The nurse who can be characterised as hardy seems to be committed to her/his work, enjoys the challenges it presents and therefore does not feel overwhelmed by the demands. Furthermore, higher job satisfaction and less tension are reported by hardy nurses and in terms of the operationalisation of the construct, it seems as if hardiness plays a role in the adoption of a healthy lifestyle. Where the positive effect of hardiness on health outcomes is undisputed, the idiosyncratic and unique operationalisation of hardiness by the individual nurse could add to the understanding and promotion of health in the nursing profession.

- **Learned resourcefulness**

Learned resourcefulness as a moderator of burnout in a sample of rehabilitation workers was studied by Clanton et al. (1992). Their findings supported the theoretical utility of learned resourcefulness. Naisberg-Fennig et al. (1991) studied three personality characteristics judged to make psychiatrists more liable to intense emotional arousal and prone to burnout. They found that burnout was positively related to anxiety state and to repression-sensitisation and negatively related to learned resourcefulness.

In a study by Rosenbaum (1989) of self-control under stress he found that highly resourceful individuals cope more effectively with stressful situations and are more capable of adopting health related behaviours and other behaviours that require reformative self-control.

Gintner et al. (1989) examined whether persons who reported a broad repertoire of coping skills varied their coping efforts as a function of situational factors. Subjects low in resourcefulness reported significantly more stress symptoms than subjects high in resourcefulness.

Although the effect of learned resourcefulness on burnout in the nursing profession has not been reported in the literature yet, it seems that the specific skills of learned resourcefulness might have an influence on the experience of burnout in the nursing profession. The reduced anxiety levels which are linked to burnout may provide some pointers to the usefulness of its construct in terms of the moderating effect on burnout in the nursing profession.

From the above it should become clear that salutogenic concepts are utilized to quite a large extent in research found in literature on the nursing profession literature. It further looks as if the three salutogenic concepts chosen for this study have been applied separately in search of the answers to several related research questions. But it also seems as if Kobasa's (1982) lament about the lack of examination of several resistance resources and their interaction with one another holds water. It certainly seems possible and likely that certain salutogenic concepts, solo or in concert, could provide answers to the burnout phenomenon in the nursing profession.

Limitations of the Salutogenic Concept

As in all conceptualisations, it should be clear that there are certain restrictions that apply. Certain restrictions in the conceptual framework will be discussed in this section, followed by a short discussion of the restrictions that apply to this research.

Limitations in the Conceptual Framework

It is difficult to find restrictions in the salutogenic concept. Seen as a whole the

salutogenic paradigm is comprehensible, logically congruent and has great utility. It is, however, a young paradigm. Antonovsky (1995) says that salutogenesis has not yet become a household word. Evidence has been found that the concepts found in the salutogenic paradigm exist, but unanswered questions remain. One such question relates to the possible interactions among resistance resources. The examination of several resistance resources in interaction with each other has not been carried out.

Kobasa (1982) raises the very valid point that work-based differences in stress-resistance have required her to examine diverse occupational and cultural contexts of different professional groups in order to find explanations for some of her hypotheses. She found different personality-based resistance resources for different professional groups.

Arguing salutogenically Kobasa (1982) states that researchers should seek to improve the perceptions and understanding that individuals have of themselves and of their complex environments in order for people to become highly aware of, and able to influence, stressful events in their lives. Strümpher (1990) points out that there are several conceptual, measurement and validity problems with the hardiness concept and that both its operationalisation and the supporting evidence are still too close to the pathogenic framework. Rosenbaum (1988) states that the time is ripe to develop effective methods for assessing the person's self-control skills and the ability to cope effectively with stressful events.

Stress researchers closer to the pathogenic paradigm have increasingly focused on the role of personality repertoires and social supports systems in buffering the effects of stressful life events (Morano, 1993; Vines, 1991). Yet most studies have failed to distinguish between the initial automatic response to the disruptive event, the cognitive evaluation of the event, and the person's activities to reduce the interfering effects of these reactions on ongoing functioning (Rosenbaum, 1988). The above-mentioned issues are some of the problems and unfinished business that still need to be answered and addressed. These can at present be considered to be some of the conceptual restrictions of the salutogenic concept.

Antonovsky (1987) himself says that salutogenesis has a long way to go before it becomes

a well-used and understood paradigm. Strümpher (1990) speaks of the 'mopping-up' activity within the salutogenic paradigm that is still much needed.

Limitations for this Research

The fundamental restriction for this research regarding salutogenesis is the possibility that the concepts chosen for this research in answer to the salutogenic question might not be encompassing enough to explain how people stay healthy in the face of burnout. Although hardiness, a sense of coherence and learned resourcefulness (among others) have been touted by Strümpher (1990) as explaining the concurrence of high stressor loads with survival and healthy functioning, these concepts may be found to be either inadequate or incomplete.

A second restriction is the possibility that the phenomenological research method will reveal more generalised resistance resources than those which are being covered by the known salutogenic literature. Following a phenomenological research approach, with the emphasis on individual differences, still leads to a preoccupation with personality and the etiology of disease, unless the ease side of the ease/dis-ease continuum is specifically borne in mind.

A third restriction is the fear that a discussion of burnout might force the focus away from salutogenesis onto pathology. This might not inherently be a restriction of the salutogenic model, but it certainly is a possible restriction for this research.

Applicability of the Salutogenic Concept

As seen in the manifestations of the salutogenic concept in the nursing literature, certain concepts of the salutogenic paradigm have been used as a point of departure in numerous studies and the constructs have proved valuable in predicting where an individual is on the health-illness continuum. Most of these studies were empirical studies and the validity of the construct is therefore now generally accepted.

Kobasa (1990) realised that the empirical validation of the constructs is not sufficient and

suggested that future studies should be undertaken regarding the psychological processes underlying the observed connections made between psychological variables and health outcomes.

This researcher wishes to find some empirical evidence on how nursing professionals stay healthy and well adjusted despite their exposure to specific work-related stressors and to the stresses and strains of everyday life. He also wants to examine the psychological processes underlying these variables. The research involves the concept of burnout as experienced in the nursing profession and seeks to determine empirically and phenomenologically how nurses stay "healthy" despite their exposure to specific work-related stressors and to the stresses and strains of everyday life. The salutogenic model is therefore an excellent model to use in order to help solve this mystery of health, as its focus is health, and not illness. It is felt that the generalised resistance resources that people use in response to stressors are explained by the salutogenic paradigm.

The frame of reference presented in this chapter was developed to present a sophisticated conceptual analysis of the salutogenic construct and of three of the concepts used to explain the salutogenic question. It is felt that despite the restrictions that exist, a critical and comprehensive perspective of the construct has been presented.

The only question that remains to be answered is whether the discussion of this concept led to the answering of the research questions posed in chapter one. The influence of the salutogenic constructs as moderator variables in stressful situations has been discussed. The other questions that concern salutogenesis have to do with the phenomenological experiences of individual nurses, and are best left for the discussion of the results in chapter 5. What has been achieved is a better knowledge and understanding of salutogenic qualities. This will permit an informed discussion of the related questions in the results chapter.

Chapter Summary

The conceptualisation of salutogenesis offers a comprehensive and critical perspective on how the individual manages to stay well intrapsychically, socially and in the organisational

setting. The salutogenic construct was conceptualised by looking at the definition and the differentiation between the pathogenic and the salutogenic paradigms. General to the salutogenic paradigm is the assumption that people manage stress and stay well. The working definition of salutogenesis for this research is the study of the strength that individuals exhibit in order to manage the tension and stress in their lives without succumbing to illness.

Salutogenesis opens up the vista of a reality where the question that is being asked is the most important. It opens the way to increasing our understanding of coping. The answers that individuals have to the salutogenic question have roots in intrapsychic, interpersonal, social and occupational functioning and there is not necessarily a single correct answer to the complex salutogenic question. The salutogenic construct was conceptualised by looking at stress that is relevant to the construct and the stress responses of individuals were discussed. Personality factors within salutogenesis were presented and an in-depth discussion of general resistance resources was given with specific focus on the functioning of general resistance resources.

Three answers to the salutogenic question were presented in great detail and for the sake of internal and theoretical validity the same frame of reference was used in the discussion of sense of coherence, hardiness and learned resourcefulness. A definition of each concept was also given. The manifestations of the concept in the nursing literature, that have not already been discussed in the rest of the chapter were also mentioned. In the last instance the restrictions of the salutogenic concept were discussed as seen from the researcher's perspective. It was concluded that salutogenesis still has a long way to go before it becomes more utilised and before all the mopping up activities in the paradigm will be completed, but that it is considered a sound and descriptive paradigm with great utilisation potential.

Specific restrictions for this research were also mentioned. Within the discussion of the applicability of the salutogenic concept for this research, it was pointed out that the salutogenic model is an excellent model to use in helping solve this mystery of health, because its focus is health, and not illness. It was further indicated that certain research questions pertinent to salutogenesis were answered within this chapter, but that others would be dealt with after consideration of the present research results.

In accordance with literature aim number two, the aim of this chapter was to present and integrate the existing literature on salutogenesis with a specific focus on the role of salutogenesis and salutogenic constructs in burnout in the nursing profession. Literature aim number two has been achieved.

The next chapter deals with the research methodology.

CHAPTER 4

**THE PHENOMENOLOGICAL AND EMPIRICAL RESEARCH
METHOD**

In accordance with the stated operational aim, namely to examine the influence of salutogenesis on the experience of burnout in the nursing profession, this chapter deals firstly with the phenomenological research method, then with the population and sample. The selection and motivation of the measuring battery will be discussed as well as the interpretation procedure. The data analysis procedure will also be discussed and the research hypothesis stated.

Phenomenological and Empirical Aims

The following phenomenological and empirical aims were formulated in chapter 1:

Aim:

To study the influence of salutogenic constructs on burnout from a phenomenological and empirical point of view. Three sub-aims are formulated:

Sub-aim 1:

To study the causes of burnout in the individual nurse from a phenomenological point of view.

Sub-aim 2:

To determine the symptoms of burnout in the individual nurse in a phenomenologically and empirically manner.

Sub-aim 3:

To study the influence of salutogenic constructs, as operationalised by the individual nurse, on the experience of burnout, from a phenomenologically and empirically perspective.

The phenomenological and empirical research is presented according to the ten steps as discussed at the end of chapter one.

Selection of the Applicable Phenomenological Research Method

Over the last twenty years there has been a re-examination of the qualitative methodologies (Kruger, 1986) to redress the balance between quantitative and qualitative methodologies. In this research two methods, the case study research method and the Duquesne phenomenological research method, will be discussed and integrated. This integrated qualitative method will be used in this research.

Case Study Research Method (CSRM)

The CSRM, in contrast to most quantitative methodologies where large samples are usually required, focuss on a single case which is examined in depth. Case studies are not only descriptive, but play a key role in theory development (Bromley, 1986; Edwards, 1991). The researcher aims to develop a conceptualisation to open up the essential qualities of the case being examined. This includes a number of tentative assumptions about the categories or constructs used to support the case, as well as the relationship between them. Assumptions or principles derived from one case are then tested against further case studies (Edwards, 1991).

The validity of the findings is not established by statistical inference but by a logical process known as “analytic generalization” (Yin, 1984, p. 39). Taylor and Bogdan (1984, p. 127) summarised the process as follows:

- Develop a rough definition of the phenomenon to be explained.
- Formulate a hypothesis to explain the phenomenon.
- Study one case to determine the fit between the case and the hypothesis.
- If the hypothesis does not explain the case, either reformulate the hypothesis or redefine the phenomenon.
- Actively search for negative cases to disprove the hypothesis.
- When negative cases are encountered, reformulate the hypothesis or redefine the phenomenon.

- Proceed until the hypothesis has been adequately tested by examining a broad range of cases.

As new cases are brought for examination, some may be dealt with without altering the established case law. Others, however, require that it be refined, modified, or extended (Edwards, 1991). Bromley (1986) equates the process to the building up of case-law in jurisprudence. The case law represents the product of a progressive conceptual refinement as knowledge from diverse cases is systemised.

Duquesne Phenomenological Research Method (DPRM)

The Duquesne phenomenological research takes as its starting point information about the direct experience of the subject and seeks to elucidate descriptively (Edwards, 1991). Tape-recorded interviews are usually used as data. A carefully phrased question directs the respondent to the type of experience the researcher is interested in. Further questions are asked as they develop out of the spontaneous progression of the interaction between researcher and research participant. The questions that are generally asked are aimed at getting subjects to elaborate on particular aspects of their responses or to speak about aspects they omitted. Usually interviews with several subjects are conducted, but only some of them are used for in-depth analysis. Interviews may be discarded when they do not constitute an aware and insightful description of the experience, or when protocols are deemed not psychologically rich. However, since most respondents do not articulately represent all aspects of an experience, the study of a set of interviews provides the basis for a comprehensive account of the experience being investigated.

Formal procedures for analysing interview protocols that are called DPRM have been described by Edwards (1991), Fisher and Wertz (1979), Giorgi (1975; 1985), Stones (1986; 1988) and Wertz (1985). Colaizzi's (1978) phenomenological methodology, which is not called DPRM, does resemble the DPRM procedures. The major DPRM steps include the following:

- Overall perspective: The researcher reads the material several times to obtain an intuitive,

holistic grasp of the data.

- Natural meaning units or significant statements are identified which reflect the central themes in the protocol. These are statements made by the respondent which are self-definable and self-delimiting in the expression of a single, recognisable aspect of the respondent's experience. The further task of this phase is an articulation of the central themes or clusters of themes that characterise the respective unfolding scenes of each protocol. It is essential to note that each meaning unit exists in the context of the other interrelated meanings of the protocol so that regardless of how clearly meanings are conceptually differentiated from each other there is nevertheless an inseparable relatedness of all these meaning units in their lived sense.
- Revelatory description: Repetitive material and natural meaning units not relevant to the phenomenon being investigated are discarded. At this stage various discrepancies might be noted, like seemingly contradictory themes, or unrelated topics. It is here that the underlying philosophical assumption comes to the fore. The researcher must proceed with the solid conviction that what is logically inexplicable may be existentially real and valid. The temptations of ignoring data or themes which don't fit must be overcome and premature theory generation must be put on hold. Giorgi (1975, 1985) and Stones (1986, 1988) rewrite the material in neutral psychological language in the third person. Wertz (1985) writes it in the first person, following the subject's language as closely as possible.
- Situated structure: The material is organised into a coherent account which reflects the structure of the subjects' experience, situated in the specific life-context of the events described by them. This can be done either through a specific description of a situated structure, which is one which communicates, through a psychological perspective, the unique structure of a particular phenomenon within a particular context, or through a general description of a situated structure, in which one communicates the meaning-structure of a phenomenon in general and which attempts to overcome the limitations of any specific context. There is an obvious tension between the expressed specifics of a concrete situation and the more general description based on psychological insights derived from the explication. It is the intent of the method to arrive at the general by going through the concrete, and not by abstraction or formalisation.

- General structure: The material is organised into a coherent general account of the structure of that type of experience, independent of the specific context.

It might prove valuable to use several subjects in order to prevent possible undetected idiosyncrasies of an individual subject and to facilitate greater fluency with the phenomenon, given the greater variability provided by several subjects. When more than one respondent is used the following steps may be added:

- Extended description: The central themes and processes from the combined situated structures are reviewed and integrated into a coherent and organised summary.
- General structure: The material from several subjects is used to derive a general account of the structure of the experience.

According to Edwards (1991), the DPRM differs from other methods of collecting and analysing interview data in the following manner. Interest focuses on events of everyday life. Researchers strive for an accurate description which is faithful to the phenomenon as it is lived, and which represents the viewpoint of the subject. Key terms and concepts are derived from the material of the interview rather than from preconceived theories and formulations. The research goal is to explicate structure, that is, the inter-relationships between the various components of the experience. This is achieved by giving and seeking meaning through collaborative dialogue with subjects. The relationship is of great importance so that subjects will disclose personal information. Empathic listening and practised questioning are required, and the interviewer must suspend personal judgments and preconceptions regarding what is being described. This process constitutes a fundamental quality of insightfulness into the data, an articulate and differentiated understanding of human experience and command of the language in which it will be rendered.

A critical look at DPRM shows that there might be some problems with the method. In the first place problems arise because researches confuse DPRM with doing phenomenology and take the view that to be faithful to phenomenological principles, all the steps of DPRM must be carried out. DPRM then comes to be used mechanically, just as quantitative techniques often are, and the results of the stages of analysis are presented without any understanding of how they are

situated in the context of specific research goals or questions (Edwards, 1991).

A related problem raised by a phenomenological stance concerns the role of theory and explanation. The principles “back to the things themselves” and “science's task is to understand reality not to dictate it” (Giorgi, 1986b, p. 165) have produced a view that once an idealized understanding of the material is achieved, the further search for theory or explanations has been succeeded. Unfortunately the overgeneralisation of this approach has led to a de-emphasis on theory which is impractical, misleading and limiting (Edwards, 1991).

In the third place DPRM is limiting in that good phenomenological research should provide a well-grounded data base for developing and testing theory. It is in this area that there is a need for integration between DPRM and CSRM. The case study method adopts a less ideological, more pragmatic approach to theory. DPRM needs to evolve into more theory development or at least a critical examination of theory.

Towards an Integration of Methods

Research using in-depth analysis of individual cases, whether in the DPRM or the CSRM mould, is a complex process with many stages. Edwards (1991) discusses this research process as a continuum, from description on the one side, to rigorous theory testing on the other side. The continuum can be divided into four categories that represent points on the continuum rather than exclusive types:

- **Exploratory-descriptive case studies** - the aim is to achieve a richly articulated description of an individual case that furnishes an in-depth understanding.
- **Descriptive-dialogic case studies** - while emphasis is still on faithful portrayal of a phenomenon, the case is expected to embody general principles already articulated in the literature. It can provide an informal test of the content of specific theories or test whether the conceptualisation is adequately differentiated. While there is an emphasis on description, there is also an active search for a language or framework to make sense of

the description or to articulate it adequately.

- **Theoretical-heuristic case studies** - which rigorously develop or test existing theory.
- **Crucial or test case-study** - here the process of rigorously validating theoretical constructs is taken a step further in that a case is selected which provides a crucial test of a particular theoretical proposition.

According to Edwards (1991), DPRM has many features in common with CSRM. In the first place both methods take as their starting point a set of one or more cases of a sort predefined by the researcher. While the data base for the DPRM is always a first-hand account by subjects of their experience, in CSRM information may be gathered from several sources including psychometric testing and interviews (Bromley, 1986). In the second place both methods recognise the importance of providing carefully documented descriptions of individual cases, and thereafter, of drawing out general principles or conclusions (Wertz, 1985). Thirdly, both methods recognise the distinction between the context of discovery and the context of verification in science, and emphasise the importance of the discovery phase which conventional psychological research has tended largely to ignore.

Within the perspective offered so far in this discussion, and as far as this research is concerned, **an integrated strategy which is specific to the phenomenological research part of the general research design** is indicated. It can be conceptualised as **multiple descriptive-dialogic case studies, using DPRM principles for data collection and preliminary analysis.**

This integrated strategy can be justified as follows. DPRM at the technical level offers a meticulously described set of practical steps which enable researchers to organise interview data in a rigorous and psychologically meaningful way. Second, its principles constitute an explicit ethic, reminding researchers to remain faithful to the experience of subjects' integrity and capacity to work as co-researchers (Edwards, 1991). Subjects describe physical symptoms, sensations, overt behaviours, thoughts, attitudes, and emotions. Also implicit in their accounts are

assumptions and beliefs that may not be directly articulated. The complex process of classification of such diverse phenomena and the conceptualisation of their interrelationships need to take into account both dynamic factors and structural factors. The model of theory development based on CSRSM provides a more flexible framework for making decisions about how to transform data and work with theory than does the concept of general structure offered by DPRM. Within the CSRSM framework, analysis can remain at the descriptive-dialogic phase (discussed above) and describe the range of experiences to be related to each other.

Stones (1986) says that since phenomenologically oriented research methodologies will always remain in the neophyte state and since each method develops specifically in a dialogue with the phenomenon to be explored, it is imperative that any method presented should not be seen as absolute. "Rather it should be seen as but one way of delineating general phenomenological principles of research" (p. 121).

The description and selection of and motivation for the specific adopted research methodology have been discussed. This concludes step one of the phenomenological and empirical research, namely the selection of the applicable phenomenological research method.

Population and Sample

The population used consisted of nursing staff. This research was conducted among nurses who are employees of Health Canada, Medical Services Branch. They are registered nurses working for the Medical Services Branch, North Zone, in Manitoba.

- **Sample selection method**

The snowball sampling method (Baily, 1987, p. 95; Lin, 1976, pp. 162-163) was used. Snowball sampling is conducted in stages. In the first stage a single research participant is drawn from the applicable population. This research participant is then used as an informant to obtain other appropriate research participants from the same population who qualify for inclusion in the sample.

In the next stage the newly obtained research participants in turn become informants for identifying further appropriate research participants who can be interviewed in the third stage, and so on. The sample then, like a snowball, becomes bigger and bigger as it rolls downhill. Twenty-three registered nurses practising in hospital and nursing station settings above the 53rd parallel in Manitoba were obtained in this manner.

This is considered an adequate sample size. According to Patton (1990), qualitative researchers should be less concerned with sample size and more concerned with the richness of the information collected. McCracken (1988) suggests that eight people are an adequate sample in qualitative research. Carey (1984) emphasises that a sample of more than eight people results in diminishing returns as data become saturated. The view expressed by Edwards (1991) has been used in this research. Edwards (1991, p. 55) comments that usually "interviews with several subjects are conducted and some four to six interviews are used for in-depth analysis".

- **Biographical and descriptive data**

The ages of the nineteen female and four male nurses ranged between twenty-three and fifty-five. They have all had at least two years' field experience. The nurses in the nursing stations work in an extended capacity, where any possible medical problem dealt with in an emergency unit may present itself at any time. Extended capacity nursing entails having some prescription privileges and in most cases it means that the nurses work without a physician present at the nursing station. All kinds of clinical and emergency work are, therefore, the responsibility of the nurse on duty.

The nurses working in the hospital setting work in a small hospital in a general ward setting. Their work includes a large component of emergency work on a daily basis, as well as care for individuals in the ward. There is, however, a physician on call. In every instance the nursing care done by these nurses is hands on, entails a very diverse range of medical problems, and involves direct patient contact.

This concludes step two of the phenomenological and empirical research, namely the selection of population and sample.

Measuring Battery

Step three of the research method, namely the selection, description and motivation of the measuring battery, will now be discussed. The qualitative measuring instrument will first be discussed, followed by a discussion of the quantitative measuring instruments.

The Qualitative Measuring Instrument

An unstructured interview was selected as a qualitative measuring instrument for research. A description of the unstructured interview will be given, followed by a discussion of its administration, the interpretation of data, and the criteria for interpretation.

Unstructured Interview

The qualitative interview is “one of the most powerful methods in the qualitative armoury” (McCracken, 1988, p. 9). According to Seidman (1991) its power lies in its potential to convey the deep meaning of the subject’s life world and in its great potential to help us understand other people's stories. Interviews were unstructured in as far as the researcher only suggested the general theme of what was to be discussed (Huysamen, 1993).

Administration

A carefully phrased question directs the respondent to the type of experience the researcher is interested in. Further questions are asked as they develop out of the spontaneous progression of the interaction between researcher and research participant. These focused questions or “questions of inclusion” (Gilchrist, 1992, p. 82) aim for a more thorough description and elaboration of themes and patterns. The questions that were generally asked were aimed at getting subjects to elaborate on particular aspects of their responses, and to follow up on what the participant said (Seidman, 1991).

For this research it was decided that the following initial question would be posed: “I

would like you to tell me about the experience of working as a nurse in the north. Tell me how it is affecting you and how it makes you feel. I would like to know whether you find it stressful and whether you feel burned out some times. I would also like to know how you cope with this, or to put it differently, how you stay healthy? Take your time. You can start wherever you like.”

It was decided that to aid clarity during the interview the interviewer would make use of phrases such as “Could you tell me more about that?” or “Could you explain that to me?” in order to facilitate the flow of the interview.

Interpretation of Data

As discussed earlier in this chapter, an integrated strategy for the qualitative interpretation of data is indicated. The importance of providing carefully documented descriptions of the individual cases, and then of deducing general principles or arriving at conclusions is recognised. The specific procedure for interpretation will now be discussed.

According to Edwards (1991), interviews may be discarded when they do not constitute an aware and insightful description of the experience. However, since most respondents do not articulately represent all aspects of the experience, **the study of a set of interviews** provides the basis for a comprehensive account of the experience being investigated. Seidman (1991) talks of the criteria of sufficiency, when the sample adequately reflects the population that is being studied. It is therefore unnecessary to continue to analyse interviews if no new information is being generated.

Stones (1986, p. 121) states that it is imperative not to see any method as an absolute. Having said that, he also states that any form of phenomenologically inspired research must at least meet the following criteria:

- The research interview situation should entail a description of experience/the phenomenon in its lived-world context.
- Explication of the protocols should be concerned with the meaning of data from the

participant's perspective.

- Essential themes should be extracted in their varying manifestations.
- The dialectic between approach, method, and content should be maintained.

The designs of the studies conducted by Colaizzis (1978), Edwards (1991), Fisher and Wertz (1979), Giorgi (1975; 1985), Stones (1986; 1988) and Wertz (1985) lead to the following methodology for interpretation of the interview protocols:

- The researcher reads the material several times to obtain an intuitive, holistic grasp of the data.
- Natural meaning units are identified which reflect the central themes in the protocol. These are also called significant statements that directly pertain to the phenomenon being studied and that are extracted from each interview. This is a purely mechanical process in which the significant statements are extracted from transcribed interview text. The further task of this phase is an articulation of the central themes or clusters of themes that describe the respective unfolding scenes of each protocol.
- Repetitive material and natural meaning units not relevant to the phenomenon being investigated are discarded.
- The material is organised into a coherent account which reflects the structure of the subjects' experience, situated in the specific life-context of the events described by them.
- The central themes and processes from the combined situated structures are reviewed and integrated into a coherent and organised summary.
- Within the Case Study Research Method (CSRM) framework, analysis can remain at the descriptive-dialogic phase: while emphasis is still on faithful portrayal of a phenomenon, the case is "expected to embody general principles already articulated in the literature" (Edwards, 1991, p. 58). It can provide an informal test of the content of specific theories or test whether the conceptualisation is adequately differentiated. For instance, does the lived experience of the individual of burnout and salutogenic properties correspond with the accounts in the literature discussed in chapters two and three? While there is an emphasis on description, there is an active search for a language or framework to make sense of the description or to articulate it adequately - and describe the range of

experiences to be related to each other.

One further issue that needs to be addressed here is transparency in qualitative research. According to Sykes (1991) the task of the qualitative researcher is to strive to communicate the whole research process in a transparent manner. This implies that the researcher must be continually aware of the entire process of reaching research conclusions and be able to communicate these conclusions in a clear, logical fashion (Segal, 1996). Transparency is likewise important to the reader of the research results. "The reader should be able to relate to and interact with the research process as outlined by the researcher" (Segal, 1996, p. 132).

Motivation for the Use of an Unstructured Interview

As indicated in chapter one, it was decided to study the influence of salutogenesis on burnout in the nursing profession from a phenomenological perspective. The idiosyncratic operationalisation of salutogenic constructs in a nursing environment could best be determined and examined by gathering information regarding the individual experience. The unstructured interview, as discussed, would best fit this purpose.

The Quantitative Measuring Instruments

Instruments already in existence that measure burnout were selected for quantitative data collection:

- The Burnout Measure (Pines & Aronson, 1988).
- Cumulative Stress Test (Freudenberger & Richelson, 1980).

Existing instruments that measure the salutogenic personality constructs were used. The measuring battery consists of three questionnaires that determine mastery of stressful situations as a function of personality characteristics. The following questionnaires were selected to measure specific characteristics:

- The Hardiness Personality Questionnaire (Kobasa, 1979; Lambert, 1991).
- The Sense of Coherence Questionnaire (Antonovsky, 1987).
- The Self-control Schedule (Rosenbaum, 1980).

The measuring battery will be discussed in the above-mentioned sequence. Each measuring instrument will be discussed by deliberating its development and rationale, providing a description of the instrument, the administration, the scoring, the psychometric properties and the justification for the use of the questionnaire in the present research.

The Burnout Measure

This questionnaire was developed to measure the theoretical concept of burnout and appeared in print in Pines and Aronson (1988).

Development and Rationale

The work of Pines and Aronson (1988) had a dual focus: research on the causes and consequences of burnout, and application of their findings to the real-life problems of people. The burnout measure was developed by Pines and Aronson (1981) with the help of Kafry, to promote the dual focus and to measure physical, emotional and cognitive weariness. A wide variety of research strategies were used to gather information. They included cognitive and experiential workshops, observation of professionals at work, analysis of responses to extensive questionnaires by professionals describing themselves and their work environment, in depth interviews, group work during short- term and long-term workshops, and individual therapy. A wide range of professionals were utilised in this process, including physicians, nurses, medical and dental personnel, psychologists, psychiatrists, social workers, teachers at all levels of the educational system, policemen, journalists, lawyers, politicians, clergy, and people at all levels of corporate management, coming from different cultural backgrounds. This research provided the information for the development of the Burnout Measure (BM) and for the discovery of the causes of burnout, its effect on people, and ways of coping with it.

The rationale of the BM questionnaire is that it measures burnout as a single score in terms of the three components, physical exhaustion, emotional exhaustion and mental exhaustion. A high score indicates a respondent high in burnout whereas a low score indicates a respondent low in burnout.

Description

The 21 item Likert type self-diagnosis instrument is scored between one and seven per item and the research participant has to indicate a general sense of affect. The burnout scale measures the symptoms of burnout in that the research participant indicates the frequency of different symptoms on a 7-point scale where 1 = never, 2 = once in a long while, 3 = rarely, 4 = sometimes, 5 = often, 6 = frequently, and 7 = always. For Pines and Aronson (1988) burnout always includes a combination of three basic components: physical, emotional and mental exhaustion. Physical exhaustion is characterised by low energy, chronic fatigue and weakness. Emotional exhaustion involves feelings of helplessness, hopelessness and entrapment. Mental exhaustion is characterised by the development of negative attitudes toward oneself, work and life itself.

Administration

The Burnout Measure (BM) can be answered individually or in groups. The instructions appear at the beginning of the scale. "You can compute your burnout score by completing the questionnaire. You can use it for diagnosing how you feel about your work, or for diagnosing how you feel about your life just today or in general. How often do you have any of the following experiences? Please use the scale". There is no time limit for the completion of this questionnaire.

Scoring and Interpretation

The burnout measure is scored as follows to compute a single score:

Add the values of the following items:

1, 2, 4, 5, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 21 = A

Add the values of the following items: 3, 6, 19, 20 = B

$B - 32 = C$ Then, $A + C = D$

Divide D by 21. This gives the burnout score.

As previously indicated, a high score indicates a respondent high in burnout whereas a low score indicates a respondent low in burnout. The following values have been assigned by the writers:

- 2 - 3 Little burnout, you are doing well.
- 3 - 4 Medium burnout, evaluate your priorities and consider possible changes.
- 4 - 5 Severe burnout, it is mandatory that you do something about it.
- 5+ Acute burnout, need for immediate help.

Psychometric Properties

- **Reliability:**

Internal consistency was assessed by the alpha coefficients for most of the samples studied. The values of the alpha coefficients ranged from between 0,91 and 0,93. According to Schaufeli, Enzmann and Girault (1993), this is not very surprising because many items can be considered synonyms or antonyms. They also argue that for reasons of economy the burnout measure can be shortened by half its items without negatively affecting its reliability (Schaufeli & Peeters, 1990). Test-retest reliability of the measure was found to be 0,89 for a one month interval, 0,76 for a two-month interval and 0,66 for a four-month interval (Pines & Aronson, 1988, pp. 220-222).

- **Validity:**

The Burnout Measure's high face validity can be seen in the close correspondence between the items and the theoretical definition of burnout (chapter one, p.2). It can also be seen in respondents' positive reaction to the measure, as individuals experience and define their own level of burnout.

Construct validity of the burnout measure was examined by correlational analysis with several other theoretically relevant measures like job turnover, health problems and work and life satisfaction. For example, burnout was found to be negatively correlated with self-ratings of satisfaction from work, from life, and from oneself in 30 samples (Schaufeli, Enzmann & Girault, 1993, p. 206). The mean correlations across these samples are -0,35 (range -0,31 to -0,63), -0,40 (range -0,37 to - 0,70), and -0,50 (range -0,34 to -0,73), respectively. In one research study involving 322 human service professionals, the following correlations were found: for satisfaction from work, the correlation was -0,62, $p < 0,001$; for satisfaction from life, the correlation was -0,65, $p < 0,001$; and for satisfaction from oneself, the correlation was -0,62, $p < 0,001$. In all cases the highly significant correlations indicated that the more burned out the professionals were, the less satisfied they were with their work, their lives, and themselves. The high, yet less than perfect correlation between burnout and satisfaction from work shows that the two are related, but not identical. All correlations between the individual items and the composite score were statistically significant at the 0,001 level of significance in all the studies in which the measure was used. The overall mean value for over 5000 subjects studied was 3,3.

A factor analysis provided evidence that the measure assesses a single meaningful construct (Pines & Aronson, 1988, pp. 220-222).

Justification for the Use of the Questionnaire in the Present Research

Conceptualisation: The Burnout Measure (BM) developed by Pines and Aronson (1988) has been chosen for this study because it operationalises the concept as it was discussed in chapter two, the burnout concept as developed by researchers such as Freudenberger (1974), Maslach (1976) and Pines and Aronson (1988). Schaufeli, Enzmann and Girault (1993) argue that despite the multidimensional definition of the burnout syndrome by the test authors, the BM was conceived as a one-dimensional questionnaire. They further argue that the BM is thus not a proper operationalisation of the definition put forward by the authors of the BM. They do concede, however, that burnout as measured by the BM is strongly associated with the Maslach Burnout Inventory and that results of studies using both questionnaires are quite comparable.

Utilisation and practical issues: Burnout measurement in the nursing literature is quite prevalent. The BM questionnaire is easy to administer and to score and gives a quick indication of where respondents find themselves in terms of burnout. The fact that the measure can be taken in only a few minutes also makes it a very economical and user-friendly instrument.

Psychometric qualities: The Maslach Burnout Inventory (MBI), another often-used burnout survey, yields independent scores for three aspects of burnout, emotional exhaustion, depersonalisation, and reduced personal accomplishment, rather than as a single overall score. Furthermore, little is known about the interrelationships between these three aspects and Maslach and Jackson (1981) warn that they should be considered separately instead of combined. Stout and Williams (1983), in a comparison of the BM and the MBI, found that the BM correlates significantly with all six dimensions of the MBI. They further found that the BM correlates significantly with health problems and with work satisfaction. They conclude that the BM may be a suitable instrument for assessing burnout in an organisation or system (p. 287). Because of the above research the BM was considered adequate for this study. As an encore to the above discussion, Schaufeli, Enzmann and Girault (1993), were to say ten years later, that the BM is a reliable and valid research instrument that indicates the individual's level of exhaustion, which is considered to be the core element of the burnout syndrome.

Cumulative Stress Test

This questionnaire was developed to measure the theoretical concept of cumulative stress and appeared in print in Freudenberger and Richelson (1980).

Development and Rationale

According to Mitchell and Bray (1990), Herman Freudenberger developed a simple scale in order to help determine if a person is developing cumulative stress reactions. It is suggested that the person should review the changes in his or her life during the past few months. The individual then has to determine whether any changes have taken place in his or her life. The scale was developed on the strength of extensive research into the burnout phenomenon, especially

Freudenberger (Freudenberger, 1974; Freudenberger, 1975; Freudenberger & Richelson, 1980). As far as can be determined, Mitchell and Bray (1990) use the term “cumulative stress” as a substitute for the term “burnout”. This substitution of terms is accepted for the purpose of this study.

The rationale for the use of the questionnaire is that it measures cumulative stress as a single score. A high score indicates a respondent high in cumulative stress whereas a low score indicates a respondent low in cumulative stress.

Description

The fifteen item Likert-type self-rating scale is scored between one and five. A score of one on each item indicates no change in the individual during the past few months, and a score of five on each item indicates a great deal of change in the individual during the past few months. There are no specific components that are measured.

Administration

The cumulative stress test can be answered individually or in groups. The instructions are straightforward and appear at the beginning of the test. “Are you burning out? Look back over the past six months. Have you been noticing changes in yourself or in the world around you? Think of the office ... the family ... social situations. Allow about 30 seconds for each answer. Then assign it a number from 1 (for no or little change) to 5 (for a great deal of change) to designate the degree of change you perceive.” There is no time limit for the completion of this questionnaire.

Scoring and Interpretation

The total score is the sum of the answers. A high score indicates a respondent high in cumulative stress (burnout) whereas a low score indicates a respondent low in cumulative stress (burnout). The higher the score, the more concern there should be about the potential to develop

cumulative stress.

The scoring is as follows:

- 0-25: You are doing fine.
26-35: There are a few things that you should watch.
36-50: You are a candidate for cumulative stress.
51-65: You are well into cumulative stress.
over 65: You are in danger. Your physical and mental health are threatened.

Psychometric Properties

Freudenberger and Richelson (1980) do not review the reliability and validity of the measure. This places the instrument under suspicion. Despite this, it is being utilised both as a self test for burnout (Freudenberger & Richelson, 1980) and in the emergency service stress literature as a test for cumulative stress (Mitchell & Bray, 1990).

Justification for the Use of the Questionnaire in the Present Research

Conceptualisation: The questionnaire used in this study was originally developed by Freudenberger and Richardson (1980). Freudenberger was the first person to name and describe burnout. Although Freudenberger, a clinician, did not bother to standardise the questionnaire, it is widely used to measure the impact of cumulative stress.

Utilisation and practical issues: Burnout and cumulative stress have quite a following in the literature (Mitchell & Bray, 1990; Mitchell & Everly, 1993). The questionnaire is easy to administer and to score and it gives a quick indication of where the respondents find themselves in terms of cumulative stress.

Psychometric qualities: This questionnaire was included in the measuring battery by the researcher mainly to serve as a concurrent validity test for the Burnout Measure (BM). This will be reported in chapter five. Since it has no proven psychometric qualities of its own, it can only

be used to examine and verify the score achieved by each research participant on the BM.

Sense of Coherence Questionnaire

This questionnaire has been selected in this research to measure the theoretical concept sense of coherence (SOC) and appeared in print in Antonovsky (1983).

Development and Rationale

The immediate aim of constructing this questionnaire was to measure sense of coherence in order to test the core hypothesis that the SOC is causally related to health status (Antonovsky, 1987). The development entailed the selection of 51 individuals who met two criteria: First, each respondent had at some stage been subjected to severe trauma with inescapable major consequences for his or her life. Second, each respondent was thought to be functioning remarkably well. Interviews were conducted with the research participants and transcribed. Each research participant was independently classified on a scale of strong to weak SOC, by a panel using Antonovsky's definition of SOC. The protocols of sixteen persons who were classified as having a strong SOC and eleven at the opposite end of the continuum, classified as having a weak SOC, were reviewed. The search was for elements in the individual's way of looking at life that were common to the former group, but absent in the latter and vice versa. Using Guttman's facet design, a mapping sentence was established (Antonovsky, 1987, p.76). At the end of the process, a twenty-nine-item questionnaire was drawn up.

The rationale of the questionnaire is that it measures an individual's personality disposition and global orientation regarding the handling of stimuli in terms of the three components, namely comprehensibility, manageability and meaningfulness. A high score indicates a respondent high in sense of coherence and a low score indicates a respondent low in sense of coherence.

Description

The 29 item Likert type self-rating scale is scored between one and seven per item. A score of one on an item indicates a low score and a score of seven on an item indicates a high score. For Antonovsky (1987, p. 86) sense of coherence (SOC) consists of three components that are “inextricably intertwined”, although they can be distinguished theoretically. The three components are: comprehensibility (11 items) - the stimuli deriving from one's internal and external environments in the course of living are structured, predictable, and explicable; manageability (10 items) - the resources are available to one to meet the demands posed by these stimuli; and meaningfulness (8 items) - these demands are challenges worthy of investment and engagement.

Administration

The SOC can be answered individually or in groups. The instructions appear at the beginning of the scale and are as follows: “Here is a series of questions relating to various aspects of our lives. Each question has seven possible answers. Please mark the number which expresses your answer, with numbers 1 and 7 being the extreme answers. If the words under 1 are right for you, circle 1; if the words under 7 are right for you, circle seven. If you feel differently, circle the number which best expresses your feeling. Please give only one answer to each question”. There is no time limit in which to complete this questionnaire.

Scoring and Interpretation

The total score is the sum of the three subscales and the SOC is reported as a single score. The highest possible score is 203. The total score gives an indication of the respondent's sense of coherence. A high score indicates a respondent high in sense of coherence, whereas a low score indicates a respondent low in sense of coherence. Normative data on the SOC questionnaire present means and standard deviations of a considerable diversity for a variety of samples. This is acceptable in the light of the idea that the questionnaire should produce differences on mean scores among samples that, on theoretical grounds, are expected to differ.

The distribution of responses, as shown by the range of scores and the standard deviations, indicates an instrument that makes a considerable distinction between members of different populations and different cultures. The mean score falls between 160,44, with a standard deviation of 16,69 for Israeli army officers trainees (a group expected to have a very high SOC) and 129,5 for U.S. undergraduates, with a standard deviation of 24,5.

Psychometric Properties

- **Reliability:**

Internal consistency has been reported using Cronbach's alpha coefficient. The average alpha, unweighted for sample size, ranged between 0,84 and 0,93 (Antonovsky, 1987). There seems to be no relationship between sample size and alpha. Kalimo and Vuori (1990) reported a reliability coefficient of 0,93 in their study.

Test-retest reliability varies between 0,91 for a six week period (Radmacher & Sheridan, 1989), 0,76 after one year and 0,41 for a two year period (Carmel & Bernstein, 1990). The test-retest reliability of the measure for two groups was found to be between 0,52 and 0,56 for a one year period and between 0,54 and 0,55 after two years (Sagy & Antonovsky, 1990). Fiorentino (1986) reports a one year test-retest correlation of 0,78.

- **Validity:**

Content and face validity are discussed by Antonovsky (1987). Given the facet approach to construction of the scale, an item was only included after four colleagues, familiar with the theory, had independently concurred that it indeed referred clearly to one and only one of the three SOC components. Antonovsky concludes that the twenty-nine items of the SOC questionnaire “do indeed cover the important aspects designed to be measured (p. 82)”.

Rumbaut as quoted by Antonovsky (1987) reports a type of criterion-related validity, namely concurrent validity, between his 22-item SOC scale and the SOC questionnaire of 0,64.

Dana et al. (1985) found a correlation of 0,72 when using the same two measurements.

As far as construct validity is concerned Payne (1982, pp. 2-3) concludes that the SOC score "was consistently and significantly related to all positive health measures while being significantly and negatively related to all illness measures, and further that the "demonstration of predictable SOC relationship with a variety of external measures is remarkably consistent". The following studies confirm this conclusion:

- **Regarding generalised perceptions of self and environment,** Dahlin et al. (1990) found a correlation of 0,44 between internal locus of control and SOC, while Williams (1990) found a correlation of 0,50 between hardiness and SOC. Petrie and Azariah (1990) reported the correlation to be 0,49 between self-esteem and SOC. Antonovsky and Sagy (1986) reported a correlation of -0,61 between anxiety and SOC while Carmel and Bernstein (1990) found a correlation of -0,69 between the same variables.
- **Regarding perceived stressors,** Carmel and Bernstein (1990) reported a correlation of -0,32 between stressor perception of Israeli medical students at course entry and SOC. Larsson and Setterlind (1990) found the correlation to be -0,33 between work load and SOC and the correlation to be 0,28 between work control and SOC. Radmacher and Sheridan (1989) found a correlation of -0,24 between life stress and SOC, while the correlation was found to be -0,67 between Sheridan's Global Inventory of Stress (GIS) and SOC. As Williams (1990, p. 183) points out, the GIS and SOC "encompass many of the same things ... (the GIS) may also be picking up the antitheses of those qualities or characteristics found in people with personality characteristics which mediate between stress and illness ... these two instruments appear to be measuring similar phenomena in a 'mirror image'". Williams (1990) found a correlation of -0,27 between life events and SOC and a correlation of -0,56 between GIS and SOC.
- **Regarding health and well-being,** Dahlin et al. (1990) found a correlation of 0,70 between quality of life and SOC, a correlation of 0,46 between global health evaluation and SOC, and a correlation of -0,70 between psychosomatic symptoms and SOC. Fiorentino (1986) found the correlation to be 0,19 between health status and SOC, and Sagy and Antonovsky (1990) found correlations of 0,42 and 0,32 between global health

index and SOC. Coe et al. (1990) found the correlation to be 0,47 between perceived health and SOC, a correlation of 0,71 between mental health and SOC, a correlation of -0,35 between disability days and SOC, a correlation of -0,31 between bed days and SOC, and the correlation to be -0,22 between doctor visits and SOC. Larsson and Setterlind (1990) found the correlation to be -0,26 between physical symptoms and SOC, a correlation of -0,31 between systolic blood pressure and SOC, and a correlation of -0,17 between diastolic blood pressure and SOC. At the same time they found the correlation to be -0,59 between psychological symptoms and SOC, the correlation to be 0,40 between subjective well-being and SOC, and the correlation is to be 0,25 between subjective health status and SOC. Williams (1990) found a correlation of -0,39 between serious illness and SOC. Petrie and Azariah (1990), using the Millon Inventory found a correlation of 0,64 between well-being and SOC and a correlation of -0,50 between distress and SOC. Sagy et al. (1990) found a correlation of 0,54 between life-satisfaction and SOC.

- **Regarding attitudes and behaviours** Antonovsky et al. (1990) found the correlation to be -0,39 between attitudes in retirement regarding losses and SOC. Larsson and Setterlind (1990) found the correlation to be 0,29 between problem (positive) focused coping and SOC, and a correlation of -0,53 between emotionally (negative) focused coping and SOC. Sagy et al. (1990) found the correlation to be 0,26 between activity level and SOC.

None of the published studies report a factor analysis of the SOC questionnaire.

Justification for the Use of the Questionnaire in the Present Research

Conceptualisation: Sense of coherence (SOC) was first identified and described in Antonovsky's (1979) principal text, and is the central concept of a salutogenic model. It is only logical that the SOC questionnaire, developed by Antonovsky (1987), has been chosen for this study because it operationalises the concept discussed in chapter three, the sense of coherence concept.

Utilisation and practical issues: The SOC questionnaire has been utilised in numerous studies (McSherry & Holm, 1994; Sullivan, 1993) to measure the sense of coherence concept. It is easy to administer and it gives a quick indication of where the respondents find themselves on the health ease-disease continuum.

Psychometric qualities: The consistent positive correlations between SOC and all positive health measures, while being significantly and negatively related to all illness measures, are a great motivating factor in using this questionnaire. A further positive factor is that normative data from around the world exist for the questionnaire and that the questionnaire can be utilised cross-culturally. The mean scores of three studies found in the literature are of importance for this study (Antonovsky, 1987). These mean scores are an indication of the range that the subjects in this study can be expected to score. The mean score for Israeli health workers was 151,42, with a standard deviation of 17,50; the mean score for Edmonton health workers was 148,63, with a standard deviation of 17,15; and the mean score for Nordic occupational health workers was 146,10, with a standard deviation of 19,90.

Hardiness Personality Questionnaire

The genesis of the hardiness concept can be traced to Kobasa (1979), whose work is central to all hardiness research. The third generation questionnaire used in this research has been developed by Kobasa to measure the theoretical concept of hardiness and has appeared in nursing education-based studies (Lambert, 1991; Langemo, 1990; Pagana, 1990).

Development and Rationale

According to Jennings and Stagers (1994) the proposition underlying Kobasa's seminal research was that people who experienced high levels of stress, but remained healthy, had a different personality structure from people who experienced high levels of stress and became ill. The original hardiness questionnaire was developed by Kobasa (1979). She proposed that hardiness is a constellation of personality characteristics that function as a resistance resource in the encounter with stressful life events. The personality dispositions of hardiness are commitment,

control and challenge. The concept of hardiness corresponds to salutogenic constructs like sense of coherence and learned resourcefulness (see chapter 3). An existential theory of personality forms the basis of the hardiness construct (Kobasa & Maddi, 1977). The initial scale, the “Cognitive Hardiness Scale” went through a series of adaptations after being criticised specifically for its focus on the negative measurement of hardiness (Funk & Houston, 1987). The questionnaire used in this study is called a third generation measurement instrument (Funk, 1992; Jenings & Stagers, 1994), and it consists of both negatively and positively scaled items. It is a 50 item scale and was used by Lambert (1991), Langemo (1990) and Pagana (1990). A newer version is now available. It is a 45 item scale and is called the Personal Views Survey (Maddi & Khoshaba, 1994).

The rationale of the questionnaire is that it measures a person's general hardiness in terms of its components, namely commitment, control and challenge. A high score indicates a respondent high in hardiness whereas a low score indicates a respondent low in hardiness.

Description

The questionnaire consists of 50 self-descriptive statements. The respondent has to indicate on a four point Likert scale how much he or she agrees with each statement. A score of zero on an item indicates total disagreement with the statement and a score of three indicates high agreement with the particular statement.

Hardiness is a constellation of personality characteristics consisting of three subscales:

- **Commitment** (vs. alienation) (16 items) - This is the ability to believe in the truth, importance and interest value of who one is and what one is doing ... and thereby the tendency to involve oneself fully in the many situations of life, including work, family, interpersonal relationships, and social institutions ... an overall sense of purpose.
- **Control** (vs. powerlessness) (17 items) - Those high in control believe and act as if they can influence the events of their experience, rather than being powerless in the face of outside forces. This construct correlates with the internal-external locus of control

construct (Rotter, 1954).

- **Challenge** (vs. threat to security) (17 items) - Life changes are the norm rather than the exception, and these changes are anticipated as a stimulus to growth rather than a threat to security.

Administration

The hardiness personality questionnaire (HPQ) can be answered individually or in groups. The directions are as follows. "Below are some statements that you may agree or disagree with. Please indicate how you feel about each one by marking a cross (X) in the allotted block provided next to each statement. A zero (0) indicates that you feel the item is not at all true; choosing three (3) means that you feel the statement is completely true. As you will see, many of the statements are worded very strongly. This is to help you decide the extent to which you agree or disagree. Please read all the statements carefully. Be sure to answer all statements on the basis of the way you feel now. Do not spend too much time on any one statement". There is no time limit in which to complete this questionnaire.

Scoring and Interpretation

The third-generation instrument does not use standardised scores. The total score is the sum of the three subscales. The highest possible score is 150. The total score gives an indication of the individual's personality hardiness. A high score indicates a respondent high in hardiness whereas a low score indicates a respondent low in hardiness. Kobasa, Maddi and Khan (1982) state that hardiness is an inter-dependent effect of all three subscales and that the separate scores of the subscales should not be used. Bernard and Belinsky (1993) state that the total hardiness score of the third generation questionnaire does appear to be improved from the earlier versions of the questionnaire in the sense that the total hardiness score, at least, has adequate internal consistency and the inter-relationships among subscales are logically consistent.

Psychometric Properties

- **Reliability:**

Internal consistency estimated for commitment, control, challenge and total hardiness scores has ranged from 0,68 to 0,89 in several studies (Maddi & Khoshaba, 1994), and these components have shown the expected pattern of positive intercorrelation with both adults and college students. Parkes and Rendall (1988) report good reliability for the questionnaire. They mention a correlation coefficient of 0,78 between the commitment and control subscales. Manning et al. (1988) report reliability estimates that ranged from 0,75 to 0,90. Test-retest reliability for a two week period has been found to be 0,60 (Funk, 1992).

- **Validity:**

This third-generation hardiness test has shown intercorrelation and validity of component and total scores with adults (Bartone, 1989) and both high school and college adolescents (Parkes & Rendall, 1988). As to concurrent validity, the HPQ has correlated at 0,93 with the second-generation measure of hardiness and at 0,71 when only nonredundant items were used (Bartone, 1989). Campbell et al. (1989) indicated a correlation of 0,89 with a different hardiness measure. As far as convergent validity is concerned, the test has shown the predicted positive association with self-reported health status (Campbell et al., 1989; Okun, et al., 1988) and with the level of immune system T-cells.

According to studies quoted by Maddi and Khoshaba (1994), hardiness has shown predicted positive association with perception of a training program as challenging, maintenance of health over time for disaster helpers, and effectiveness of basketball performance. Subjects undergoing hardiness training have shown more of an increase on this third-generation measure than have controls.

As to discriminant validity, the third-generation measure appears unrelated to social desirability bias (Parkes & Rendall, 1988). "Evidence is accumulating that the third-generation

hardiness test is psychometrically adequate in internal consistency and in yielding commitment, control, and challenge scales with the expected interrelationships that justify deriving a total hardiness score. Further, this test is similar in what it measures to earlier hardiness tests and shows promising construct validity” (Maddi & Khoshaba, 1994, p. 267).

A factor analysis has yielded three factors identifiable as commitment, control and challenge (Maddi & Khoshaba, 1994).

Justification for the Use of the Questionnaire in the Present Research

Conceptualisation: The questionnaire used in this study, a third generation measurement instrument (Funk, 1992), was originally developed by Kobasa (1979) and chosen for this research because it operationalises the concept of hardiness as discussed in chapter three. Maddi and Khoshaba (1994) are of the opinion that hardiness is a general measure of mental health. Other findings (Pollack & Duffy, 1990; Tartasky, 1993) suggest that hardiness is a multidimensional construct. In a useful contribution to this discussion, Jennings and Stagers (1994) suggest that qualitative approaches for the better conceptualisation of the hardiness construct may be useful in differentiating hardiness from competing constructs.

Utilisation and practical issues: Hardiness, as shown in the nursing literature, has had an enduring appeal for researchers. Thirty-five papers about instrument development and research exploring the construct have been found in recent literature (Jennings & Stagers, 1994).

Psychometric qualities: Little consistent documentation (Huang, 1995) concerning the psychometric properties of hardiness was reported in the literature. The current results indicate that hardiness is a single construct with three dimensions. Since the purpose of the use of the questionnaire in this study was to identify high and low scoring research participants, the questionnaire was deemed adequate for that purpose.

The Self-control Schedule

This questionnaire was developed to measure the theoretical concept learned resourcefulness and appeared in print in Rosenbaum (1980).

Development and Rationale

Rosenbaum (1980) developed a self-report instrument to assess individual tendencies in order to apply self-control methods to the solution of behavioural problems. The Self-control Schedule (SCS) was developed with the purpose of measuring specific self-control actions within a cognitive-behaviouristic framework. The concept “learned resourcefulness” was operationalised in terms of learned behaviour and skills that are utilised in specific situations. The types of skills that are measured are based on stress-handling methods (Lazarus, 1976) and on various coping-skills therapies proposed by the cognitively oriented behaviour therapists (Meichenbaum, 1977). Coping-skills therapies are characterised by their emphasis on general coping strategies for dealing more effectively with stressful life events. Self-control behaviours were categorised in the following way (Rosenbaum, 1980, pp. 110-111):

- use of cognition and “self-statements” to control emotional and physiological responses (twelve items)
- the application of problem solving strategies (e.g., planning, problem definition, evaluating alternatives, anticipation of consequences) (eleven items)
- the ability to delay immediate gratification (four items)
- perceived self-efficacy, a belief by the individual in his or her coping ability or competence (nine items)

According to Zauszniewski (1995), these four content areas closely parallel the three conceptual dimensions of resourcefulness identified in the literature. The use of cognition and self-instruction reflects self-control, the application of problem solving strategies reflects self-direction, and the belief in one's coping effectiveness represents self-efficacy.

The rationale of the questionnaire is that it measures the extent to which individuals have self-regulation or self-control in daily situations, which translates as learned resourcefulness. A high score indicates a respondent high in learned resourcefulness whereas a low score indicates a respondent low in learned resourcefulness.

Description

The 36 item 6-point Likert type self-rating scale is scored between +3, which indicates that behaviour is very characteristic of the respondent, and -3, which indicates that the behaviour is very uncharacteristic and extremely nondescriptive of the respondent. The SCS was designed to measure the four content areas described in the previous section, namely self statements, problem solving strategies, delaying immediate gratification and self-efficacy.

Administration

The Self-control Schedule (SCS) can be answered individually or in groups. The instructions appear at the beginning of the scale. "Indicate how characteristic or descriptive each of the following statements is of you by using the codes given below.

- +3 very characteristic of me, extremely descriptive
- +2 rather characteristic of me, quite descriptive
- +1 somewhat characteristic of me, slightly descriptive
- 1 somewhat uncharacteristic of me, slightly undescriptive
- 2 rather uncharacteristic of me, quite undescriptive
- 3 very uncharacteristic of me, extremely nondescriptive".

There is no time limit for completing this questionnaire.

Scoring and Interpretation

Scoring of the Self-control Schedule (SCS) requires the reversal of eleven negatively scaled items out of the 36 items. The total score is the sum of the individual items and is an indication of the respondent's learned resourcefulness. A high score indicates a respondent high in learned resourcefulness whereas a low score indicates a respondent low in learned resourcefulness. The SCS has been used in a number of studies to distinguish between high and low resourceful participants. Normative data on the SCS indicate that means for Israeli students ranged from 23 to 27 (standard deviation ranged from 21-25). The SCS means obtained from a sample of American students ranged from 25,9 to 27,5. This indicates that the SCS might be applicable cross-culturally (Rosenbaum, 1980).

Psychometric Properties

- **Reliability:**

Internal consistency has been reported using data obtained by the use of Kuder-Richardson formula 20. The alpha coefficients for the Self-Control Schedule (SCS) obtained ranged from 0,78 to 0,91 (Rosenbaum, 1988). These levels of reliability were considered satisfactory. Redden et al. (1983) reported a Cronbach coefficient alpha of 0,82.

Test-retest reliability, using the Pearson correlation between the scores at the two testing periods, was 0,86 over a four-week period, indicating a fairly high stability of test scores. The mean score at the first testing was 25,1 (with a standard deviation of 23,7) and at the second testing 24,4 (with a standard deviation of 25,1). The difference between the means was not significant (Rosenbaum, 1980). Leon and Rosenthal (1984) reported a correlation of 0,77 after an interval of 11 months.

- **Validity:**

“In contrast with other existing behavioural assessment instruments the validation of the SCS is a complex task since self-control behaviours are mostly covert and must be inferred from the behaviour of a person under specific circumstances or from self reports” (Rosenbaum, 1980, p. 115). Convergent validity and discriminant validity of the SCS were examined by comparing scores obtained on the SCS to scores obtained on a number of existing scales. The SCS had low, but statistically significant, correlations with Rotter's I-E Locus of Control Scale, the Irrational Beliefs Test of Jones, and the G Factor (self-control) of Cattell's 16 PF (Rosenbaum, 1988, p. 493). In addition, the SCS was found to correlate with Fitz's Self-Esteem Scale and with various kinds of antidepressant cognition and behaviours. High correlations were obtained between SCS scores and assessment of specific self-efficacy expectations in situations that require self-control behaviour (Leon & Rosenthal, 1984; Rosenbaum & Ben Ari, 1985).

A factor analysis performed on the SCS yielded three factors: problem-focused coping, mood and pain control, and externality (Gruber & Wildman, 1987, as quoted by Rosenbaum, 1988).

Justification for the Use of the Questionnaire in the Present Research

Conceptualisation: The Self-Control Schedule (SCS) questionnaire developed by Rosenbaum (1980) has been chosen for this study because it operationalises the learned resourcefulness concept discussed in chapter three. The self-report instrument has been developed to assess individual tendencies to apply self-control methods to the solution of behavioural problems. Rosenbaum (1980) says that the SCS will be useful to the researcher who wishes to assess individual differences in the tendency to employ self-control methods.

Utilisation and practical issues: The SCS is a reliable measure and a number of studies have supported its validity (Rosenbaum, 1980). The SCS is also helpful in evaluating increases in resourcefulness (Zauszniewski, 1995). The questionnaire is easy to administer and to score and it gives a quick indication of the research participant's level of resourcefulness.

Psychometric qualities: Two measures of resourcefulness are currently available: the Tower-Scarr Index of Priorities and the SCS. Empirical studies of resourcefulness have consistently used Rosenbaum's SCS as the measure of learned resourcefulness (Zauszniewski, 1995). For this reason the SCS has been chosen for this study. Further research results (Rosenbaum, 1980) also suggest that research participants scoring high on learned resourcefulness are not less sensitive to noxious stimulation than research participants who score low on learned resourcefulness, yet they are perceived as having greater control over painful feelings and are able to tolerate pain better than research participants low on learned resourcefulness. This is additional evidence for the construct validity of the SCS as a measure of self-control behaviours.

This completes step three of the phenomenological and empirical research.

Administration of the Measuring Battery

Respondents were contacted and interview appointments were set up. The quantitative measuring battery was sent to respondents who completed the questionnaires and brought them to the interview.

In-depth unstructured interviews with twenty-three nurses who have had practical experience of stress and burnout were used. All interviews were tape recorded. The ensuing open-ended interview was conducted in an informal, non-directive manner, the interviewer attempting to influence the subject as little as possible (Stones, 1986).

Most interviews took between sixty and ninety minutes to complete. All the research participants knew the interviewer through prior work contact and therefore had prior and subsequent contact with the interviewer. A "trusting relationship" which is the foundation for an effective, in-depth, qualitative interview (Segal, 1996, p. 138), already existed between the interviewer and the research participants.

This completes step four of the phenomenological and empirical research.

Data Analysis

The following data analysis steps were executed:

- The qualitative data collected were interpreted by following the criteria for interpretation and the interpretation procedure as discussed in the phenomenological research method earlier in this chapter for seven research participants.
- Each research participant's quantitative measuring battery was scored according to the scoring and interpretation guidelines of the relevant questionnaire.
- Since individual rating may be considered unreliable because valid norms for some of the research instruments are lacking, the mean scores ($n = 23$) obtained in this research were selected to act as arbitrary cutoff points for the research participants in this research.
- The quantitative results of this research were compared with the normative data provided in the discussion of the measuring battery and the mean scores of the measuring instruments found in the literature. The mean scores reported in the literature are an indication of the range within which the subjects in this study can be expected to fall.
- The information gathered from the psychometric instruments was used to divide the research participants into high burnout prone individuals and low burnout prone individuals as well as to find out whether each individual scored high on salutogenic properties or low on salutogenic properties. The reason for this is that one would expect, from a quantitative perspective, that an individual who scores high on burnout would score low on salutogenic properties and an individual who scores low on burnout to score high on salutogenic properties. It is expected that the salutogenic properties act as generalised resistance resources and have buffering effects on stress and burnout. The possibility exists, however, that the mere presence or absence of burnout symptoms is not enough to explain the individual's functioning. Entering the life world of the individual might prove more informative.
- It was ensured that all research questions had been answered.

This concludes step five of the phenomenological and empirical research.

Hypotheses

The central research hypothesis underlying this research was given in chapter one. The hypothesis states that, seen phenomenologically, salutogenesis and specific salutogenic constructs have an influence on the experience of burnout in the nursing profession.

The following hypotheses were formulated from this central research hypothesis:

- H0: Seen phenomenologically, salutogenesis and specific salutogenic personality characteristics have no influence on the experience of burnout in the nursing profession.
- H1: Seen phenomenologically, salutogenesis and specific salutogenic personality characteristics have an influence on the experience of burnout in the nursing profession.

This concludes step six of the phenomenological and empirical research.

Chapter Summary

A discussion of the empirical research method included a review of the empirical aims of the study, a discussion of the population and sample, and a discussion of the measuring battery. Three questionnaires that determine mastery of stressful situations as a function of personality characteristics were discussed, namely the Hardiness Personality questionnaire, the Sense of Coherence questionnaire and the Self-control Schedule. Two instruments already in existence that measure burnout were also discussed, namely the Burnout Measure and the Cumulative Stress Test.

Each measuring instrument was discussed by deliberating its development and rationale, providing a description of the instrument, the administration, the scoring, the psychometric properties and the justification for the use of the questionnaire in the present research.

The information from the quantitative data collection procedure will be utilised to add to the information gathered by the multiple descriptive-dialogic case studies that will be reported in

general principles that were being sought for:

Three sub-aims were formulated in chapter one:

- * Sub-aim 1
To study the causes of burnout in the individual nurse from a phenomenological perspective.
- * Sub-aim 2:
To determine the symptoms of burnout in the individual nurse from a phenomenological and empirical perspective.
- * Sub-aim 3:
To study, from a phenomenological and empirical perspective, the influence of salutogenic constructs, as operationalised by the individual nurse, on the experience of burnout.

The extracted significant statements were thus re-ordered and categorised into the following three central themes: **What causes burnout in the nursing profession; What are the symptoms experienced by the individual and what are the consequences of the symptoms for the individual; How do nurses operationalise salutogenic qualities in their lives when they experience burnout?**

Theme Clusters

The fourth step in the analytical process is that meanings, as they became apparent under the central themes, will be formulated for the extracted significant statements and these units of meaning will then be categorised. Each central theme cluster will further be categorised into subclusters or theme clusters. It should come as surprise that these theme clusters not only come from the significant statements in each interview, but will embody the general principles already articulated in the literature. They will both provide an informal test of the content of specific theories and examine the question whether the conceptualisation is adequately differentiated. There will be an emphasis on description. At the same time there will also be an active search for a language or framework to make sense of the description and describe the range of experiences as they relate to each other.

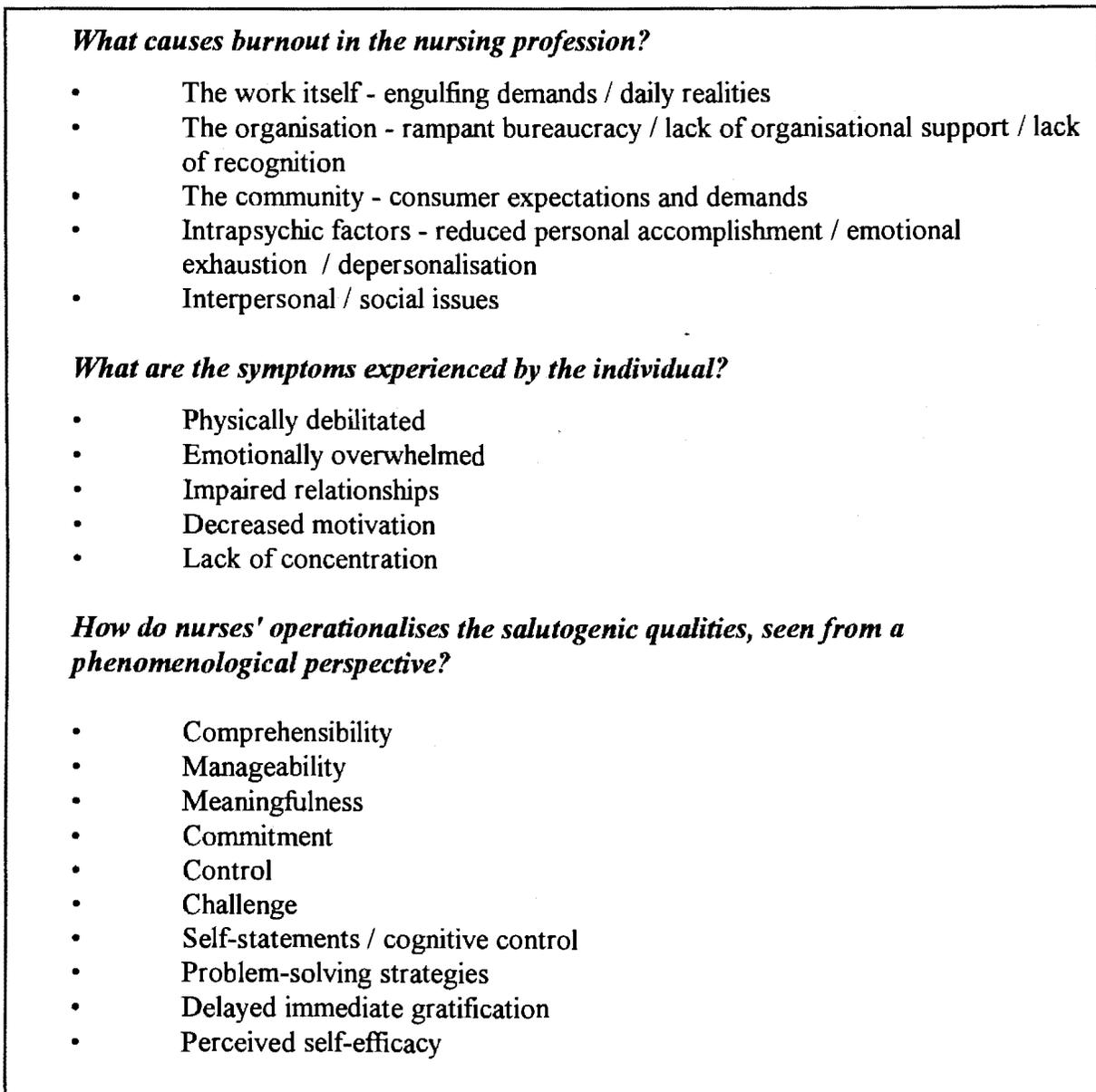


Figure 5.1: Theme clusters

Each central theme cluster will be further categorised into subclusters or theme clusters. The central theme of what causes burnout in the nursing profession was divided into the following theme cluster: **the work itself, the organisation, the community, intrapsychic factors and interpersonal /social issues**. The central theme of which symptoms are experienced by the individual and their consequences was divided into the following theme cluster: **physically debilitating, emotionally overwhelmed, impeding relationships, decreased motivation and lack of concentration**. The central theme of how nurses operationalise salutogenic qualities in

their lives when they experience burnout was divided into the following theme cluster: **commitment, control, challenge, comprehensibility, manageability, meaningfulness, self-statements/cognitive control, problem solving strategies, delaying immediate gratification, and perceived self-efficacy.**

These procedures will be repeated for each of the interviews. Following this the formulated meanings of all the interpreted interviews will be presented in summary form. Then the central themes and combined situated structures of all the interpreted interviews will be reviewed and integrated into a coherent and organised summary.

Central Themes – Respondent # 1

What causes burnout in the nursing profession?

I don't think that you can get out of here and not be burned out.

There is just too much going on with the job. There is too much.

They are providing absolutely no support.

They're supposed to be giving all these things to these nursing stations and they're not, they don't give you what you feel you need to practice as a nurse.

You're not getting all the staff that you need to practice as a nurse,

If nurses were to look at what it is they're doing in their practice and their own practical nursing training, they'd realise that they're not practising correctly .

It's because of the constraints of the Federal Government that they're not doing it.

So you've got the Federal Government contributing to your burnout in your practice.

You've got a community that, for the most part, knows that you're here for money,

They know that you're here because it's a job and you're getting paid well to do the job, they put expectations on you to perform

You get one bad apple who will colour your view of the community for everyone else,

Even if someone who is nice to you, you can't see it because all you've seen is people who are bitter and angry that you happen to be there.

It's particularly if you're white and it becomes even a greater issue.

It happens to the Native nurses as well but particularly if you're white.

Your reason for being there will always be questioned,

when you stay, your reason for staying will be questioned.

Why are you staying here? Do you really like us, or are you just going to leave in ten years?

When I'm not there they ask when I'm going to go back, but I'll always be seen as a nurse.

I won't be able to separate myself from that role that I can do that with my own family.

If they do come up here with their family, eventually Medical Services is going to get to them.

I think eventually it's the employer or the community that will make them move.

They'll either see that they're not doing any good.
Nurses leave because they just cannot put up with it any longer.

When I start to feel like I'm doing it by myself, that's when I know I'm getting burned out.
When I feel like I'm the only one who is doing anything.
When I feel like I'm isolated then I know that I'm starting to get fried.
There's a fair amount of negative things going on here.
A lot of the nurses don't feel like they're doing anything.
They feel like they're just spitting into the wind.
They feel nothing is happening with regard to their work.
They feel there's always a lot of patients that's going to keep coming every day.
They feel it is going to keep coming every day because it's a very sick community.
They feel we have to provide a service and that's the position that we're in.
They feel we're in a service position and we have to do what we have to do.
I think that a lot of them, particularly the ones that have been here a while or been around a while, do not see any purpose to their being in the north.
I don't think that you should have this view of coming to the north in order to make a lot of money so that you can live your life at a later time.
I feel that if you're not living it while you're up here, you're never going to get satisfaction from it.

I'm running into nurses who feel that after all these years, there is just nothing more that they can do.

I was really, really constricted by my supervisors.
what it was they were telling me I had to do and what I knew that I wanted to do.
they are working in a set of rules and they look at it and what their idea of what they should be doing is different from the person that they're working under.

The money -- you cannot get paid enough money to do this job as far as I'm concerned, the work we do deserves probably twice the amount of pay for what we're doing.

We're in a service industry and service industries, except for physicians, are always very underpaid people.

We have lost control of where we've been and what we're doing and I don't think that we're getting paid enough.

I'm getting paid for what I'm doing and I'm getting rewards on the side for what I'm doing.

If I'm at the point where I feel like I haven't got a list in my mind anymore, then I'm getting tired.

I've got two kids in school, now, so I can't just pick up and go like I used to.

But I'm not sitting during those times when I'm not exercising,

I mean I'm cleaning the house and taking care of kids.

But I ended up leaving there because my family life was suffering.

I think you're always on the balancing act between your family life and your work life.

The only thing that pushes you over, if they don't support their nurses.

They don't let them know that they are doing something, you are doing something of value here.

It helps to be told from the outside. It helps.

If they don't see that they're doing anything then the balance gets tipped

you end up being fried as a nurse.

It goes right into your personal life because you can't separate the two.

You're one person, you can't separate.

So I feel like it's always the balancing act for the nurses.

I have become very, very cynical about the Federal Government and it's ability to provide for the nurses.

We've got this bureaucratic system above us that is working because we are out there.

The only reason that they have jobs is because we are working here

yet the attitude that we get from the upper echelons is that they are the ones who are supposed to create the rules,

they are the ones who have the complete power over what's going on in the field when it's supposed to be the other way around.

I used to feel that they were working for us, but I don't anymore.

I think that most of those people have not seen a nursing station, they don't know what it is we're doing here.

When they start questioning what it is we're doing here and saying that they know better, then they shouldn't be doing it anymore.

A lot of what we should be doing is being held back by the bureaucracy.

I think that that in itself is contributing to burnout, that nurses are getting the feeling that they just don't matter to anyone after a while.

I think it's something that always has a potential for being there,
all you need is the right environment for it to flourish.

To me burnout is part of the job.

If you think that you are going to come to the north and not get tired of the job after a specific period of time, then you're kidding yourself.

As soon as they come in I tell them to make sure they're planning a break in about four months' time because they will get tired.

I don't know what it is that's causing it.

I think that there's a lot of pressures on the nurses to do a lot of things that they just don't feel are working after a while.

They can't get what they need.

If they got out every second weekend,

if they had some kind of support system in the community,
a friend in the community

someone that they can talk to and someone that they can just let loose with every once in a while,

They're contained in the nursing station and they stay in the nursing station,

they work in the nursing station and the only time they really get out is to go to the store and

come back.

If I see a nurse doing that day after day after day, I know that they're going to burnout

Either way if you're happy with your job or you're not happy with your job, you still have to have a life.

When I see nurses who will work every day and not have a life outside of their job, I know that they just can't possibly be coping.

If you don't have anything going on outside your work, you're not living.

I don't think you can come particularly into the north and work day after day after day after day, and live your life every four months on the vacations. I don't think that you can do that.

You have to find some sort of a happiness on a daily basis up here, something outside of your work.

If I get a complaint that's directed right at me, I take it very personally because I feel like I have not done what it is I wanted to do.

It adds up with me because I'm living here in the community too.

If I start not satisfying a lot of people then people aren't going to like me in the community either.

You know what Medical Services, now, they've designed a critical incident stress program that pulls nurses out of the community and sends them on talks to someone and they'll pay for the first five sessions which is very gallant, but five sessions doesn't cut it.

They put this band aid on an entire problem that isn't going to be solved.

They aren't talking to the nurses,

they aren't saying, "What can we do for them on a daily basis that's going to help them?"

Maybe we should make sure they have adequate numbers of staff every day so they don't get tired at work.

Maybe we should provide them with some positive feedback for what they're doing and you do not get that.

The nurse who is burned out will not recognise it.

It is someone else who points it out and then that nurse has to come to terms with it -

either choose to get out of the job for a while or revamp her life in order to make sure that they're fending it off a bit better like upset the balance a little bit so that they can get back on course again.

What I've seen is usually an event that will get the nurse out and

this wonderful critical incident stress program which is going to fix the event but it does nothing for the ongoing day to day burnout involving the job.

Until they stop this wheel from rolling they're just not going to be able to hang on to their nurses.

There aren't nurses (inaudible) their rations. The nurses aren't allowed to buy junk food, diet pop, pop at all. Nurses drink pop. Nurses eat popcorn, they eat granola bars.

These are all things that they've now been told they're not allowed to buy them.

It's like it's this great big thumb of that the government is on top of you and it will always tip the balance.

The things that will always tip the balance is some sort of personal event or some sort of problem with the community if the community starts to do some political gesturing which has happened (inaudible).

As soon as they start to bring politics into the nursing station, the nurses really feel like they aren't doing anything when the politics starts.

The community thinks we're not good enough.

Well, if they would look at it from the outside, no, we are providing a good service, but is this community getting what it should get in terms of the city standards, no, they're not. They're not getting what they should get and they have a right to choose that, in fact they should be encouraged to do that. when you're told that again and again and again that you're no good then you start to believe that.

They will say that this nursing station is not satisfactory and they're right.

The nurses have to allow them to say that and still be able to continue with their work.

I feel like I've got a lot of responsibility to the running interference for this community, so it's quite a bit of stress for me

If I see a nurse that doesn't like the community I know that they just aren't seeing a lot of the good,

they're only seeing the bad.

I'm always trying to help them see that, but right now I'm actually at the point now where (inaudible) nurses do that because I can't take on the responsibility (inaudible). I'll just (inaudible) myself a lot and I shouldn't.

All I'm doing now is I tell them where I'm at, this is how I feel about it and I as a manager will do this.

What are the symptoms experienced by the individual and what are the consequences of the symptoms for the individual?

My problem is more rooted in the fact that I get tired from work,

I'll go home and I'll sit instead of keeping myself mobilised.

I think that half the battle to staying healthy is keeping yourself mobilised keeping yourself moving and doing something,

I feel like I must be constantly running ahead of burnout.

I don't know if it works for me because I -- right now, I'm not exercising, I haven't got any crafts to do.

Right now I've got a project, I'm taking an ECLS course

It's certainly going to increase my self-esteem if I pass the course, so it's good.

I have to do a lot of things that I don't necessarily feel like I want to do in order to stay healthy.

I have to do a lot of things that I don't necessarily think are useful.

I feel that burnout is a very pervasive thing,

Burnout creeps up on you and you're not aware of it.

You will become tired,

you will be aware that you are tired but you'll think that you're functioning quite well on the job.

This will go on for a period of between one and two years.

Your heart won't be in it after a while.

You'll be able to get all your tasks done during the day but your satisfaction will decrease and decrease,

then there will be an event that will shake you.

It will be an assault, it will be something in your personal life.
 With me, when my father died, that was the event.
 There is always an event that will make you look and realise that you just were not coping with the job.
 You have to get out and re-evaluate.
 You're not just re-evaluating your job, you're also re-evaluating your personal life.

They're just too tired,
 they're just too tired because of the demands of the job.
 I just no longer could see any point to it.
 I was just tired.
 I was really bound by other people's feelings.
 I think that I lose sight after a while.
 I just get tired of all the stuff and I look for someone to blame.

If you don't have any other supports or any other outlet, anything just for you, then you lose sight of the point to it all,
 it starts to build up.
 It's very, very small, it starts to invade you, tiredness at night and not sleeping.
 You're feeling like you don't really want to come into work that day.
 I don't want to come into work every day
 When I wake up in the morning I'm either overwhelmed with all that I have to do
 I feel like, well, there wasn't really anything I have to do,
 I know that if I have to look at that because there is always something to do in this job.

I'm losing sight of what it is that I should be doing.
 If I don't see them(my family) twice a year I feel that.
 I feel like I am homesick
 I feel like I want to go home and that will probably happen to me for as long as I remain here.

Do you think you can learn? I think I might have become stronger,
 I think I've become very keen in my ability to recognise when I'm getting burned out.
 Because I look at myself now and I look at myself in say 1986, 1985, when I had a social life,
 I was fending off burnout then just as well as I'm doing it now,
 but the things that I did then was I would walk, I would write letters, I would listen to music.
 Of course I had no other people in my life that I was responsible to so the things that I did then were different.
 It's because of the way that my life has changed now that the way that I have to deal with the burnout is different.
 I would still like to see this lost life of writing letters and reading books and listening to music.
 I think that my ability to deal with burnout is I don't think it's changed all that much
 I can recognise it more.
 I can put more of an effort into trying to stay ahead of it, rather than letting it get to me.
 I think you can go through burnout once and you might learn from it.
 You might learn from it and you might not -
 you'll likely go through it again.
 I think it's the second time that gets you.

I think it's like getting stung by a bee.

You knew in your mind that you were supposed to do something about it and you didn't do anything about it and you still let it happen.

At least I'll tell people. I think in this situation I'll tell them, if you see I'm not coping with the job then you better tell me.

Don't hide it from me and make sure that within two to three years I have made a significant life change that's going to get me out of the position.

I do not think that anybody can do this job long term, particularly nurse in charge but even community health nurse.

I'm not taking that little bit of extra time to take care of me.

I think regardless for me personally I'd still think I'd have to get out of this job every two to three years.

I wasn't satisfied with the work anymore,

I sat on a couch for seven months. I got up in the morning, I turned on T.V. at eight o'clock in the morning, I watched T.V. until five o'clock at night everyday. It was like my work schedule. That is exactly what I did.

I should have been happy. I should have been happy to be in the city but I was so fried that I did nothing.

All I did was get up and I watched soaps and talk shows all day long and I waited for my husband to come home and I had no money.

I have to force myself to go outside when I don't feel like I want to go outside but I feel better for having done it.

That is actually the biggest battle is trying to get on the cycle of the things that make you feel good,

the things you have to make yourself do until your body wants them, until your body gets into this routine,

if you don't get into that routine of doing things that are going to make you healthy, then you'll just sit and you won't ...

it'll creep up with you in your own life.

I left because I knew it was time to leave this community.

I felt that if I didn't get out of the community I wouldn't be able to stay in the community long term (inaudible) at a later date.

I just didn't feel that what we were doing in the clinic at that time was going to achieve any goal. usually I'm very goal - directed during the day.

I try and get a certain number of things done and clear my desk

I can't always do that.

I think it happens probably about after three months even from starting.

I know that if I don't get out in November or December, I'm going to be very, very tired.

I know that if you haven't got any support systems outside this Federal Government building, you cannot make it.

you can't live a life just for a job.

How do you stay healthy, how do you cope? Well, I don't. Well, I obviously don't because I get burned out every two years.

"I don't believe that anybody working here will not burnout."

I don't stay healthy,

I just know when it's time to get the hell out.

I've got a life outside work, but I've got two kids to take care of, I've got a husband who I live with and have to maintain a relationship with and it's work, it's work to maintain this family life outside my work.

I will look at that and I go well, where is the time for myself?

Because there isn't any.

The actual only time that I get to myself is between twelve and one when I go home for lunch and there's no-one there.

I take my time for myself when there's no one else around.

I have to find little things to do,

most of it is work, it's work around the house or something like that.

But what I know that I need to do is I need to exercise.

I need to get outdoors.

I need to have a project that's going to provide me with something at the end like a craft,

I haven't got the time to exercise

I haven't found a time of day when I feel like I can do that so I have to do that.

I don't exercise.

I don't find the time for myself.

I don't sit down and read a good book like I used to.

I don't write letters like I used to.

Things that used to make me very, very happy, I don't do them anymore.

it's because of my lack of time or my lack of ability to find the time.

I find the time for all the other things but I can't find the time for myself,

that's probably why I am in this two to three year cycle of burnout.

I don't know what the difference is between me and the other nurses.

I felt that I would never go back into a station.

I got to the point where I was so tired from doing the same thing day after day after day after day.

I can't blame myself because I know that I'm working hard so I never look at myself when I'm getting burned out.

I always seem to look outward and try and look for something else, the cause of that.

I have to have time for myself on top of that.

It's hard to do. You can't leave all the time, you can't be gone all the time.

That will stretch out into my home life, and I don't want that.

I try and separate myself from that but I can't really do it.

How do nurses operationalise salutogenic qualities in their lives when they experience burnout?

I think it's like depression.

I think that everybody has a propensity to be depressed and you choose not to be depressed,

you choose to be happy,
 you choose to find something that is going to prevent you from becoming depressed.

You can choose to have a healthy, mental attitude, and that comes with work.
 You choose to always be fending off burnout.

I've got a support system outside the community with his family.
 I know that if something were to ever happen to me at this nursing station, I would still have a life here, I would still live here. that's why I know that I need to get out of this position every two years so I don't lose sight of why it is I'm here.
 I'm here because I feel that I've been doing a good job.
 When I'm not doing a good job then I need to step out of the position for a while, put it back into perspective and then start again after that.
 I take it very personally.
 I try not to because that can affect me long term.
 I'm here to do a job, but I know that if I didn't have that personalised attitude towards the work, I don't think I'd be able to cope.
 I stay goal-directed in my daily tasks.

There's a fair amount of negative things going on here but really there isn't.
 If you really look closely at what you're doing and if you're finding some happiness in what it is that you're practicing.
 It's time to either make a change -
 make a move in a different direction.
 That's probably why I change so much in what I'm doing at work.
 That's probably why I change what I'm doing at home too.
 I'm trying to avoid static,
 I'm trying to avoid being in one spot.
 I feel like if I stay in one spot and keep doing the same thing day after day after day after day after day, I'm going to get burned out, so I try to avoid that at all costs.
 If you're happy with what it is that you're doing at that time and you're doing your best for that client,
 when you send them away you really do feel like you've done something.
 If you don't see a purpose to why you're here then you should reconsider why you are here .
 You will never be happy up here unless you are gaining some sort of satisfaction from your daily work.
 I find it tremendously satisfying.
 I feel like I'm doing something,
 I feel like I'm doing more than I would be had I remained in the city.,
 I'm doing what I was meant to do.
 I feel like I'm doing what I'm good at.
 I think that the satisfaction that I get is probably what's keeping me here.

I'm less restricted.
 I'm more independent in my ability to do things.
 I can deal with people on a one to one without having restrictions placed on me.
 I can pretty well practice in the way that I want to practice.

I feel like I have a lot of control over what it is I want to do for the community.
 I feel like I have a lot of control over where I see the health care going for the community.
 I feel like when I'm making decisions I'm making long term decisions that are going to affect a lot of people.
 Any of the changes that I make, even though it seems like slow change, I know that with time a lot of it will work.
 I can use a lot of input from people I work with in terms of programs that everybody's going to be happy with.
 I feel like when I'm working with this community I'm working with a lot of people in order to build something.
 I don't feel like I'm doing it by myself.

I recognise that we have to provide a service and that's the position that we're in.
 I run across a lot of nurses who don't recognise that we have to provide a service and that's the position that we're in.
 I wonder if I'm on the same track as those nurses.
 I had absolutely no preconceived ideas as to what I was going to be doing.
 It was all a complete surprise to me when I got up here and I liked the work from the start.

They're saving a lot of money, they're working for the money.
 The only positive thing they can see with regard to their work is the pay cheque that they're getting.
 I find it really hard to believe because money has never been that issue with me.

The reason that I'm happy with this job is because I get satisfaction from it.
 I see these people and I know them.
 I know either them, personally, or I know their families or I know something that has happened to them in the past that connects me up with them.
 I see them and I see them for their ailment and I send them away satisfied.
 I have to find satisfaction in parts of my life that aren't necessarily right there
 You know, like bath time with the kids, I love that.
 I'll take them for a walk up the road and down Saturday mornings and those are the things that are really ...
 I think that you can lose sight of your family life too
 I need to know that I've got a family there and I can get support from that as well and I have a responsibility to these children. I brought them into the world.
 My husband has a responsibility to the family. I'm responsible. We're all this unit and we're responsible to keep each other together and doing things as a family.
 it's difficult to find the time to do that.
 You have to work to find the time to make a family life,
 I've got goals outside of work that have absolutely nothing to do with my nursing.
 I leave here and I'm thinking on the way home, what am I going to make for supper tonight.
 I'm finding enjoyment in those things that are right in front of me.

I shouldn't have to look very far. That's what they say about having kids, you don't have look very far. It's right there.
 I always try and tell them when they are doing well because I think that people need that, I think

they need to know that.

I'll tell nurses, "Boy, that patient really likes you. It's obvious you've got a good rapport with them."

Theme Clusters - Respondent #1

What Causes Burnout in the Nursing Profession?

The work itself (engulfing demands / daily realities)

I don't think that you can get out of here and not be burned out.
There is just too much going on with the job. There is too much.

To me burnout is part of the job
if you think that you are going to come to the north and not get tired of the job after a specific period of time, then you're kidding yourself.

The work we do deserves probably twice the amount of pay for what we're doing.
We're in a service industry and service industries, except for physicians, are always very underpaid people.
We have lost control of where we've been and what we're doing and I don't think that we're getting paid enough.

I think it's something that always has a potential for being there
all you need is the right environment for it to flourish.

I think that there's a lot of pressures on the nurses to do a lot of things that they just don't feel are working after a while.

The organisation (rampant bureaucracy / lack of organisational support / lack of recognition)

I have become very, very cynical about the Federal Government and its ability to provide for the nurses, they are providing absolutely no support.

We've got this bureaucratic system above us, they are the ones who are supposed to create the rules,
they are the ones who have the complete power over what's going on in the field -
I used to feel that they were working for us, but I don't anymore.
I think that most of those people have not seen a nursing station, they don't know what it is we're doing here.

When they start questioning what it is we're doing here and saying that they know better, then they shouldn't be doing it anymore.

A lot of what we should be doing is being held back by the bureaucracy

I think that that in itself is contributing to burnout, that nurses are getting the feeling that they just

don't matter to anyone after a while.

They don't give you what you feel you need to practice as a nurse.

You're not getting all the staff that you need to practice as a nurse,

if nurses were to look at what it is they're doing in their practice and their own practical nursing training, they'd realise that they're not practicing correctly.

It's because of the constraints of the Federal Government that they're not doing it.

So you've got the Federal Government contributing to your burnout in your practice

I was really, really constricted by my supervisors,

what it was they were telling me I had to do and what I knew that I wanted to do.

They are working in a set of rules and they look at it and what their idea of what they should be doing is different from the person that they're working under.

The only thing that pushes you over the cliff, if they don't support their nurses

they don't let them know that they are doing something, you are doing something of value here.

It helps to be told from the outside. It helps.

If they don't see that they're doing anything then the balance gets tipped,

you end up being fried as a nurse.

You know what Medical Services, now, they've designed a critical incident stress program that pulls nurses out of the community and sends them on talks to someone and they'll pay for the first five sessions, which is very gallant, but five sessions doesn't cut it,

they put this band aid on an entire problem that isn't going to be solved.

They aren't talking to the nurses,

they aren't saying: "What can we do for them on a daily basis that's going to help them?"

Maybe we should make sure they have adequate numbers of staff every day so they don't get tired at work.

Maybe we should provide them with some positive feedback for what they're doing and you do not get that.

The nurse who is burned out will not recognise it.

It is someone else who points it out and then that nurse has to come to terms with it,

either choose to get out of the job for a while or revamp her life in order to make sure that they're fending it off a bit better like upset the balance a little bit so that they can get back on course again.

What I've seen is usually an event that will get the nurse out and

this wonderful critical incident stress program which is going to fix the event but it does nothing for the ongoing day-to-day burnout involving the job

Until they stop this wheel from rolling they're just not going to be able to hang onto their nurses.

There aren't nurses (inaudible) their rations. The nurses aren't allowed to buy junk food, diet pop, pop at all. Nurses drink pop. Nurses eat popcorn, they eat granola bars.

These are all things that they've now been told they're not allowed to buy them.

It's like it's this great big thumb of that the government is on top of you and it will always tip the balance.

The community (consumer expectations and demands, questioning motives)

They know that you're here because it's a job and you're getting paid well to do the job they put expectations on you to perform,
 You get one bad apple who will colour your view of the community for everyone else, even someone who is nice to you, you can't see it because all you've seen is people who are bitter and angry that you happen to be there.
 It's particularly if you're white and it becomes even a greater issue.
 It happens to the Native nurses as well but particularly if you're white.
 Your reason for being there will always be questioned.
 When you stay, your reason for staying will be questioned.
 "Why are you staying here? Do you really like us, or are you just going to leave in ten years?"
 You've got a community who, for the most part, knows that you're here for money,

When I'm not there they ask when I'm going to go back, but I'll always be seen as a nurse. I won't be able to separate myself from that role that I can do that with my own family.

It adds up with me because I'm living here in the community too.
 If I start not satisfying a lot of people then people aren't going to like me in the community either.

The things that will always tip the balance is some sort of personal event or some sort of problem with the community if the community starts to do some political gesturing which has happened (inaudible)....
 As soon as they start to bring politics into the nursing station, the nurses really feel like they aren't doing anything when the politics starts.

The community thinks we're not good enough.
 Well, if they would look at it from the outside, no, we are providing a good service, but is this community getting what it should get in terms of the city standards, no, they're not. They're not getting what they should get and they have a right to choose that, in fact they should be encouraged to do that. when you're told that again and again and again that you're no good then you start to believe that.
 They will say is that this nursing station is not satisfactory and they're right.
 The nurses have to allow them to say that and still be able to continue with their work.
 I feel like I've got a lot of responsibility to the running interference for this community, so it's quite a bit of stress for me.
 If I see a nurse that doesn't like the community I know that they just aren't seeing a lot of the good,
 they're only seeing the bad.
 I'm always trying to help them see that, but right now I'm actually at the point now where (inaudible) nurses do that because I can't take on the responsibility (inaudible). I'll just (inaudible) myself a lot and I shouldn't.
 All I'm doing now is I tell them where I'm at, this is how I feel about it and I as a manager will do this.

Intrapsychic factors (reduces personal accomplishment / emotional exhaustion / depersonalisation / feelings of isolation / being taken for granted / worthlessness)

When I start to feel like I'm doing it by myself, that's when I know I'm getting burned out
 When I feel like I'm the only one who is doing anything.
 When I feel like I'm isolated then I know that I'm starting to get fried.
 There's a fair amount of negative things going on here.

A lot of the nurses don't feel like they're doing anything.
 They feel like they're just spitting into the wind.
 They feel nothing is happening with regard to their work.
 They feel there's always a lot of patients that's going to keep coming every day,
 They feel it is going to keep coming every day because it's a very sick community
 They feel we have to provide a service and that's the position that we're in,
 particularly the ones that have been here a while or been around a while, do not see any purpose
 to their being in the north.

If I'm at the point where I feel like I haven't got a list in my mind anymore, then I'm getting tired.

Either way if you're happy with your job or you're not happy with your job, you still have to have a life.

When I see nurses who will work every day and not have a life outside of their job, I know that they just can't possibly be coping.

If you don't have anything going on outside your work, you're not living .

If I get a complaint that's directed right at me, I take it very personally because I feel like I have not done what it is I wanted to do.

I felt that I would never go back into a station.

I got to the point where I was so tired from doing the same thing day after day after day after day, I can't blame myself because I know that I'm working hard so I never look at myself when I'm getting burned out,

I always seem to look outward and try and look for something else, the cause of that.

I have to have time for myself on top of that.

It's hard to do. You can't leave all the time, you can't be gone all the time.

Interpersonal / social issues (conflicting demands / lack of social support / focus on monetary reward)

I don't know what the difference is between me and the other nurses.

I don't think that you should have this view of coming to the north in order to make a lot of money so that you can live your life at a later time.

I feel that if you're not living it while you're up here, you're never going to get satisfaction from it.

They're saving a lot of money, they're working for the money.

the only positive thing they can see with regards to their work is the pay cheque that they're getting.

I find it really hard to believe because money has never been that issue with me.

I'm running into nurses who feel that after all these years, there is just nothing more that they can do.

I've got two kids in school, now, so I can't just pick up and go like I used to.
But I'm not sitting during those times when I'm not exercising,
I mean I'm cleaning the house and taking care of kids.

I think you're always on the balancing act between your family life and your work life
it goes right into your personal life because you can't separate the two.

You're one person, you can't separate.
So I feel like it's always the balancing act for the nurses.

They can't get what they need.
If they got out every second weekend,
if they had some kind of support system in the community,
a friend in the community
someone that they can talk to and someone that they can just let loose with every once in a while...
They're contained in the nursing station and they stay in the nursing station,
they work in the nursing station and the only time they really get out is to go to the store and come back.
If I see a nurse doing that day after day after day, I know that they're going to burnout.

What are the Symptoms Experienced by the Individual?

Physically debilitated (tiredness / passivity)

I don't exercise,
I don't stay healthy,
I don't find the time for myself,
I don't sit down and read a good book like I used to.
I don't write letters like I used to.
I'll go home and I'll sit instead of keeping myself mobilised .
I think that half the battle to staying healthy is keeping yourself mobilised.
It's very, very small, it starts to invade you, tiredness at night and not sleeping.
I sat on a couch for seven months. I got up in the morning, I turned on TV at eight o'clock in the morning, I watched TV until five o'clock at night every day. It was like my work schedule. That is exactly what I did.
I should have been happy. I should have been happy to be in the city but I was so fried that I did nothing.
All I did was get up and I watched soaps and talk shows all day long and I waited for my husband to come home and I had no money.

Emotionally overwhelmed

How do you stay healthy, how do you cope? Well, I don't. Well, I obviously don't because I get burned out every two years.

I don't believe that anybody working here will not burnout.

I do not think that anybody can do this job long term, particularly nurse in charge but even community health nurse.

My problem is more rooted in the fact that I get tired from work,

I feel like I must be constantly running ahead of burnout.

I feel that burnout is a very pervasive thing,

Burnout creeps up on you and you're not aware of it.

You will become tired,

then there will be an event that will shake you.

It will be an assault, it will be something in your personal life.

With me, when my father died, that was the event.

There is always an event that will make you look and realise that you just were not coping with the job,

you have to get out and re-evaluate.

You're not just re-evaluating your job, you're also re-evaluating your personal life.

I just no longer could see any point to it,

I was just tired

I was really bound by other people's feelings

I think that I lose sight after a while.

I just get tired of all the stuff and I look for someone to blame.

I'm not taking that little bit of extra time to take care of me.

I think regardless for me personally I'd still think I'd have to get out of this job every two to three years.

I wasn't satisfied with the work anymore.

I feel like I am homesick

I feel like I want to go home and that will probably happen to me for as long as I remain here.

Things that used to make me very, very happy, I don't do them anymore.

It's because of my lack of time or my lack of ability to find the time.

I find the time for all the other things but I can't find the time for myself, that's probably why I am in this two to three year cycle of burnout.

I think you can go through burnout once and you might learn from it.

You might learn from it and you might not,

you'll likely go through it again.

I think it's the second time that gets you.

I think it's like getting stung by a bee.

Impaired relationships

I run across a lot of nurses who don't recognise that we have to provide a service and that's the position that we're in.

I wonder if I'm on the same track as those nurses.

I think that you can lose sight of your family life too

I need to know that I've got a family there and I can get support from that as well.

It's difficult to find the time to do that.

You have to work to find the time to make a family life,

I've got a life outside work, but I've got two kids to take care of, I've got a husband who I live with and have to maintain a relationship with and it's work, it's work to maintain this family life outside my work.

I will look at that and I go well, where is the time for myself?

Because there isn't any.

The actual only time that I get to myself is between twelve and one when I go home for lunch and there's no one there.

Decreased motivation

Usually I'm very goal directed during the day

I try and get a certain number of things done and clear my desk

I can't always do that.

I think it happens probably about after three months even from starting

I know that if I don't get out in November or December, I'm going to be very, very tired.

I felt that if I didn't get out of the community I wouldn't be able to stay in the community long term (inaudible) at a later date.

I just didn't feel that what we were doing in the clinic at that time was going to achieve any goal.

I have to do a lot of things that I don't necessarily feel like I want to do in order to stay healthy.

I have to do a lot of things that I don't necessarily think are useful.

Keeping yourself moving and doing something,

I don't know if it works for me because I -- right now, I'm not exercising, I haven't got any crafts to do.

Your heart won't be in it after a while.

You'll be able to get all your tasks done during the day but your satisfaction will decrease and decrease .

It's very, very small, it starts to invade you, tiredness at night and not sleeping.

You're feeling like you don't really want to come into work that day.

I don't want to come into work every day.

When I wake up in the morning I'm either overwhelmed with all that I have to do

I feel like, well, there wasn't really anything I have to do,

I know that if I have to look at that because there is always something to do in this job.

I have to force myself to go outside when I don't feel like I want to go outside

but I feel better for having done it.

That is actually the biggest battle is trying to get on the cycle of the things that make you feel good,

the things you have to make yourself do until your body wants them, until your body gets into this routine,

if you don't get into that routine of doing things that are going to make you healthy, then you'll just sit and you won't.

It'll creep up with you in your own life.

But what I know that I need to do is I need to exercise,
 I need to get outdoors,
 I need to have a project that's going to provide me with something at the end like a craft.
 I haven't got the time to exercise
 I haven't found a time of day when I feel like I can do that so I have to do that.
 You knew in your mind that you were supposed to do something about it and you didn't do
 anything about it and you still let it happen.

Lack of concentration

You will be aware that you are tired but you'll think that you're functioning quite well on the job.
 This will go on for a period of between one and two years.
 They're just too tired.
 They're just too tired because of the demands of the job.

If you don't have any other supports or any other outlet, anything just for you, then you lose sight
 of the point to it all.
 It starts to build up.
 I'm losing sight of what it is that I should be doing.

How do Nurses Operationalise Salutogenic Qualities in their Lives when they Experience Burnout?

Comprehensibility

I feel like when I'm making decisions I'm making long term decisions that are going to affect a lot
 of people.
 If you really look closely at what you're doing and if you're finding some happiness in what it is
 that you're practicing ...
 Any of the changes that I make, even though it seems like slow change, I know that with time a
 lot of it will work
 If you're happy with what it is that you're doing at that time and you're doing your best for that
 client ...
 I've got goals outside of work that have absolutely nothing to do with my nursing.
 I leave here and I'm thinking on the way home, what am I going to make for supper tonight.
 I'm finding enjoyment in those things that are right in front of me.
 There's a fair amount of negative things going on here but really there isn't,
 When you send them away you really do feel like you've done something.
 if you don't see a purpose to why you're here then you should reconsider why you are here
 you will never be happy up here unless you are gaining some sort of satisfaction from your daily
 work.
 When I'm not doing a good job then I need to step out of the position for a while, put it back into
 perspective and then start again after that.
 Now at least I'll tell people (when I get tired). I think in this situation I'll tell them, if you see I'm
 not coping with the job then you better tell me.
 Don't hide it from me and make sure that within two to three years I have made a significant life
 change that's going to get me out of the position.

Manageability

I feel like I'm doing what I'm good at.

I'm less restricted

I'm more independent in my ability to do things.

I can deal with people on a one to one without having restrictions placed on me.

I can pretty well practice in the way that I want to practice.

I feel like I have a lot of control over what it is I want to do for the community.

I feel like I have a lot of control over where I see the health care going for the community

I can use a lot of input from people I work with in terms of programs that everybody's going to be happy with.

I feel like when I'm working with this community I'm working with a lot of people in order to build something.

I don't feel like I'm doing it by myself.

I had absolutely no preconceived ideas as to what I was going to be doing.

It was all a complete surprise to me when I got up here and I liked the work from the start.

Meaningfulness

I think that the satisfaction that I get is probably what's keeping me here

I find it tremendously satisfying.

I feel like I'm doing something.

I feel like I'm doing more than I would be had I remained in the city.

I'm doing what I was meant to do.

I have to find satisfaction in parts of my life that aren't necessarily right there, you know, like bath time with the kids, I love that.

I'll I take them for a walk up the road and down Saturday mornings.

I'm getting paid for what I'm doing and I'm getting rewards on the side for what I'm doing.

I've got a support system outside the community with his family.

I know that if something were to ever happen to me at this nursing station, I would still have a life here, I would still live here, that's why I know that I need to get out of this position every two years so I don't lose sight of why it is I'm here.

Right now I've got a project I'm taking an ECLS course.

It's certainly going to increase my self-esteem if I pass the course, so it's good.

Commitment

I feel like I'm doing something.

I feel like I'm doing more than I would be had I remained in the city.

I'm doing what I was meant to do.

I can use a lot of input from people I work with in terms of programs that everybody's going to be happy with.

I feel like when I'm working with this community I'm working with a lot of people in order to build something.

I don't feel like I'm doing it by myself.

I take it very personally.

I try not to because that can affect me long term.
 I'm here to do a job, but I know that if I didn't have that personalised attitude towards the work,
 I don't think I'd be able to cope.
 I stay goal-directed in my daily tasks.
 that will stretch out into my home life, and I don't want that.
 I try and separate myself from that but I can't really do it.

Control / Freedom of Choice

I feel like I'm doing what I'm good at.
 I'm less restricted.
 I'm more independent in my ability to do things.
 I can deal with people on a one to one without having restrictions placed on me,
 I can pretty well practice in the way that I want to practice.
 I feel like I have a lot of control over what it is I want to do for the community
 I feel like I have a lot of control over where I see the health care going for the community.
 I think it's like depression. I think that everybody has a propensity to be depressed and you choose
 not to be depressed,
 you choose to be happy,
 you choose to find something that is going to prevent you from becoming depressed.

You can choose to have a healthy, mental attitude, and that comes with work.
 You choose to always be fending off burnout.

Challenge

I think that the satisfaction that I get is probably what's keeping me here.
 I find it tremendously satisfying.
 I feel like when I'm making decisions I'm making long term decisions that are going to affect a lot
 of people.
 Any of the changes that I make, even though it seems like slow change, I know that with time a
 lot of it will work.
 I had absolutely no preconceived ideas as to what I was going to be doing.
 It was all a complete surprise to me when I got up here and I liked the work from the start.
 I've got goals outside of work that have absolutely nothing to do with my nursing.
 I leave here and I'm thinking on the way home, what am I going to make for supper tonight.
 I'm finding enjoyment in those things that are right in front of me.
 It's time to either make a change,
 make a move in a different direction.
 That's probably why I change so much in what I'm doing at work
 That's probably why I change what I'm doing at home too .
 I'm trying to avoid static,
 I'm trying to avoid being in one spot.
 I feel like if I stay in one spot and keep doing the same thing day after day after day after day after
 day, I'm going to get burned out, so I try to avoid that at all costs.
 Do you think you can learn? I think I might have become stronger,
 I think I've become very keen in my ability to recognise when I'm getting burned out.

Because I look at myself now and I look at myself in say 1986, 1985, when I had a social life, I was fending off burnout then just as well as I'm doing it now, but the things that I did then was I would walk, I would write letters, I would listen to music.

Of course I had no other people in my life that I was responsible to so the things that I did then were different.

It's because of the way that my life has changed now that the way that I have to deal with the burnout is different.

Self statements / Cognitive control

I think that the satisfaction that I get is probably what's keeping me here.

I find it tremendously satisfying.

I'm doing what I was meant to do.

I'm less restricted.

I'm more independent in my ability to do things.

I can deal with people on a one to one without having restrictions placed on me.

I can pretty well practice in the way that I want to practice.

I feel like I have a lot of control over what it is I want to do for the community.

I feel like I have a lot of control over where I see the health care going for the community.

I have to find satisfaction in parts of my life that aren't necessarily right there, you know, like bath time with the kids, I love that

I'll I take them for a walk up the road and down Saturday mornings.

Problem solving strategies (relying on other people / staying active)

I know that if you haven't got any support systems outside this Federal Government building, you cannot make it, you can't live a life just for a job.

I can use a lot of input from people I work with in terms of programs that everybody's going to be happy with.

I feel like when I'm working with this community I'm working with a lot of people in order to build something.

I don't feel like I'm doing it by myself.

I've got goals outside of work that have absolutely nothing to do with my nursing.

I leave here and I'm thinking on the way home, what am I going to make for supper tonight.

I'm finding enjoyment in those things that are right in front of me.

It's time to either make a change,
make a move in a different direction.

I'm trying to avoid static,

I'm trying to avoid being in one spot

I feel like if I stay in one spot and keep doing the same thing day after day after day after day after day, I'm going to get burned out, so I try to avoid that at all costs.

I take my time for myself when there's no one else around.

I have to find little things to do,

most of it is work, it's work around the house or something like that.

Delay immediate gratification

I feel like when I'm making decisions I'm making long term decisions that are going to affect a lot of people.

Any of the changes that I make, even though it seems like slow change, I know that with time a lot of it will work.

Perceived self-efficacy

I feel like I'm doing something.

I feel like I'm doing more than I would be had I remained in the city.

I feel like I'm doing what I'm good at.

I'm here because I feel that I've been doing a good job.

This concludes the interpretation for this interview. The procedures followed above will be repeated for each of the interviews.

Central Themes and Theme Clusters – Respondent # 2

To streamline the process all subsequent interviews are reported in the same manner. The central themes and the theme clusters will be analysed in the manner discussed at the beginning of this chapter.

What Causes Burnout in the Nursing Profession?**The work itself (engulfing demands / daily realities / unpredictability of demands / incomplete information / exhaustion)**

It can be busy and stressful at time,
like when you've got someone coming in who is overdosing and you don't know what pills they've taken, and of course, the person who found them is gone, you know, and you don't have an idea of the history or the story and it's very frustrating trying to figure out, piece together what's happened and what you're supposed to treat.

If you end up having a day off here, say a night off or an evening off, or even a day off, you're still called sometimes if it's really an emergency.

We were so tired

we were checking each other because we knew we were so tired that we were unsafe.

Of course, nobody stepped off the plane and that was it.

Well, I'll do it the best I can and I'll do it really slow because that's the only way I know I'm going to do it properly.

But I just had to take some time to do it because I was thinking slower.

If I sat there getting overwhelmed by it, it wouldn't get done. I'd be freaking.

The organisation (rampant bureaucracy / lack of organisational support / unexpected demands)

Well, when I first came up here, I didn't have a clue what I was getting into and I think most people don't.

I was very stressed out then because I didn't have an idea why, like how am I supposed to do this? I was just sort of thrown up here without any guidance and no orientation, pretty much, They did the paperwork and that was it, sent me up there.

Said that there's a couple of things that Medical Services should be doing to retain staff. Don't just throw them into the nursing station with absolutely no idea of what they're getting into. Before they go up they should be trained in, this is how you do blood work, Even just like to look at what a normal ear looks like. I had no idea when I came up here. I had no idea how to use any of the equipment like that. You must take time off after so long especially in busy places and I said two months.

Three nurses in a community this size that they know is this busy.

How many times have we been running short staffed.

The reason I gave up the prenats is because I never got any admin time to do it.

I have to do it on my own time because there's no staff to give me the time for admin.

On paper we have seven on staff, but that is not how it works out.

I guess, like people take time off they never replace.

They don't know what they're doing with staffing.

I don't have a very high opinion of that anyway,

but telling you, you can't take your time off period.

You should stay because we can't send you anybody, and yet they were turning people away earlier. And they had the board there in his own office and it's saying where people are going and stuff, they do that ahead of time. They knew.

They replaced all three of us with one nurse who couldn't come.

Why are you replacing three people with one in a place like this?

I can't understand how this is run. I know it's government, I know it's bureaucratic and stuff like that.

It takes forever to get paid,

It takes forever to get anything in writing,

The paperwork is always slow because it's that caught in the wheel thing,

but knowing ahead of time that you're not going to have staff and then not be given any then what is everybody else left to do?

It's not fair. I mean life isn't fair, but that's really not fair.

That's asking for your nurses to get stressed and burnt out.

The ZNO laughs, it was very inappropriate, "Gee, I feel for you but I'm not going to do anything for a solution. I can't give you any staff. That's too bad. I sympathise with you."

they go home at five o'clock, she is not sitting here.

I would insist on more training and I would insist on some other stuff. I would insist on it before I came up.

The demanding community (consumer expectations / questioning motives / questioning qualifications)

If only it wouldn't be so political as well. I find that really stressful.

If someone phones me and says, "my kid's got a fever, " I tell them how to handle the fever and then I get a call from the Chief, or just people who are saying, "well, so and so is sick". And where did they get that from, what kind of assessment, here, like that's all they can tell me and "they need to sent out". And then sometimes you feel like let me do my job. That's stressful.

I assess somebody and I assume that this is what the assessment is, this is my assessment, they can be sent home.

They get sent home and then I get a call from Chief and Council.

In places I've had six counsellors show up at the door demanding to see the nurse in charge, saying that so and so is really sick, and so and so is not.

There's a lot of attention-seeking with that.

Some people like it, that sick role.

I've had to defend myself against Chief and Council before where they sat me down with the chart and said, "Now, why did you do this? Why did you send them home? Why did you do this treatment? Why did you give them this?" and all sorts of stuff.

Usually it was because the person who complained about me didn't have the facts, you know what I mean, they misunderstood me or, I don't know, they just plain lied.

One girl said I put her in the corner to die and I was in there every hour taking her vital signs and monitoring her. She had the call bell and I kept offering her stuff for pain, she was having pain, but she didn't want any.

She told Chief and Council I sat her in the corner to die and I had to prove myself.

The Chief had to sit there with the doctor and all the other nurses, sitting there with the health committee from the community, Chief and Council, and they just kept sitting there saying, "now, why did you do this, why did you do that?" And I said I didn't leave her in the corner to die because I was in there every hour. And it was written, "refusing pain medication," that kind of thing, the vital signs were there and stuff like that, and I don't know where she got that from.

If you want a second opinion, get a second opinion, but don't tell me I don't know what I'm doing.

The chief said he wants all of the nurses' qualifications before they come here or when they come here, he wants to know what your experience is, what your qualifications are to work here. All I've got to say to that is if I have to prove my qualifications to him, he better give me his qualifications as Chief to ask that.

And that's what I mean by the political thing.

If they don't like the way you did something or they don't like the way you told them something, or you put the responsibility where it belongs on the person, "well, this is your responsibility, you're supposed to be taking your medication," or whatever, and then they run to the Chief and say, "well, I don't like this person".

Sometimes it's like general clinic at eleven o'clock at night and that shouldn't be happening.

I don't know if it's all attention-seeking or what, but it's really, really big here. I've seen people come in here with cuts and they're bleeding and nobody thought to put something on it, even their hand.

Intrapsychic factors (reduced personal accomplishment / emotional exhaustion / depersonalisation / lack of resources / self-blame)

I was very stressed out then because I didn't have an idea why, like how am I supposed to do this? I was just sort of thrown up here without any guidance and no orientation, pretty much.

It can be busy and stressful at time.

I thought she could have died and it was all my fault.

It's like you can only feel it for so long and then once you've exhausted that feeling, you can't bring it back. It's like pain.

Interpersonal / social issues (blame)

And the nurse in charge was just going up one side of me and down the other.

I can't put a finger on it, but it's just you really got to watch your step now because if somebody complains about you, you're really going to be up shit's creek without a paddle.

It was because the person who complained about me didn't have the facts.

I've had to defend myself against Chief and Council before where they sat me down with the chart.

If they don't like the way you did something or they don't like the way you told them something, or you put the responsibility where it belongs on the person, "well, this is your responsibility, you're supposed to be taking your medication", or whatever, and then they run to the Chief and say, "well, I don't like this person".

What are the Symptoms Experienced by the Individual?

Physically debilitated

Have you ever freaked? Oh, I don't know what to do." I have to think. Once. And boy, did I catch shit for it. I cried about it for a week.

I thought she could have died and it was all my fault,

and the nurse in charge was just going up one side of me and down the other.

It was just experience after that. The more exposure you get to stuff like that, the less it scares you. Cuts don't bother me so much anymore.

Emotionally overwhelmed

It's like you can only feel it for so long and then once you've exhausted that feeling, you can't bring it back. It's like pain.

There's whatever, guilt, there's anger, there's, I don't know, sadness.

If I feel guilty about something, like I should have done more or I'm really angry about something, you don't have an idea of the history or the story and it's very frustrating trying to figure out, piece together what's happened and what you're supposed to treat.

Impaired relationships

I do let it out verbally, I'm quite verbal and emotional about things.
 There's a lot of attention seeking with that.
 Some people like it, that sick role.
 They misunderstood me or, I don't know, they just plain lied.

Decreased motivation

"I keep saying that sort of like it's a litany in my head. Hang on till the end of the week, you're going to get out of here".
 It's not fair. I mean life isn't fair, but that's really not fair.
 That's asking for your nurses to get stressed and burnt out.

Lack of concentration

I mean we'd been going all day already, we were so tired
 we were checking each other because we knew we were so tired that we were unsafe.
 of course, nobody stepped off the plane and that was it.
 Well, I'll do it the best I can and I'll do it really slow because that's the only way I know I'm going to do it properly.
 But I just had to take some time to do it because I was thinking slower.
 If I sat there getting overwhelmed by it, it wouldn't get done. I'd be freaking.

How do Nurses' Operationalise Salutogenic Qualities in their Lives when they Experience Burnout?

Comprehensibility / placing things in perspective

I'm trying to put this into some kind of perspective sometimes when it starts happening.
 It's like you do the best you can with what you got.
 that's part of the job.
 I mean, shit happens. It does.

You got to look on the bright side, life's too short to sit there and stew
 anyways like things that you really can't control.
 I'm just learning now that you just can't control them,
 I used to get really emotional about it, but it's not worth it
 Sometimes, you sort of just have to sit there.

What am I going to do, wave a magic wand and make the weather go better?
 I mean I can't do it. I've got to live with what's happened.
 usually when I'm not too happy with somebody I'll try and let them know as soon as possible. I don't pull any punches.

Manageability

Generally, the job is really good when you work in the clinic and stuff like that.
I don't mind seeing real emergencies after hours, I don't mind it at all.
People come and they're really sick, I'm just like "oh, let's do something," and that's fine.

I was quite happy about that because I had done the right thing by just sheer common sense and I was really proud about it and I carried that with me for a while.

Where does it go? Out into outer space in that big pink ball that I hoof out there.
I do that imagery thing when things really bug me.
If I feel guilty about something, like I should have done more or I'm really angry about something, I do let it out verbally, I'm quite verbal and emotional about things, the way I react to things, not necessarily at that time but maybe in private.
But bad feelings I try and dump as soon as I can. In my pink bubble.
It's huge and sometimes I fill and sometimes I only half fill it and sometimes I'll barely like start filling it, but once I exhaust the feeling, I hoof it and it's gone.
It makes me feel better to know that I was getting rid of it, that I actually felt it and then it's gone. I can't feel angry about this anymore so I'm going to get rid of it now.
Because I've felt as angry as I'm going to be. I was only angry about five minutes about this.
I imagine, I'm feeling it and as I'm feeling it, it's coming out of me and I see it filling in the ball. There's whatever, guilt, there's anger, there's, I don't know, sadness.
It's all in the ball because as I'm feeling it, it's going and towards the end I'm sort of going (inaudible) mad about this.
Well, that's what I do. It's probably the weirdest way of handling things that you've ever heard.

Meaningfulness

Why did I want to be a nurse because I have this idea that a nurse helps people and I wanted to be useful, I wanted to help people help themselves.
And after awhile I got used to it and I really enjoy it.
I enjoy having, like, well, here you're doing a bit more, which is nice, and you sometimes have the time to do it.

Commitment

But it's a good job.
Generally, the job is really good when you work in the clinic and stuff like that.
I don't mind seeing real emergencies after hours, I don't mind it at all.
People come and they're really sick, I'm just like "oh, let's do something," and that's fine.

Control

I find that I need to get out every so often.
I have to physically remove myself from here.
I'm doing my exercise,
I'm trying to lift weights and keep fit that way.

I'm eating low fat diet and really proud of it.
 I'm trying to put this into some kind of perspective sometimes when it starts happening.
 It's like you do the best you can with what you got.
 That's part of the job.
 I mean, shit happens. It does.

Challenge

After a while I got used to it and I really enjoy it.
 I enjoy having, like, well, here you're doing a bit more, which is nice, and you sometimes have the time to do it.
 As compared to hospital nursing, I hate doing bed baths, in a hospital you're doing kind of aid work.

But that's the challenge of being here? I couldn't go back to doing bed baths and begging the doctor for glycerin suppositories, no way.
 It wasn't what I expected, it was a lot more than I ever bargained for but I think that I've become a better person because of it at times.
 It's kind of rounded me out a bit seeing these things because I've never seen certain things.
 It's like you do the best you can with what you got.
 That's part of the job.
 I mean, shit happens. It does.

Self-statements / Cognitive control

"I keep saying that sort of like it's a litany in my head. "Hang on till the end of the week, you're going to get out of here".
 But also, I wish I could have more time,
 It's like you do the best you can with what you got.
 That's part of the job.
 I mean, shit happens. It does.

Problem solving strategies (use of imagery / outside interests / physical activity / using common sense)

I do that imagery thing when things really bug me.
 How I cope with it, I find that I need to get out every so often.
 I have to physically remove myself from here
 I'm trying to do that for myself and plus I'm bringing up all my little hobbies and stuff .
 I bought a sewing machine, I learned how to sew, I sewed my first dress, I do my knitting and I knitted my first cap and I'm doing my exercising and stuff.

When I work out I get a lot of that out too, doing something physical
 or I'll tear around the house, "it's time to do laundry and it's time to wash the walls
 I try and do something constructive with it.
 It makes you feel better because then afterwards you've got this sense of accomplishment.
 I was kind of pissed off but at least I waxed the floor, I did something good with it.

I was quite happy about that because I had done the right thing by just sheer common sense and I was really proud about it and I carried that with me for a while.

Delay immediate gratification

“I keep saying that sort of like it's a litany in my head. Hang on till the end of the week, you're going to get out of here”.

I'm trying to do that for myself and plus I'm bringing up all my little hobbies and stuff I bought a sewing machine, I learned how to sew, I sewed my first dress, I do my knitting and I knitted my first cap.

Perceived self-efficacy

I was quite happy about that because I had done the right thing by just sheer common sense and I was really proud about it and I carried that with me for a while.

What am I going to do, wave a magic wand and make the weather go better?

I mean I can't do it. I've got to live with what's happened.

usually when I'm not too happy with somebody I'll try and let them know as soon as possible. I don't pull any punches.

If you want a second opinion, get a second opinion, but don't tell me I don't know what I'm doing.

I do let it out verbally, I'm quite verbal and emotional about things,

the way I react to things, not necessarily at that time but maybe in private.

But bad feelings I try and dump as soon as I can.

This concludes the interpretation for this interview.

Central Themes and Theme Clusters – Respondent # 7

All interviews are reported in the same manner.

What Causes Burnout in the Nursing Profession?

The work itself (engulfing demands / daily realities / long working hours)

It is very challenging, especially going from a hospital setting into the northern communities. What about the feeling very tired sometimes? Yes. Go home, go to bed when the kids go to bed to sleep. But that just seems to be a part of it. I don't think I've gotten burnt out from it or not, but I think it's just a part of it.

So do you think that in time this might be too much for somebody? I don't think I could do it forever and ever. Because it's hard on your life (inaudible).

Well, the hours and that can be very stressful, working that amount of time you do 70 hours a week sometime and I guess that can be tiring.

The organisation (rampant bureaucracy / lack of organisational support)

(no inscription)

The community (restrictive and isolated / racism)

You can't do certain things in a remote community that you can do elsewhere.

-- You can't do certain things in a remote community that you can do elsewhere.

"Just because of the isolation?"

Yes, the isolation. And for me I can't do it forever with the kids and that, it would be too hard. Like this is the only school I'll let the kids go to. The other communities are too -- they're really behind in it.

Kids call them little pork chops, but (inaudible).

I guess it's white meat or something, I don't know. They say they call them that on the bus. (Inaudible).

Intrapsychic factors (reduced personal accomplishment / emotional exhaustion / depersonalisation)

It sounds like I'm going, "God, I go home and my family is a big burden to me so if I go back to work, I'm happy again."

And what you also say is that you don't spend enough time with yourself --no. I don't.

My time is so limited with two little kids and a husband, how --

like I don't know how I'm supposed to, like they say, make time for yourself, but how do you do that?

Like how am I supposed to do that? What can I do, you know?

Like, really, when you're on call and you're supposed to be available, even when you're not on call because if something goes on you have to come back here, so how do you do that?

You just have to do the most important things,

I guess I'm leaving myself out as being important or something.

My priorities are everything else except little old me.

Interpersonal / social issues (conflict between work and family / no personal space)

It's stressful not being away from your family.

And coping, well, it's a lot easier to do it when your family is not around. If find it, anyways.

Six years ago in Shamatawa I did it by myself and then at the beginning, up to November, I was by myself. And it's a lot easier.

It's stressful not being away from your family, but it's a lot -- it's more stressful having your family here because you have to bounce back and forth.

You can't sit down on your break and have a break.

You now have to quick, go be a mom instantly and it's very hard and I know the kids find it hard, but I find it hard. It's difficult.

You have your time by yourself, you have your own time to unwind, do whatever, but I don't have that.

You don't get the time to unwind and to do the things just for yourself, I guess that can be a burden because you put expectations onto yourself. I do anyways. More expectations to please everybody else, and I'm kind of left out and sometimes that's hard. So then you put yourself aside and you go back to work and you're fine and then you go back to being that, but then every now and then it pops in, "I never get any time to do this", or whatever. But that's the most stressful part for me, it really is.

And for me I can't do it forever with the kids and that, it would be too hard. Like this is the only school I'll let the kids go to. The other communities are too -- they're really behind in it. Kids call them little pork chops, I guess it's white meat or something, I don't know.

Everybody here knows that it is really hard for me to go back and forth like that, it's not something that's not obvious or whatever.

What are the Symptoms Experienced by the Individual?

Physically debilitated (exhaustion / tiredness)

Well, the hours and that can be very stressful, working that amount of time you do 70 hours a week sometime and I guess that can be tiring. I go back and I can no longer go put my feet up or whatever, I have to go and attend to the needs of the kids and the husband, but I'm left out, you know -- So then you put yourself aside and you go back to work and you're fine and then you go back to being that, but then every now and then it pops in, "I never get any time to do this", or whatever. But that's the most stressful part for me, it really is.

Emotionally overwhelmed (work and family demands overwhelming)

The most stressful part for me is splitting myself. So it's not really work-related, it's both. It's work-related, it's family.

I mean you're a minute away from home, here, and the one moment you're in the nursing station, you're a nurse, and the next minute you're out and you're a mom and there's no -- And just when you're trying to be a mom, you get called back to be a nurse and that's hard.

Impaired relationships (trying to please everyone places an unreasonable demand on self)

It's stressful not being away from your family.
It's more stressful having your family here because you have to bounce back and forth. So it is, it's more as if you're now split between family and work?
You can't sit down on your break and have a break.
You now have to quick, go be a mom instantly and it's very hard and I know the kids find it

hard, but I find it hard. It's difficult.

But to be up here and to be without family or to be single, I think it would be different. "In terms of easier?" Yes.

You have your time by yourself, you have your own time to unwind, do whatever, I don't have that.

You don't get the time to unwind and to do the things just for yourself, because you bounce back into spending as much time as you can with your kids and your husband, because of the on call and stuff, you try and make every little time and, yes, I guess that can be a burden because you put expectations onto yourself. I do anyways. More expectations to please everybody else, and I'm kind of left out and sometimes that's hard.

Decreased motivation

(no inscription)

Lack of concentration (divided attention between work and family)

The most stressful part for me is splitting myself. So it's not really work-related, it's both. It's work-related, it's family. It's all split up between it?

I mean you're a minute away from home, here, and the one moment you're in the nursing station, you're a nurse, and the next minute you're out and you're a mom and there's no -- and just when you're trying to be a mom, you get called back to be a nurse and that's hard.

How do Nurses Operationalise Salutogenic Qualities in their Lives when they Experience Burnout?

Comprehensibility (work enjoyment / added monetary reward)

The stress of work is alleviated by enjoying the work.

In terms of the work of being up here I like it.

It's rewarding and that part of it, I guess, makes me feel good.

And coping, well, it's a lot easier to do it when your family is not around. If find it, anyways. Six years ago in Shamatawa I did it by myself and then at the beginning, up to November, I was by myself. And it's a lot easier.

You can do it for awhile and I guess the money is a lot better too, so that pushes you a little bit too.

You get a lot more money than you have where you go back to the hospital and your wage is cut in half.

Manageability (coping with added responsibility in expanded role gives satisfaction)

It's a reward, I guess, all in it's own as far as being able to do the things that you can't do elsewhere, except in the northern communities.

The expanded role is really good. Coping.

It allows you to do more than what you can do.

That's my biggest thing, being able to do a lot more.

Meaningfulness (taking responsibility / being in control)

As far as to back to the hospitals I don't know if I can because it's such different nursing.

The expanded role is really good. Coping.

In a hospital setting, you follow the doctors around. It sounds bad, but it's the nurse/doctor stigma, you follow behind. You do as you're told, what you're told and you do it when you're told,

here, you're in complete control of yourself.

Commitment (attractive financial reward)

You can do it for a while and I guess the money is a lot better too, so that pushes you a little bit too.

You get a lot more money than you have where you go back to the hospital and your wage is cut in half.

Control (being in charge / freedom of choice)

Here, you're in complete control of yourself.

And coping, well, it's a lot easier to do it when your family is not around. If find it, anyways.

Being in control. Like I think that's a big thing with me because I'm almost finished here.

You go to work with a smile and they'll never know that you like it.

When I was in the hospital tour, I used to like being in charge.

I used to like that a lot as far as charge nurse or whatever, so that's what it is then. But then if I have to go back to hospital, I give up all of this stuff. I now go back to not really having any, you have a little bit of say in stuff, but not really having any -- you're just basically following very, very strict guidelines or whatever with no ability to expand. You just do your job and that's it.

I eat okay, I eat good and I exercise running after the kids and I like the job.

Challenge

It's a continual challenge.

About six years ago I did a stint in Shamatawa and I never forgot it.

I loved every minute of it, and that was just after the nursing station got blown up, or shot at, or whatever.

I still liked it just because of the big difference going from, I guess, hospitals to the north.

Challenge and it allows you to do more than what you can do.

That's my biggest thing, being able to do a lot more.

You find the work stressful? Yes. I did what I liked here. I would thrive on that. I guess that's part of the thing.

Self-statements / cognitive control

How do you deal with that? I don't think I do anything for it.

Sometimes I stick it away and, "oh, well, tomorrow", whatever.

The stress of work is alleviated by enjoying the work.

I don't feel like I'm above anything. I mean as in work, I like it.

how do you stay healthy then? A born natural, I don't know.

Problem solving strategies (foster outside interests / pampering self / exercise / healthy eating habits)

Do you think there are other things that keep you healthy? Yes. My kids, my family. Well, contradicting what I said before, but (inaudible) my kids and just enjoying this part of it and I guess I make plans to try and get something going, like go camping and that makes me feel good, I guess.

Or sometimes I try to sneak in a nice long hot bath or whatever and read a bit, and that's my extent of my time (inaudible).

And coming to work is almost my time, too, because I like it. But I don't know, (inaudible). I eat okay, I eat good and I exercise running after the kids and I like the job.

Delay immediate gratification (work is stressful, but success in the work situation, despite the stress, gives gratification)

"You find the work stressful?" Yes,

(but) I did what I liked here. I would thrive on that. I guess that's part of the thing.

Perceived self-efficacy

"Do you think you have a great calling to help other people?" No.

I don't ever feel like that. I feel like I'm, I guess, good at my job,

This concludes the interpretation for this interview.

Central Themes and Theme Clusters – Respondent # 8

All interviews are reported in the same manner.

What Causes Burnout in the Nursing Profession?**The work itself (daily realities / isolation and starkness)**

The whole experience of living on a reserve, isolated in the north, that's a whole thing in itself too. The experience of living in the nursing station doing that kind of work, operating the nurse practitioner role.

Three years of living in an isolated community -
three years of no road,
not being able to get out for a weekend off,
not enough staffing,
being confined to this one little community.

I guess the whole lifestyle of being so closely tied to your work, I don't think that that's healthy.

The organisation (lack of organisational support)

Not enough staffing.

The community (consumer realities / socio-economic hardship / culturally different)

I knew nothing about the Indians.

I think I'd only seen them like I said lying around drunk on Main Street before,
certainly I had my share of that in Gibson,
but you certainly see them sober.

They rarely come into clinic during the day drunk. For the most part, sober.

They sort of begin to know you and trust you and talk more and you laugh along with them.

The conditions that people live in -

no running water,

doing wash for 15 kids by hand,

spending all day chopping down wood so you can heat your house.

You go into some of the houses in the winter time and they're freesing.

It's eye opening and then how the Band runs things. That's another thing.

The mismanagement.

The not caring for the environment.

The Band's broke right now.

What's good? Well, they're basically a fun loving people, but kind of screwed up.

Like learning about the culture,

I guess just being so unconnected from the rest of the world -
almost, like you're in some northern bubble.

Like I have often felt those people in Gibson haven't got a hot clue what it's like.

I just figure off the reserve there's no way they'd survive, like they haven't got a clue what the real world is like.

They're so dependent,

I know that's part of the whole slue of things, all this history and whatever.

Intrapsychic factors (emotional exhaustion)

You just shake your head, like, where's it going to end?

This is a fairly negative experience. I guess so.

It's all part of the eye-opening part I think, you know, I've seen these things.

I would say it's been more of a positive experience even though it doesn't sound like it.

I guess it because I'm trying to take everything all in together.

Interpersonal / social issues

The first thing that comes to mind is the Rina thing and if we can use that. You know what I'm talking about. It always seem to be things that aren't really inherent in the work but it always seems to be something else, like something maybe in my personal life but not the work specifically I don't think.

I've known Rina since about ten years so I consider her a fairly good friend. You know you have an attachment to that person and when you see something like that start happening, you know I guess I seen it happening but I -- here I am, I'm going to eat my own words. I said I didn't feel I could do anything about it. Like I really felt it was over my head. I just didn't know -- did a lot of (inaudible) which I see now I shouldn't have.

What are the Symptoms Experienced by the Individual?

Physically debilitated

(No inscription)

Emotionally overwhelmed

I have not really eroded so much yet but if I stay it will. I think.

I just feel I'm ready for a change.

So I'm taking a six month (inaudible) the end of March.

Impaired relationships

A lot of it was just telling her how I felt about things that she was doing.

I'd flap off to somebody, you know, Karla was there to listen,

Or I'll phone up a friend in Winnipeg, "Oh my God", you know. They just probably sit there and listen to me spout off and not have a clue what I was really going on about, but.

It's a strange position because your friend is your boss and you have the work part that you have to separate from the social part.

And that worked up until recently and then it really got to be a problem in resolving the issue I think or for letting it go on for so long.

I never felt really overwhelmed by it or anything but just sort of nagging on your mind.

Decreased motivation

I don't think I'm burned out, I just feel that I've had enough.

Lack of concentration

(No inscription)

How do Nurses Operationalise Salutogenic Qualities in their Lives when they Experience Burnout?

Comprehensibility

It's basically been what I thought it would be.

I found it interesting learning about the different cultural group which I really knew nothing about before.

I've learned tons, made my money.

That wasn't the main reason why I went up, but it helps because I would like to get into community health someday.

Up north was another experience.

Like I said it was maybe a bit of a stepping stone and probably opened up some doors for me.

I'll never say I ever resented going up north. Never.

Manageability

It's basically been what I thought it would be.

I don't think I let things really get to me.

I don't. There's some things, but for the most part I think I tend to let things roll off of me.

I'm a type B personality, I'm quite laid back.

I've had that on past jobs, my performance appraisals. I have a calming affect on people.

If something happens, I don't go off in a flap. I don't know why I'm like that, it's just that's me.

Meaningfulness

I've enjoyed it for the most part.

Challenging, it's been very interesting work.

I found it interesting learning about the different cultural group which I really knew nothing about before.

I've learned tons, made my money.

That wasn't the main reason why I went up, but it helps because I would like to get into community health someday.

My choice in the jobs I've had over the years have gradually been more positions with more and more independence. Then I went into critical care where you're very independent actually and given wide open doctor's orders,

it is kind of there, but you do a lot of stuff on your own.

This is gone even more, you know, you're it. A lot of people say to me isn't that scary, but I've

never found it that way. I don't know why because I know I can always pick up a phone and I can phone a physician somewhere and get some advice on something and you don't have that (inaudible).

I guess the gradual gaining of independence, making your own decisions, not relying on other people so much.

I've had lots of experiences and you feel good when you've diagnosed something correctly and actually over the years it gets easier,

you've seen things you can rely on past experiences more and gut feelings.

It is something totally new where you're able to do

Someone comes in with a complaint, you have to take a history and do a physical assessment and basically come up with a diagnosis.

It is not something you're taught in nursing school. That's the physician's role.

I guess it must affect your self esteem.

I don't think I was ever really lacking in it, but it certainly hasn't -- I mean it's definitely helped a bit more.

I shouldn't say I wasn't lacking in it, but, you know, once in a while you'll have little things, "Oh, can't do that, couldn't possibly do that". I don't say that so much anymore.

I think it's a positive thing.

I think it's good to be independent.

I'm not saying you shouldn't rely on other people for anything, but when it comes down to it, you know, you have to help yourself. No one else is going to.

I've learned from this experience.

Commitment

I found it interesting learning about the different cultural group which I really knew nothing about before.

I've learned tons, made my money.

Control

It's basically been what I thought it would be.

I don't think I let things really get to me.

I don't. There's some things, but for the most part I think I tend to let things roll off of me.

I'm a type B personality, I'm quite laid back.

I've had that on past jobs, my performance appraisals. I have a calming affect on people

If something happens, I don't go off in a flap.

I don't know why I'm like that, it's just that's me.

Challenge

I've enjoyed it for the most part.

Challenging, it's been very interesting work.

My choice in the jobs I've had over the years have gradually been more positions with more and more independence. then I went into critical care where you're very independent actually and given wide open doctor's orders,

it is kind of there, but you do a lot of stuff on your own.

This is gone even more, you know, you're it. A lot of people say to me isn't that scary, but I've never found it that way. I don't know why because I know I can always pick up a phone and I can phone a physician somewhere and get some advice on something and you don't have that (inaudible).

I guess the gradual gaining of independence, making your own decisions, not relying on other people so much.

I've had lots of experiences and you feel good when you've diagnosed something correctly and actually over the years it gets easier,

you've seen things you can rely on past experiences more and gut feelings.

It is something totally new where you're able to do.

Someone comes in with a complaint, you have to take a history and do a physical assessment and basically come up with a diagnosis.

It is not something you're taught in nursing school. That's the physician's role.

I guess it must affect your self-esteem.

I don't think I was ever really lacking in it, but it certainly hasn't -- I mean it's definitely helped a bit more.

I shouldn't say I wasn't lacking in it, but, you know, once in a while you'll have little things, "Oh, can't do that, couldn't possibly do that". I don't say that so much anymore.

I think it's a positive thing.

I think it's good to be independent.

I'm not saying you shouldn't rely on other people for anything, but when it comes down to it, you know, you have to help yourself. No one else is going to.

I've learned from this experience.

Up north was another experience.

Like I said it was maybe a bit of a stepping stone and probably opened up some doors for me.

I'll never say I ever resented going up north. Never.

Self-statements / cognitive control

I tend to intellectualise things a lot, I'll sit and think about it, what's going on.

I've enjoyed it for the most part.

It's basically been what I thought it would be.

I don't think I let things really get to me.

I don't. There's some things, but for the most part I think I tend to let things roll off of me.

I'm a type B personality, I'm quite laid back.

I've had that on past jobs, my performance appraisals. I have a calming affect on people.

If something happens, I don't go off in a flap. I don't know why I'm like that, it's just that's me.

A lot of times I go with the flow, I think I'd like to get into community health.

I think being up north has shown me that I'm not so sure if I want to live in the city, I think I might always want to live in a smaller place but not way up there in the boonies anymore.

I like being out in the country, but I like to have some access to things I enjoy, like going to restaurants, maybe going to a play.

Problem-solving strategies

I found it interesting learning about the different cultural group which I really knew nothing about before.

I stay healthy by trying to stay connected with the outside, phone calls to friends and family, watching the news, getting out frequently, like we've said this how many times, like even a weekend out in Thompson. You sort of connect again.

So we were just talking about our staying healthy. Oh, and something that I -- you also exercise, I know that you do exercise.

I try to eat right.

That's kind of hard sometimes, lack of fresh fruit and vegetables sometimes.

I guess trying to do a variety of things, having interests.

Like I enjoy reading, I'm doing some crafts, I love listening to music,

I like getting outside on the Hondas and the snowmobiles wherever the season.

Of course there's a lot of socialising that goes on here.

Delay immediate gratification

I've learned tons, made my money.

That wasn't the main reason why I went up, but it helps because I would like to get into community health someday,

Up north was another experience

like I said it was maybe a bit of a stepping stone and probably opened up some doors for me.

I'll never say I ever resented going up north. Never.

Perceived self-efficacy

Challenging, it's been very interesting work.

My choice in the jobs I've had over the years have gradually been more positions with more and more independence. then I went into critical care where you're very independent actually and given wide open doctor's orders,

it is kind of there, but you do a lot of stuff on your own.

This is gone even more, you know, you're it. A lot of people say to me isn't that scary, but I've never found it that way. I don't know why because I know I can always pick up a phone and I can phone a physician somewhere and get some advice on something and you don't have that (inaudible).

I guess the gradual gaining of independence, making your own decisions not relying on other people so much.

I've had lots of experiences and you feel good when you've diagnosed something correctly and actually over the years it gets easier.

You've seen things you can rely on past experiences more and gut feelings.

it is something totally new where you're able to do.

Someone comes in with a complaint, you have to take a history and do a physical assessment and basically come up with a diagnosis.

It is not something you're taught in nursing school. That's the physician's role.

I guess it must affect your self-esteem.

I don't think I was ever really lacking in it, but it certainly hasn't -- I mean it's definitely helped a bit more.

I shouldn't say I wasn't lacking in it, but, you know, once in a while you'll have little things, "Oh, can't do that, couldn't possibly do that". I don't say that so much anymore.

I think it's a positive thing.

I think it's good to be independent.

I'm not saying you shouldn't rely on other people for anything, but when it comes down to it, you know, you have to help yourself. No one else is going to.

If you want to do something you have to do it yourself. No one else is going to.

This concludes the interpretation for this interview.

Central Themes and Theme Clusters – Respondent # 9

All interviews are reported in the same manner.

What Causes Burnout in the Nursing Profession?

The work itself (engulfing demands / daily realities / being understaffed)

At times it can be very stressful

it was hard because there was only two of us and there should have been three.

We dealt with a lot of trauma, really bad trauma,

a lot of deaths and to me there was a couple of deaths I found really difficult to handle.

One was a munchkin, when a munchkin died and the nurse there was quite cynical and when I was sitting there and I had tears in my eyes, she just turned and looked at me and said, "I don't know what you're crying for because you're born and you die and that's all there is to it."

I found that really hard to take.

There was just no support and stuff.

Another one was a traumatic death that we all went through and it was just that he was such a nice person and I'd seen him lots in the clinic and that took me a long time to get over .

It gets scary, though, when you just sort of fly by the seat of your pants .

I know a few times we've had cardiac cases and the phone lines were out .

You pray that all things are going to mesh.

A couple of times that's happened when I've thought, "What am I doing here, like this is nuts".

But that stuff doesn't last very long.

Sense of isolation though because you kind of wonder if they know out there if your phones are out.

Nelson was a blur because I just worked and slept for six months.

It was horrible.

The most I ever felt stressed out was when they left me in there by myself for a week.

The organisation (rampant bureaucracy / lack of organisational support)

Dealing with co-workers and management I find usually more stressful than the actual work.

The zone officers, other than one that I really enjoy working with, I don't find that they support the nurses very well.

If a nurse is complaining of something the first thing they'll say is you're burned out when that's actually not the case. They just don't seem to listen.

Burnout is not a stigma to a lot of people but the way they say it, you know you tend to take it as such.

They're a little bit more supportive but I know before they weren't.

There's still a lot of work to go on their part for supporting the nurses in the field.

The thing that was hardest to deal with was the zone office.

Most of them feel a nurse shouldn't be there more than a year.

They would do everything they could to get you out like saying you're burned out, it's time you left, it's too stressful for somebody to be there that long and always having to hear that.

The preconception is that it doesn't matter how often you get out but when you're dealing with as much as you deal with in Gibson, you shouldn't be there more than a year.

As far as that goes, when I was in Nelson, we saw trauma far more than we saw it in Gibson.

People just accept that you will burnout after a year in the field.

I sometimes wonder if that is because of what used to happen before when they take nurses straight out of training who had no experience or anything.

That happened quite frequently, but now the majority of nurses that are coming out into the field I should say, have several years' experience and they basically know what they're getting into. Before you didn't.

I think they should get nurses out more frequently in all the stations and not just one that they think is high risk.

The community (consumer expectations)

It was all the suicides that we were dealing with.

I found as much as I tried not to get pulled in, I did get pulled in.

Chief and Council were dragging me into a lot of meetings

Intrapsychic factors (reduced personal accomplishment / emotional exhaustion / depersonalisation)

You don't function well.

You just don't meet your deadlines.

You don't enjoy your work,

you just don't want to be there anymore.

I know when I was younger, when I first started nursing and stuff, I was taught the old school, nurses don't cry, nurses don't talk about what they've been through, nurses are strong, nurses are supposed to do this, this and this and be the support for everybody.

It took me a long time to learn I can talk to them about what I'm going through.

I think it's something I just learned along the way.

I've been nursing for over 20 years, I started nursing when I was 19 and 20 and I'm 44 now, I have learned the hard way, like holding everything back or inside (inaudible).

Interpersonal / social issues

The most stressful part was dealing with the nurses I was working with and with some of the zone officers.

With those nurses, personality clashes.

I felt like I was dealing with youngsters instead of mature women that are supposed to be professionals.

They tended to be a bit more careful in clinic with their attitude.

Whispering behind the back,
the purposeful isolating,
the talking in angry tones when a simple question was asked.

Just little things like that.

It just built up and built up

It was once in a while and then it was like almost every day and then it was several times a day. I don't want to deal with this anymore.

If I asked them how things were, they'd say things were right and fine and then I find out later it wasn't,

or they wouldn't even answer at all.

Like they wouldn't want to discuss anything

I don't know how to deal with stuff like that.

It's not that I didn't want to do my job anymore, I just didn't want to work with them. I was burned out with them.

A lot of that tiredness had to do with the stress of having to deal with them every day a sort of waiting, now, what's next that are they going to pull? What stunt are they going to pull next?

I found that very stressful.

I think most people would find it a bit stressful.

But I still liked my work.

I resented having to leave.

What are the Symptoms Experienced by the Individual?

Physically debilitating

Very tired (inaudible).

You can't get out when there's only two or three of you and you're so tired you don't want to get out.

You just want to go into your apartment and sleep because you're so tired because you've only had a few hours' sleep.

I was really stressed, I was really exhausted too.
 I was really tired, physically and mentally.
 I'll never let them do that to me again.
 I thought it was okay but I found out it wasn't.
 So I know better now, I've learned from that.

The first time I ever left the station crying in all the time I've worked up there.

Emotionally overwhelmed

Burned out sometimes? Stressed out is more like it.
 When I left Gibson in June I was really glad to leave

Burnout is different --It accumulates.
 My family couldn't believe, they said that was the worse they've ever seen me coming out of the north.
 I said, "I can't talk about it right now. You have to give me some time here".

Hurt is the only word to use. And I was just tired,
 I just wanted to sleep and I did sleep for about three days .
 After that I just started getting my energy back
 I've got to start making some decisions here,
 I think I needed that time away from them.

Impaired relationships

That's probably something I should learn, but how do you deal with people who don't want to talk and tell you what their issues are and you know you're supposed to be supporting each other in the type of work that we do.
 Whether I want to work with one of them in particular, that's debatable.
 That wasn't so much the work as the nurses who I was working with,
 I just couldn't handle them any more.
 I didn't want to be around those nurses any more.

That last few months with the girls, even though I was sleeping, it wasn't a restful sleep.
 I'd wake up tired even though I'd go to bed early .
 It was just knowing I had to deal with them again the next day,
 it just tired me out.

We all needed a break from each other.

Decreased motivation

You don't enjoy your work,
You just don't want to be there anymore.

Lack of concentration

You don't function well.
You just don't meet your deadlines.

How do Nurses Operationalise Salutogenic Qualities in their Lives when they Experience
Burnout?

Comprehensibility

I know you can work anywhere no matter what the conditions are if you work with someone that you enjoy.
I know you can work anywhere no matter what the conditions are if you get along and work well together.
I know you can work anywhere no matter what the conditions are if you get out frequently.
I still believe that.
The majority of them appreciate when you do something nice for them or if you help them.
I even had patients phone back or see me on the road there and apologise if they swore at me the night before.

Manageability

It's made me a better and a stronger nurse
I know we did everything we could.
They let you think.
I'm glad they have the limitations that they do.
There's certain things we're not allowed to do.
We're not doctors and there is guidelines and I'm glad there's the guidelines there.
It just makes things a little bit more safer for the patient.

Meaningfulness

We have more autonomy and you're allowed to think.
I prefer it to working in the city.
I really enjoy it.
I don't know if it's the people or if it's the challenge.
I think a lot of it has to do with the challenge of working there.
I really like working there as opposed to the other stations I've been in .

Commitment

The majority of them appreciate when you do something nice for them or if you help them. I even had patients phone back or see me on the road there and apologise if they swore at me the night before.

I really enjoy it.

I want to go back to Gibson,

I like my work there.

I feel like I've left something undone.

I don't know what it is, but I have to go back and see.

It's never been my intention to stay there forever and retire from there type thing

I haven't hit that point yet with Gibson.

Control

We have more autonomy and you're allowed to think.

I prefer it to working in the city.

I eat well,

I have the usual binges, sometimes I'll have a junk food night and stuff.

I try and maintain my weight so it's not too high or too low.

I went to Montana for a week and it was at a sun dance.

Just for me praying and just being by myself,

being able to calmly think about things and being so far away from it,

I just felt so much better and lighter when I go back, like I just felt good.

It was something I knew I had to keep working at.

I just took my time with it, like I didn't rush it.

I just thought about it and it just made me think about what I'd been through.

It worked for me.

Challenge

It's made me a better and a stronger nurse

I know we did everything we could.

There's something about Gibson that I really like and I don't know what it is.

I don't know if it's the people or if it's the challenge.

I think a lot of it has to do with the challenge of working there.

I really like working there as opposed to the other stations I've been in.

Self-statements / Cognitive control

I prefer it to working in the city.

We have more autonomy and you're allowed to think.

I know you can work anywhere no matter what the conditions are if you work with someone that you enjoy.

I know you can work anywhere no matter what the conditions are if you get along and work well together,

I know you can work anywhere no matter what the conditions are if you get out frequently.

I still believe that.

I really enjoy it.

I know we did everything we could.

Problem solving strategies (close friendships / frequent breaks)

I have a lot of friends that I can phone at any time of the day or night and they'll sit and listen, I can talk to them about mention person's names and situations I've been through or I'm going through.

I find, too, that if I can get out frequently, like every four to six weeks, it really helps.

Even if it's just for a weekend or a day, even.

I'm not afraid to say when I'm tired, talking about what I'm going through.

She gave me three choices and one of them was to come out for critical incident stress debriefing. Because I knew her and had dealt with her in the past and sort of run into brick walls, like she was just so closed, she just does not listen,

I'll take that one because I don't want to deal with this woman anymore.

It was the best thing I could have done.

Being able to calmly think about things and being so far away from it.

Delay immediate gratification

The majority of them appreciate when you do something nice for them or if you help them.

I even had patients phone back or see me on the road there and apologise if they swore at me the night before.

I just felt so much better and lighter when I go back, like I just felt good.

It was something I knew I had to keep working at

I just took my time with it, like I didn't rush it.

I just thought about it and it just made me think about what I'd been through.

It worked for me.

Perceived self-efficacy

It's made me a better and a stronger nurse.

It's been a nice break but I'm ready to go back to work.

Being able to calmly think about things and being so far away from it,

I just took my time with it, like I didn't rush it.

This concludes the interpretation for this interview.

Central Themes and Theme Clusters – Respondent # 10

All interviews are reported in the same manner

What Causes Burnout in the Nursing Profession?

The work itself (isolation / engulfing demands / daily realities)

The nurses are very isolated.

Some of them stay a few years and some of them just stay a few days.

There's a high level of burnout in stations

Stuff that happened in the nursing station.

Lots of things happened, you know, people die and sometimes a violent death, sometimes they'd just have a heart attack, they're so young,

sometimes hangings and self-inflicted gun shot wounds, and sometimes accidental,

I find that was sometimes very painful for me especially (being) at home

When I think of Lost Lake I still want to go back and work there but I can't work that much.

It's too busy. I don't think any nurse can work that long in that -- it's too busy in Lost Lake.

It's just too busy.

I think burnout happens there so quickly. I didn't realise that until I could sit here and think of that place.

“What you are saying is that inherent in that nursing station, the pressure is just too much and that over a period of time people will burnout”? Yes.

The organisation (rampant bureaucracy / lack of organisational support / inadequate facility / staffing problems)

The facility, I think, is inadequate for the people in the community

Medical Services gives us time off when we feel burned out.

We can go through this program or something if you need to talk to someone and then you get time off.

That doesn't solve the problem.

You go back there and burnout all over again.

They need something bigger, I think, than that.

Maybe a system where nurses can have some time off.

In the station you feel when you live there, you feel that you have no time off at all, not a day off because you're right there, you're at work.

Even if I feel like I have a flu or something, I just come to work because I'm just here anyway.

I might as well be at work because I'm right here.

Medical Services have very little support for their nurses out in the field.

I think the only time they come in to support their nurses is when something not nice has happened to them.

Medical Services has to step in and give their nurses a little bit more support.
 You don't know what's going to happen.
 You are told there's a nurse coming in today and they don't show up,
 they send them somewhere else
 because something has happened where a nurse had to get out of the community,
 Anything can happen sometimes, weekends, some violence towards the nurses,
 then they have to take them out and someone else has to go in and I guess that's why that's not
 happening, the time off.

It's not weak people, it's just the way that place is set up. I think the facility is inadequate.
 There's lots of people and there's only six nurses working and that's not enough nurses.
 Somebody's always away. Even here with us we have three nurses on staff. One of us is away
 sometime during the week. One of us will be away. Either somebody's sleeping because
 they've been up all night or someone's on a Medi Vac or somebody's off doing something on a
 holiday or upgrading or something. There's always one person off.

The community (consumer expectations / rampant violence)

I worked there and I felt that I had a lot of demand from the people because I was from there.
 They would talk to me all the time, even in the store.

Older people, they don't speak any English and maybe I felt too that because I'm from there,
 they felt freely to talk to me whenever they wanted to talk which I don't see anything wrong
 with that but sometimes I felt they should go to the Clinic and talk over there when the Clinic
 is open.

The after-hour calls and people that were so (inaudible).

People sometimes, well, I guess they don't understand what's happening.

When people call you they think that's the first phone call you got is when they're talking to
 you,

because of the pressure and because of there's just too many people in that community.

We had a few hangings and drownings

There's a lot of violence in this community, like on the weekends people come in and they're
 alcohol-related violence.

Intrapsychic factors (reduced personal accomplishment / emotional exhaustion / depersonalisation)

I was starting to hate people.

I also think now when I look back that I may have been burned out a few times before.

I don't feel like I'm always burned out.

I think I've been burned out a few times in the years that I have worked for Medical Services.

I don't think I'm burned out now.

I don't feel burned out.

I know that I was burned out for sure when I was in Lost Lake.

When I think of the other years that I was in Lost Lake, I may have burned out a few times
 and recovered or coped with my burnout, but the last burnout, I think I just couldn't have
 coped in Lost Lake. I couldn't have.

“But still you didn't quit nursing”? “You just moved venue, places”. Yes. Yes.

Interpersonal / social issues (feeling isolated from your family)

It wasn't just work there was other things that were going on in the station.
The nurses that worked there they're not from the community so they live and work in the same place and socialise.
I don't think that's healthy.

My family, my own parents, sometimes I felt that they didn't understand what was happening in the station,
the pressure that we felt,
I knew the people and it was difficult.
Sometimes even when people phoned and said someone got run over by a skidoo or something, the first thing that came into my mind was my own family, whether it's them, how am I going to cope?
What am I going to do if that's my mother?
That was just briefly, you know I'd think of that just briefly and then carry on. But that's caused a lot of stress for me because I was from there and the people had died. Deaths.

It was time for me to get out otherwise I wouldn't have been able to go back if I didn't get out when I did.
There was fighting in the nursing station amongst nurses and support staff,
I think that was my biggest burnout, why I burned out.

You work with these people and sometimes some of the nurses that's all they see is just the people that they work with when people are feeling kind of upset.
Someone's mad at you then you almost have to talk about it to carry on.
When somebody's not feeling good or you think someone's a little edgy, it's not a good feeling, not in a place where you have to live together and work together.
I coped, I think, with the little burnouts that I had
but I had a big burnout and I had to get out.

They don't understand the native people, there's very little understanding of the native people and sometimes they bring with them their own values and expect the people to have the same values to fit into their values and I think sometimes that's why they leave. Some stay and some leave

What are the Symptoms Experienced by the Individual?

Physically debilitated

I wasn't sleeping but my body was tired.
I couldn't sleep.
I had pain sometime, leg pain, headaches, just physical pain.
I had sore legs and sore head and sore other things because I wasn't coping,
but at the time when I think I was burned out, maybe I didn't cope too well.

I was burned out when I left the previous nursing station where I worked
 I felt that I was burned out, that's why I had to leave.
 I really did feel burned out and I was burned out last year. I had to leave.

Emotionally overwhelmed

I was starting to hate people.
 I find that very tiring and sometimes I was exhausted.
 I was just so fed up with what was going on.
 So I had to leave.

Tired like physically tired.
 You don't sleep very well and you're kept awake and you think
 when we tried to resuscitate people sometimes you go through what you did and then you
 think, I wonder if I could have done that another way? I do anyway.

Impaired relationships

I was starting to hate people.
 If I didn't get out of there I was going to hate everybody.

I feel that if I get to know too many people and too close to them that maybe they'll start
 putting pressure on me like the people did before.

I feel that if I get to know too many people and too close to them that maybe they'll start
 putting pressure on me like the people did before.

"You are sort of protecting yourself a little bit"? Yes. I guess. I think so.

Decreased motivation

I didn't want to walk out like that because I felt that I would disappoint too many people.
 Many times I feel I have to get out but I can't work anywhere else other than in a station.
 I'd like to stay in nursing.
 I was burned out when I left the previous nursing station where I worked.
 I felt that I was burned out, that's why I had to leave.
 I really did feel burned out and I was burned out last year. I had to leave.

I felt I was at the bottom, I guess, of burnout. It's really bad.
 I felt I would be ready to go back last Christmas but I went back for a while, for Christmas
 holidays and it was still the same there.
 I'm not going to go back, not for a year. I'm going stay here for another year.

Lack of concentration

I didn't feel at that time (that I could not cope) but when I look back now, that's probably why
 I couldn't sleep.
 I wasn't coping well .

How do Nurses Operationalise Salutogenic Qualities in their Lives when they Experience Burnout?

Comprehensibility

Northern nursing experience is far different from what you work as a nurse when you're in a hospital.

The people, they're different, the Indian people, because most of the stations are on the reserves here in Manitoba,

I find northern nursing very rewarding for me.

One reason I became an RN was to go back and work with my own people.

We discussed the incident that happened and sometimes feelings would be discussed with the nurses.

I feel that I couldn't do anything else except northern nursing.

But I'm part of the north so maybe that's why I feel like that because I grew up in the north

I know the people and I know their lifestyle, so I think it's easier for me to stay than a girl coming from Winnipeg.

Manageability

They make their own decisions.

They just do things on their own.

They don't need doctors' orders for everything.

When something happened really bad like people died, many times the nurses would just sit together and talk about it. I think that's how we cope with those emergencies that we have.

But I don't feel the tension that I felt when I was at the previous nursing station, so it's kind of different.

I guess it's because I don't know the people at the personal level, the difference for me is they're not attached to me personally,

Meaningfulness

Northern nursing experience is far different from what you work as a nurse when you're in a hospital.

It's interesting and the nurse is on her own.

They don't have to have, like in the morning we have to do a bed bath and feed the patient, there's nothing like that in northern nursing,

It's just different.

It's interesting when lots of things happen that don't happen in the hospital. Well, they do happen in the hospital but in the hospital they're all separate, but in a station it's everything.

That's what makes the work interesting.

I find northern nursing very rewarding for me.

One reason I became an RN was to go back and work with my own people.

I guess any nursing is rewarding if the people sometimes even just say "thank you".

How do I stay healthy? I just work. I have my own support, my own family and I talk to them and I feel that the job for me is very rewarding. I feel that. I really enjoy this type of nursing. It is a challenge for me.

Commitment

Northern nursing experience is far different from what you work as a nurse when you're in a hospital.

It's interesting and the nurse is on her own.

I find northern nursing very rewarding for me.

One reason I became an RN was to go back and work with my own people.

Control

When something happened really bad like people died, many times the nurses would just sit together and talk about it. I think that's how we cope with those emergencies that we have. We discussed the incident that happened and sometimes feelings would be discussed with the nurses.

Challenge

Northern nursing experience is far different from what you work as a nurse when you're in a hospital.

it's just different.

It's interesting when lots of things happen that don't happen in the hospital. Well, they do happen in the hospital but in the hospital they're all separate, but in a station it's everything. That's what makes the work interesting.

They make their own decisions

They just do things on their own.

They don't need doctors' orders for everything.

The people, they're different, the Indian people, because most of the stations are on the reserves here in Manitoba.

I guess any nursing is rewarding if the people sometimes even just say "thank you".

How do I stay healthy? I just work. I have my own support, my own family and I talk to them and I feel that the job for me is very rewarding. I feel that. I really enjoy this type of nursing. It is a challenge for me.

Self-statements / cognitive control

That's what makes the work interesting.

The people, they're different, the Indian people, because most of the stations are on the reserves here in Manitoba,

How do I stay healthy? I just work. I have my own support, my own family and I talk to them and I feel that the job for me is very rewarding. I feel that. I really enjoy this type of nursing. It is a challenge for me.

Problem-solving strategies (spontaneous debriefings)

When something happened really bad like people died, many times the nurses would just sit together and talk about it. I think that's how we cope with those emergencies that we have. You just carry on and carry on and then clean up and then go and have some coffee and sit and talk about what had just happened.

Then for me is that I would talk to David.

We discussed the incident that happened and sometimes feelings would be discussed with the nurses

We'd go out on holidays just to get away, and things kind of settled down in the station.

I think you have to leave your workplace and sometimes even socialise outside the workplace to stay healthy.

I thought that when I was there, that's what I'd do.

That's why I lasted in Lost Lake as long as I did.

I have a lot of support from them (my family). That's my biggest support is with David, but with David, just feelings because he didn't know what we did. Just feelings.

Delay immediate gratification

I find northern nursing very rewarding for me.

One reason I became an RN was to go back and work with my own people.

I guess any nursing is rewarding if the people sometimes even just say "thank you."

Perceived self-efficacy

They make their own decisions.

They just do things on their own.

They don't need doctors' orders for everything.

I feel that I'm a good nurse because there's a few people that have said that to me.

This concludes the interpretation for this interview.

Central Themes and Theme Clusters – Respondent # 15

All interviews are reported in the same manner.

What Causes Burnout in the Nursing Profession?**The work itself (tragic demands / daily realities / politics)**

I found the people very interesting.

I'm not saying there wasn't sad times involved and there wasn't tragedy, there was all of that.

The environment was dynamic, ever changing and you never knew from one minute to the next what you'd see.

It always kept you on the edge which I sort of liked in a way.

Like as much as it was difficult to do that, it was still almost invigorating.

Near the end of my field work I could tell that things weren't as good as they should have been. I was tired of seeing the same thing.

But the political arena just frustrates me to no end.

That's when I just feel, I don't need this anymore.

The organisation (rampant bureaucracy / lack of organisational support / feeling trapped)

The negative aspect of the work that I did feel, didn't come from the work itself or the job that I was doing or the people, but from management and they caused me an awful lot of stress for about two years of my career.

The only time that I really got stressed out was when management was causing me the terrible problems.

That was extremely frustrating for me, very, very frustrating.

They put a lot of pressure on me.

I was just so frustrated with the organisation that I couldn't take it and what I couldn't handle, the thing that was really, really annoying and the thing that if anything is upsetting or if anything is sort of breaking, will break you, that feeling of being trapped, that feeling that you've got a problem and you can't go anywhere with it, you can't change it, you can't deal with it, it's there and that's it.

And you get into that feeling too of being trapped when you feel I can't go anywhere, this is it.

The situation with management was terribly devastating because you just felt that there was absolutely no out, there was no way of reaching past that invisible barrier of zone office to tell people that somebody here is affecting us in a very negative way.

You couldn't do that, like all your points of exit were blocked and that was part of the thing, nobody would listen, there was nobody there to talk to and nobody there to listen.

The only person you had was your supervisor who was doing it to you.

If you went beyond her, you were defying or breaking the lines of communication and you'd be disciplined.

It was a terrible situation to be in. Terrible.

There's just nobody to talk to and nobody to share it with.

As soon as that particular supervisor left and after that whole group of (inaudible) left, it was like it was a weight that's gone and I can function again.

The community (consumer realities / expectations and demands)

The people, I found that in both the communities I worked in, when I worked in Gibson, I just knew it was time to go because I could not affect change anymore.

I could see that it was going nowhere,

that the people were going nowhere except downhill.

I was getting frustrated because things weren't getting better, things were getting worse and people weren't taking responsibility or charge for their lives, they always wanted you to do it for them.

That just became too frustrating after a while, too frustrating.

Person A would come in and you thought you had affected change and then you found you didn't at all,

they were wanting, again, you to do it for them.

I got tired as I said about the not being able to see change and that started to drag me down.

Whether it's hearing all the time about how bad the health care is in the north

how nurses can't do that,

or whether it's Mrs Smith coming in with a blood sugar of 30 again, after I've been through this with her and we've done all we can do for her and we have taught her and still it's 30 and still things aren't changing, and I think a year of that with 20 Mrs Smiths, it's frustration and tiring.

There comes a time after a while too where you feel like you're never really a part of the community.

Never. No matter how involved you are, you are still an outsider, you will always be an outsider.

Feeling trapped and feeling confined in a way that I'm here in a community that I'll never be a part of.

Intrapsychic factors (reduced personal accomplishment / emotional exhaustion / depersonalisation / feeling unproductive)

Near the end of my field work I could tell that things weren't as good as they should have been.

I was tired of seeing the same thing.

I was getting frustrated because things weren't getting better,

So near the end I was tired, I was very tired and it stopped being fun.

It became mundane and, "here we go again,"

like too much of the same thing and it was getting worse.

Like I'm confined by the boundaries of this community.

You just start to stagnate,

that's when I started getting really stressed, frustrated, when I feel like I'm no longer growing.

But then about three or four years after that I started getting tired, I got tired as I said about the not being able to see change and that started to drag me down.

I'm planning on going back to the field so I don't know how it'll be.

I've had a lot anxieties about doing that because I can almost feel the way I felt when I left.

I'm not sure that it's a good idea.

Frustration for me is feeling tired, unproductive.

Trapped but not trapped like I felt when I was in the field when I was knowing that it was time

for me to go.

When I'm frustrated, there's certainly anger, there's a quiet anger, it's not an expressed anger.

It comes down to how long is my life going to be on hold here?

The only way out is to take that plane,
I can only go this far before I'm in bush and I can't go any further.
The isolation, after a while, I think does close in on people.

Interpersonal / Social issues (lack of responsibility / lack of motivation to change)

Person A would come in and you thought you had affected change and then you found you didn't at all,

They were wanting, again, you to do it for them.

I just found that frustrating.

Looking back, generally, in my career in nursing, that's the thing that turns me off the most is people that won't take responsibility for their health care, people that expect everything to be given to them.

Nobody would listen, there was nobody there to talk to and nobody there to listen.

I think there certainly are nurses that are narrow in their thinking or narrow in their perspective and narrow in their outlook but that's a given.

What are the Symptoms Experienced by the Individual?

Physically debilitating (feeling trapped / fatigue)

Of course, you get tired, but I don't remember that, I don't remember the fatigue.

That feeling that you've got a problem and you can't go anywhere with it, you can't change it, you can't deal with it, it's there and that's it.

And you get into that feeling too of being trapped when you feel I can't go anywhere, this is it.

I knew it was time either to quit or take a leave.

I had to get out.

When I was in it, how did I cope? Well, I don't know. I walked, I did a lot of walking.

I don't know how I coped. In the beginning I used to socialise a lot but then that dropped off.

I become quite vocal about it but how it affects me is fatigue, yes, mainly fatigue I think is the big one,

lack of interest and unproductivity.

Emotionally overwhelmed (frustration / negative self-talk)

I don't mind taking charge for a while but don't ask me to do it forever and don't count on me to do it for you forever, because I won't do it.

I just know that that's when my frustration starts to show.

It was a very devastating experience (inaudible) perspective.

That's when I started getting really stressed, frustrated,
when I feel like I'm no longer growing.

It was a terrible situation to be in. Terrible.
There's just nobody to talk to and nobody to share it with.
I just lost interest in that.

Had have coped I would have still been there I suppose.
I would have gotten over it,
but I could see it going down,
in retrospect, now, at the time I didn't, but in retrospect I could see that I was heading down.
It was time to get out.
Had I not gotten out I don't know where I would have ended up.
I really don't, because I was getting tired.

I've had a lot anxieties about doing that because I can almost feel the way I felt when I left.
It would scare me.

I just get so frustrated with the system.
I get frustrated with the attitude of the not -- I'm frustrated with the politics.

If that's burned out, then maybe I am, maybe I shouldn't be working anymore in the north, I
don't know.

Impaired relationships

The thing that turns me off the most is people that won't take responsibility for their health
care.
Nobody would listen, there was nobody there to talk to and nobody there to listen.
there was no way of reaching past that invisible barrier of zone office
to tell people that somebody here is affecting us in a very negative way.
But that will just make me pull my hair out and make me walk out and quit all together.

Decreased motivation

I was tired of seeing the same thing.
Like I'm confined by the boundaries of this community .
You just start to stagnate.
I got tired as I said about the not being able to see change and that started to drag me down.
It was just too hard to get out of bed for those night calls.
After a while the money didn't make any difference at all. It just didn't make up for it, for the
stress.
But I don't know how it's going to go.
Frustration for me is feeling tired, unproductive.
trapped but not trapped like I felt when I was in the field when I was knowing that it was time for
me to go.
When I'm frustrated, there's certainly anger, there's a quiet anger, it's not an expressed anger.

Shuffling papers from one side of the table to the other desk,
 not getting the report done that you're supposed to do,
 focusing on the things that aren't important and you sort of think (inaudible).
 That's how it manifests, and not wanting to go to work.
 That's not all the time, that's not as strong as I'd say on occasion, but not a lot.

When I think about going back, that's what bothers me.
 I really feel that my life is on hold.
 When I go back there if I go back it would be for a year or two years or three years.

Lack of concentration

I spent a lot more time to myself.
 I didn't go out as much as I did before,
 that's not coping that's succumbing, basically, to it.

How do Nurses Operationalise Salutogenic Qualities in their Lives when they Experience Burnout?

Comprehensibility

My experiences working, being a nurse in the north have been very positive right from the beginning.
 I've enjoyed it a lot and I've learned a lot and I have found it very dynamic.
 My memories of the field are very positive actually and I don't have a lot of negative memories or feelings about the work or the people.

I mean practical reasons is why I'm doing it.

The grass roots individual, I still see the laughter,
 I see the sparkle and I see that sad individual.

Manageability

I remember feeling very accepted within the environment in which I was working with the people there.
 Like as much as it was difficult to do that, it was still almost invigorating.
 And when you'd accomplished something and you had done well, which you had an abundance of, it augmented those positive feelings.
 I altered my work environment.
 I work at it from a different angle now.

Meaningfulness

I've enjoyed it a lot and I've learned a lot and I have found it very dynamic.

My memories of the field are very positive actually and I don't have a lot of negative memories or feelings about the work or the people.

But I just found the thing that made it so positive was the people themselves, their attitude, their tragedies, being able to reach out to people and really feel like you were making a difference.

The other thing that was positive about the experience was you were growing all the time. Professionally, you were growing all the time.

And part of it I'm going back because I feel like my skills are fading.

I need to go back

I'm not current anymore and I really want to keep my skills up and I feel like I'm going to lose them if I don't. So it's sort of for a refresher as well.

Commitment

I find the nursing personnel, I enjoy working with them.

I like them and there's a lot of good ideas out there and a lot of very strong people with really strong ideas.

I like people with a vision and I like people that can contribute and have good ideas and I think a lot of the nurses out there are like that, I mean generally speaking.

Control

I work at it from a different angle now.

You were making a difference in a very small way, you weren't changing things in a big way, but there were times when people would leave and you felt you had touched them in some way.

The more I talk about it the more I realise it, the issue is control.

I couldn't handle being in a situation where I wouldn't feel like I had control of the work situation.

I like having the power, control, I don't know.

I don't look at it as power and control, it's having that ability just to speak out and have your views heard.

Challenge

I've enjoyed it a lot and I've learned a lot and I have found it very dynamic.

being able to reach out to people and really feel like you were making a difference.

you had affected them in some way that wasn't necessarily negative all the time.

The environment was dynamic, ever changing and you never knew from one minute to the next what you'd see.

Like as much as it was difficult to do that, it was still almost invigorating.

And when you'd accomplished something and you had done well, which you had an abundance of, it augmented those positive feelings.

Self-statements / cognitive control

My memories of the field are very positive actually and I don't have a lot of negative memories or feelings about the work or the people.

I found the people very interesting.

They were very different from people that I had known and worked with before.

They had a wonderful sense of humour and there was always laughter. I remember laughter in the field,

I remember feeling very accepted within the environment in which I was working with the people there.

They liked me, they liked me being there and I liked them.

Problem-solving strategies (taking responsibility)

And even if I look at right across the board, that's generally the way I feel about life in general, that you've got to take charge here, you know.

Nobody is going to do it for you.

The only thing that helped me survive that were friends that I had in the community plus local people.

"So how did you cope with that, you left"? Yes. Basically, I left. I think if I hadn't have -- I got out.

I made plans to (inaudible) into another job for a while and to get away from it.

And I haven't been back.

I altered my work environment

I work at it from a different angle now.

Delay immediate gratification

(No inscription)

Perceived self-efficacy

They liked me, they liked me being there and I liked them.

This concludes the interpretation for this interview. The formulated meanings of all the interpreted interviews will be presented in summary form next.

Summary of Formulated Meanings

The formulated meanings from the extracted significant statements categorised into the three central themes and subsequent theme clusters are presented below.

The Formulated Meanings from the Extracted Significant Statements of what Causes Burnout
in the Nursing Profession

The five main causes of burnout in nursing as presented by the respondents are presented below.

The Work Itself - Engulfing Demands / Daily Realities.

The amount of work, too much going on, the fast pace in the work place, what the job entails, which includes lack of sleep, and at times bad weather that influences medivacs or causes dead telephone lines, make for extremely high stress levels and a sense of extreme fatigue among nurses. It is an environment which burnout is conducive to the rapid development of burnout (there is just too much going on with the job / we were so tired / I know of a few times we've had cardiac cases and the phone lines were out / sense of isolation though because you kind of wonder if they know out there if your phones are out / I think [burnout] it's something that always has a potential for being there, all you need is the right environment for it to flourish/ the hours and that can be very stressful / you do 70 hours a week sometime / the most I ever felt stressed out was when they left me there by myself for a week / it's too busy / I don't think any nurse can work that long in that - it's too busy in Lost Lake).

The acceptance by nurses that the busy nursing lifestyle will lead to burnout over time (to me burnout is part of the job / I don't think you can get out of here and not be burned out / I think there is a lot of pressures on the nurses to do a lot of things that they just don't feel are working after a while / I don't think I've gotten burnt out from it or not, but I think it's just part of it / there's a high level of burnout in [nursing]stations / I don't think any nurse can work that long in that - burnout happens there so quickly).

Nurses do experience a lot of deaths - young or old, violent or medical, and trauma - hangings, gun shot wounds, accidents, sexual abuse and alcohol related trauma, some of it really bad, which make for an abundance of emotionally taxing baggage and stress carried by the nurses (we dealt with a lot of trauma, really bad trauma / a lot of deaths / there was a couple of deaths

I found really difficult to handle / I found that really hard to take, there was just no support and stuff / another one was a traumatic death that we all went through and it was just that he was such a nice person and I'd seen him lots in the clinic and that took me a long time to get over / lots of things happened, people die and sometimes a violent death / sometimes they'd just have a heart attack, they're so young / sometimes hangings and self inflicted gun shot wounds).

The experiences of living on a reservation, isolated in the north, living in the nursing station and operating in the nurse practitioner role are all sources of both negative and positive feelings, but over time the negative seems to overcome a lot of the positive feelings (the whole experience of living on a reserve, isolated in the north, that's a whole thing in itself too / the experience of living in the nursing station doing that kind of work / operating in the nurse practitioner role / some stay a few years and some of them just stay a few days / the nurses are very isolated).

The isolated and confined communities, the lack of roads in some instances, the inability to go away over weekends, the staffing shortages and at times extreme shortages, the whole lifestyle of being so closely tied to nursing and the nursing station add up and cause tremendous feelings of tiredness and burnout in nurses over time (three years of living in an isolated community / no road, not being able to get a weekend off / not enough staffing / the whole lifestyle of being so closely tied to your work, I don't think that that's healthy / the nurses are very isolated / the isolation, after a while. I think does close in on people).

The never-ending return of patients and seeing the same patients with the same problems over and over (I was tired of seeing the same thing / like too much of the same thing and it was getting worse / here we go again / I was getting frustrated because things weren't getting better).

Nurses in nursing stations are always on call for emergencies, even when it is during their time off, this leads to a tendency not to relax (if you end up having a day off here, say a night off or an evening off, or even a day off, you are still called sometimes if it's really an emergency).

Limited information and history about emergency cases arriving for treatment are at times very frustrating and stressful (like when you've got someone coming in who is overdosing and

you don't know what pills they've taken / you don't have an idea of the history or the story).

Not getting paid enough adds to the feelings that nurses have of not being valued enough for their effort (the work we do deserves probably twice the amount of pay for what we're doing / I don't think that we are getting paid enough).

The Organisation - Rampant Bureaucracy / Lack of Organisational Support.

Perceived lack of support from Zone office or from Chief and Council as experienced by the nurses cause an immense amount of stress and burnout (I have become very, very cynical about the Federal Government and it's ability to provide for the nurses, they are providing absolutely no support / how many times have we been running short staffed / three nurses in a community this size that they know is this busy / I can't understand how this is run. I know it's government, I know it's bureaucratic and stuff like that / [next time] I would insist on more training and I would insist on some other stuff. I would insist on it before I came up / zone officers, I don't find that they support the nurses very well / Medical Services have very little support for their nurses out in the field).

Zone office, its perceived bureaucracy and lack of support for nurses in the field, its policies, its staffing policies, the lack of a consistent supply of relief nurses, the lack of action in support of nurses, how the Zone Nursing Officers (ZNO's) treat nurses in the field, the experience of nurses that Zone office see nurses in the field as a problem instead of it's reason for being, all cause extensive negativism and eventual burnout in nurses (I used to feel that they were working for us, but I don't anymore / I was just sort of thrown up here without any guidance and no orientation, pretty much, they did the paperwork and that was it, sent me up there / I was very stressed out then because I didn't have an idea why, like how am I supposed to do this / not enough staffing / a lot of what we should be doing is being held back by the bureaucracy / the only thing that pushes you over the cliff, they don't support their nurses, they don't let them know that they are doing something, you are doing something of value here / if the nurses don't see that they are doing anything then the balance gets tipped, you end up being fried as a nurse / don't just throw them into the nursing station with absolutely no idea of what they're getting into / I had no

idea how to use any of the equipment like that / they don't know what they're doing with staffing / I don't have a very high opinion of that anyway / but telling you, you can't take your time off period / You should stay because we can't send you anybody, and yet they were turning people away earlier. And they had the board there in his own office and it's saying where people are going and stuff, they do that ahead of time. They knew. / they replaced all three of us with one nurse who couldn't come / it takes forever to get paid / it takes forever to get anything in writing / the thing that was hardest to deal with was the zone office / they just don't seem to listen / the negative aspect of the work that I did feel, didn't come from the work itself or the job that I was doing or the people, but from management and they caused me an awful lot of stress for about two years of my career / the only time that I really got stressed out was when management was causing me the terrible problems / that was extremely frustrating for me, very, very frustrating / they put a lot of pressure on me).

- The bureaucratic system, which is seen as a very powerful system over the nurses and over what is going on in the field, is experienced as largely ignorant of the realities of working in the field and over time nurses get the feeling that they just do not matter to anyone. (I have become very cynical about the Federal Government and it's ability to provide for the nurses, they are providing absolutely no support / I think that most of those people have not seen a nursing station, they don't know what it is we're doing here / that nurses are getting the feeling that they just don't matter to anyone after a while / they are the ones who have complete power over what's going on in the field / I was really really constricted by my supervisors / they are working in a set of rules and they look at it and what their idea of what they should be doing is different from the person they're working under / it's like this great big thumb of that the government is on top of you and it will always tip the balance / but knowing ahead of time that you're not going to have staff and then not be given any / then what is everybody else left to do? / I was just so frustrated with the organisation that I couldn't take it / the thing that was really, really annoying and the thing that if anything is upsetting or if anything is sort of breaking, will break you, [is] that feeling of being trapped / that feeling that you've got a problem and you can't go anywhere with it, you can't change it, you can't deal with it, it's there and that's it).

- The organisational setup of the nursing stations, the inadequacy of the facility and the staffing in terms of the amount of people served, the amount of on call duty, the lack of physician availability, all add to an increase in dissenting feelings in nurses over time (they don't give you what you feel you need to practice as a nurse / you're not getting all the staff that you need to practice as a nurse / the reason I gave up prenatals is because I never got any admin time to do it. I have to do it on my own time because there's no staff to give me time for admin / on paper we have seven on staff, but that is not how it works out, like people take time off they never replace / the facility, I think, is inadequate for the people of the community / I think the facility is inadequate / there's lots of people and there's only six nurses working and that is not enough nurses / somebody is always away / Even here with us we have three nurses on staff. One of us is away sometime during the week. One of us will be away. Either somebody's sleeping because they've been up all night or someone's on a Medi Vac or somebody's off doing something on a holiday or upgrading or something. There is always one person off).
- Some nurses contribute to their eventual feelings of burnout by not attending and taking responsibility for their personal well-being, instead, they blame their tiredness on the lack of organisational support and being short staffed (In the station you feel you live there, you feel that you have no time off at all, not a day off because you're right there, you're at work / even if I feel like I have a flu or something, I just come to work because I'm just here anyway / I might as well be at work because I'm right here / the nurse who is burned out will not recognise it).
- Although many nurses express qualified support for the Critical Incident Stress Management Services (CISMS) program, it is generally equated with a band aid solution by Medical Services (in this sense, the whole bureaucracy somewhere out there), to a much deeper and continuous problem of bad management and lack of support of the nurses in the field, overall (You know what Medical Services, now, they've designed a critical incident stress program that pulls nurses out of the community and sends them on talks to someone and they'll pay for five sessions which is very gallant, but five sessions doesn't cut it / they put this band aid on an entire problem that isn't going to be solved /

Medical Services gives us time off when we feel burned out, we can go through this program or something if you need to talk to someone and then you get time off / that doesn't solve the problem / they need something bigger, I think, than that).

- Critical Incident Stress Management Services (CISMS) is seen by nurses as too little too late, the symbolic representation that this is a solution by Medical Services (again, in this sense, the whole bureaucracy somewhere out there) to much greater, deeper and continuous problems of bad management, instead of the perception that CISMS is there to address critical incidents in order that nurses not suffer from long-term effects of these incidents (until they stop this wheel from rolling they're just not going to be able to hang on to their nurses / I think the only time they [Medical Services] come in to support their nurses is when something not nice has happened to them / Medical Services has to step in and give their nurses a little bit more support / maybe a system where nurses can have some time off / I think they should get nurses out more frequently in all the stations and not just one they think is high risk).
- This conforming view by nurses of CISMS even in the face of consistent explanations by CISMS staff as to what their program is about points to a deep and persistent frustration that nurses in the field have with the organisation, with Medical Services, with Zone Office, and their management policies, to the extent that any intervention presented to and for the nurses will be viewed with deep suspicion as just another band aid solution (this wonderful critical incident stress program which is going to fix the event but it does nothing for the ongoing day to day burnout involving the job / they aren't talking to the nurses / they aren't saying what can we do for them on a daily basis that's going to help / maybe we should make sure they have adequate numbers of staff every day so they don't get tired at work / Anything can happen sometimes, weekends, some violence towards nurses / then they have to take them out and someone else has to go in [to the nursing station] and I guess that's why that's not happening, the time off / it's not weak people, it's just the way that place is set up).
- Zone officers and their personal perception of the nurses in the field, as well as of burnout

and its management, time nurses should spend in nursing stations, and nurses turnover, add to organisational fracturing (The ZNO laughs, it was very inappropriate, “Gee, I feel for you but I’m not going to do anything for a solution. I can’t give you any staff. That’s too bad. I sympathise with you”. They go home at five o’clock, she is not sitting here / the zone officers, I don’t find that they support the nurses very well / if a nurse is complaining of something the first thing they’ll say is you’re burned out when that’s actually not the case. They just don’t seem to listen / burnout is not a stigma to a lot of people but the way they say it, you know you tend to take it as such / most of them feel a nurse shouldn’t be there more than a year / they would do everything they could to get you out like saying you’re burned out, it’s time you left, it’s too stressful for somebody to be there that long and always having to hear that / the preconception is that it doesn’t matter how often you get out but when you’re dealing with as much as you deal with in Gibson, you shouldn’t be there more than a year / people just accept that you will burnout after a year in the field).

The Community - Consumer Expectations and Demands

The hardships endured by the community members are not lost on the nurses, the painful realities of existence in the community cause much emotional circumstantiality in which the nurses must continue to function (It adds up with me because I’m living here in the community too / The conditions that people live in / no running water / doing wash for 15 kids by hand / spending all day chopping down wood so you can heat your house / you go into some of the houses in the winter time and they’re freezing / It’s eye opening and then how the Band runs things. that’s another thing / the mismanagement / the not caring for the environment / the Band’s broke right now / I could see that it was going nowhere / that the people were going no where except downhill).

- The many roles of the nurse as caregiver, as public health professional, as clinician, as first responder to emergencies and violent situations, as representative of Medical Services, as health specialist in the community, as attending meetings with and for Chief and Council in the role of nursing administrator, all these roles and their permeable nature become a very heavy load to carry for nurses (Chief and Council were dragging me into a lot of meetings / I found as much as I tried not to get pulled in, I did get pulled in / The

people, I found that in both the communities I worked in, when I worked in Gibson, I just knew it was time to go because I could not affect change anymore).

- Murders in the community, physical violence, alcohol and drug abuse, threats and violent danger to nurses from community members become overwhelming at times for nurses (it was all the suicides that we were dealing with / I found as much as I tried not to get pulled in, I did get pulled in / we had a few hangings and drownings / there is a lot of violence in this community, like on the weekends people come in and they're alcohol- related violence).
- Some nurses become seemingly desensitised or hardened to acts of violence, in order to protect themselves (I was getting frustrated because things weren't getting better / things were getting worse and people weren't taking responsibility for or charge of their lives).
- Issues that are called "political" which nurses have to deal with at all times add tremendously to nurses' feeling stressed out and becoming burned out (but the political arena just frustrates me to no end. That's when I just feel, I don't need this anymore / the things that will always tip the balance is some sort of personal event or some sort of problem with the community if the community starts to do some political gesturing which has happened / as soon as they start to bring politics into the nursing station, the nurses really feel like they aren't doing anything when the politics starts / if only it wouldn't be so political as well. I find that really stressful).
- Political issues can be considered interference by Chief and Council in the assessment and treatment of a patient after an emotional reaction of by a patient and/or family member based on dislike, anger, perceptual urgency, feelings that assessment and treatment are inadequate, the family's standing in the community, or whatever reason Chief and Council feel allows them to interfere (If someone phones me and says, "my kid's got a fever", I tell them how to handle the fever and I get a call from the Chief, or just people who are saying, "well so and so is sick, they need to be sent out" / sometimes you feel like let me do my job / that's stressful / I assess somebody and I assume that this is what the

assessment is, this is my assessment, they can be sent home. They get sent home and then I get a call from Chief and Council / in places I've had six counsellors show up at the door demanding to see the nurse in charge, saying that so and so is really sick, and so and so is not / I've had to defend myself against Chief and Council before where they sat me down with the chart and said, " Now why did you do this? Why did you send them home? Why did you do this treatment? Why did you give them this?" and all sorts of stuff / one girl said I put her in the corner to die and I was in there every hour taking her vital signs and monitoring her. She had the call bell and I kept offering her stuff for pain, she was having pain, but she didn't want any / she told Chief and Council I sat her in the corner to die and I had to prove myself / The Chief had to sit there with the doctor and all the other nurses, sitting there with the health committee from the community, Chief and Council, and they just kept sitting there saying, "now, why did you do this, why did you do that?" And I said I didn't leave her in the corner to die because I was in there every hour. And it was written, "refusing pain medication," that kind of thing, the vital signs were there and stuff like that, and I don't know where she got that from).

- Political issues are usually based on inadequate information, impulsive emotional reaction, racism, different perceptions of issues, years of repressed anger, these issues that community members experience may then become a huge political issue with its resultant negative influence on the nurses (If they don't like the way you did something or they don't like the way you told them something, or you put the responsibility where it belongs on the person, "well, this is your responsibility, you're supposed to be taking your medication," or whatever, and then they run to the Chief and say, "well, I don't like this person" / it was because the person who complained about me didn't have the facts / they misunderstood me / I don't know, they just plain lied).
- Resentment experienced by the nurses as a result of the Orwellian notion that Chief and Council are always out there as big brother and are used extensively by community members to threaten, coerce, and manipulate them (If they don't like the way you did something or they don't like the way you told them something, or you put the responsibility where it belongs on the person, "well, this is your responsibility, you're

supposed to be taking your medication," or whatever, and then they run to the Chief and say, "well, I don't like this person"/ the Chief said he wants all of the nurses' qualifications before they come here or when they come here, he wants to know what your experience is, what your qualifications are to work here / All I've got to say to that is if I have to prove my qualifications to him, he better give me his qualifications as Chief to ask that / and that's what I mean by the political thing).

- Lack of proper use of communication avenues and a proper discussion forum to deal with mutual misunderstandings in the community contribute to burnout (the community thinks we're not good enough / if you want a second opinion, get a second opinion, but don't tell me I don't know what I'm doing / Chief and Council, they just kept sitting there saying, "now, why did you do this, why did you do that?").
- Lack of knowledge in some instances of basic personal care, first aid, and personal responsibility of community members add to feelings of resentment in nurses (I've seen people come in here with cuts and they're bleeding and nobody thought to put something on it, even their hand / they always wanted you to do it for them / that just became too frustrating after a while, too frustrating / person A would come in and you thought you had affected change and then you found you didn't at all, they were wanting, again, you to do it for them / I got tired as I said about the not being able to see change and that started to drag me down / whether it's Mrs Smith coming in with a blood sugar of 30 again, after I've been through this with her and we've done all we can do for her and we have taught her and still it's 30 and still things aren't changing, and I think a year of that with 20 Mrs Smiths, it's frustrating and tiring).
- Misuse and overuse of the nursing station as a general clinic at all hours of the night with the expectation that misuse like that is a right of community members, cause many feelings of resentment in nurses (sometimes it's like general clinic at eleven o'clock at night and that shouldn't be happening / I don't know if it's all attention seeking or what, but it's really, really big here).

- Nurses easily become the focus of a repressed dislike of white people shared by some community members because they represent an organisation and/or a government that for years has yielded tremendous power over the community members, and this causes nurses to feel they are the target of reversed discrimination and racism (you see people who are bitter and angry that you happen to be there, it's particularly if you're white and it becomes even a greater issue / for me I can't do it forever with the kids and that, it would be too hard / kids call them little pork chops / I guess-it's white meat or something, I don't know. They say they call them that on the bus).
- Nurses' motives for being in the community are always questioned, and they are on numerous occasions deemed uncaring money-hungry mercenaries by community members, which leads to extraordinary negativity in nurses because of the inherent catch-22 properties of the argument (they know that you're here because it's a job and you are getting paid well to do the job / your reason for being there will always be questioned / you've got a community that, for the most part, knows that you're here for the money).
- One bad political incident is enough to cause nurses to feel resentful towards community members who are perceived as bitter and angry towards the nurses. In these cases words like "racist", "prejudiced" and "racism" seem to be used as a matter of course by most individuals involved, adding more pain to an already inflamed situation (you get one bad apple who will colour your view of the community for everyone else, even when someone is nice to you, you cannot see it, because all you've seen is people who are bitter and angry that you happen to be there / it's particularly if you're white and it becomes even a greater issue / if I see a nurse that doesn't like the community I know that they just aren't seeing a lot of the good, they are only seeing the bad).
- The inability of nurses to ever, even after years of devoted service to the community, become fully accepted by community members because of the transient nature of their position in the community leads to frustration and stress in nurses (your reason for being there will always be questioned / when you stay, your reason for staying will be questioned / Why are you staying here? Do you really like us, or are you just going to

leave in ten years?/ there comes a time after a while too where you feel like you're never really a part of the community. Never. / No matter how involved you are, you are still an outsider, you will always be an outsider feeling trapped and feeling confined in a way that I'm here in a community that I'll never be a part of).

- Although nurses individually usually provide the best service possible to the community, this may not be sufficient to fulfil community needs: the nursing station may not be sufficient to fulfil community needs. In these instances nurses in their individual capacity easily get blamed for not being able to provide appropriate care and they may be called down as being no good. This places nurses under extreme and unfair stress (the community thinks we are not good enough / well, if they would look at it from the outside, no, we are providing a good service, but is this community getting what it should get in terms of city standards, no, they're not. / they are not getting what they should get and they have a right to choose that, in fact they should be encouraged to do that. When you are told again and again and again that you're no good then you start to believe that / they will say that this nursing station is not satisfactory and they're right / the nurses have to allow them to say that and still be able to continue with their work).
- Lack of knowledge of the cultural differences causes stress for nurses (I knew nothing about the Indians / I think I'd only seen them like I said lying drunk on Main Street before / well they are basically a fun-loving people, but kind of screwed up).
- The unconnectedness between what exists in the reservation setting and the world outside the reservation causes many feelings of unreality and fragmentation in nurses which over time becomes quite disconcerting to nurses (you can't do certain things in a remote community that you can do elsewhere / the isolation / I guess just being so unconnected from the rest of the world / almost like you're in some northern bubble / I have often felt those people of Gibson haven't got a hot clue what it's like [outside their community] / I just figure off the reserve there's no way they'd survive, like they haven't got a clue what the real world is like / they are so dependent).

- Some nurses who work in their communities of birth, found that an added amount of stress and added demands were placed upon them by community members in the form of lack of privacy after hours, expecting privileged treatment from the nurses and acting as if the nurses were on duty at all times (I worked there and I felt that I had a lot of demand from the people because I was from there / they would talk to me all the time, even in the store / older people, they don't speak any English and maybe I felt too that because I'm from there, they felt free to talk to me whenever they wanted to talk which I don't see anything wrong with that but sometimes I felt they should go to the Clinic and talk over there when the Clinic is open / the after hour calls and people that were so (inaudible) / people sometimes, well, I guess they don't understand what's happening / when people call you they think that's the first phone call you got is when they're talking to you because of the pressure and because of there's just too many people in that community).

Intrapsychic Factors - Reduced Personal Accomplishment / Emotional Exhaustion / Depersonalisation

Nurses feeling that they have burned out in the past because they did not see the signs and were not aware of the problem as it happened to them until after the fact, now feel more prone to burnout (I also think now when I look back that I may have been burned out a few times before / I don't feel like I'm always burned out. I think I've been burned out a few times in the years that I have worked for Medical Services. / I don't think I'm burned out now. I don't feel burned out. / I know that I was burned out for sure when I was in Lost Lake / I can't blame myself because I know that I'm working hard so I never look at myself when I'm getting burned out / I always seem to look outward and try and look for something else, the cause of that / I have to have time for myself on top of that. It's hard to do / I was very stressed out then because I didn't have an idea why, like how am I supposed to do this? / I was just sort of thrown up here without any guidance and no orientation / But then about three or four years after that I started getting tired, I got tired as I said about the not being able to see change and that started to drag me down).

Overwork, overextension and lack of knowledge of own limitations seem to be contributing factors to burnout in nursing (When I start to feel like I'm doing it by myself, that's

when I know I'm getting burned out / When I feel like I'm the only one who is doing anything / When I feel like I'm isolated then I know that I'm starting to get fried / There's a fair amount of negative things going on here / It can be busy and stressful at time / I thought she could have died and it was all my fault / like I don't know how I'm supposed to, like they say, make time for yourself, but how do you do that? / Like how am I supposed to do that? What can I do, you know? / Like, really, when you're on call and you're supposed to be available, even when you're not on call because if something goes on you have to come back here, so how do you do that? / You just have to do the most important things, I guess I'm leaving myself out as being important or something / My priorities are everything else except little old me).

Negative self-talk, sleep disturbances, unhealthy eating habits, smoking and moving to a new community seems to be the prevalent behaviour pattern in nurses who feel overwhelmed in their jobs (A lot of the nurses don't feel like they're doing anything / they feel nothing is happening with regard to their work / when I think of the other years that I was in Lost Lake, I may have burned out a few times and recovered or coped with my burnout, but the last burnout, I think I just couldn't have coped in Lost Lake / I couldn't have. "But still you didn't quit nursing?" "You just moved venue, places." "Yes" / I'm planning on going back to the field so I don't know how it'll be. I've had a lot anxieties about doing that because I can almost feel the way I felt when I left. I'm not sure that it' a good idea).

- Extreme negativity towards patients, an inadequate level of functioning as deemed by the nurses themselves, spitting in the wind, not meeting deadlines, lack of enjoyment of their work, a sense of isolation, a profound sense of wanting to leave have been reported by a number of nurses (I was starting to hate people / They feel there's always a lot of patients that's going to keep coming every day / They feel like they're just spitting into the wind / They feel it is going to keep coming every day because it's a very sick community / They feel we have to provide a service and that's the position that we're in / particularly the ones that have been here a while or been around a while, do not see any purpose to their being in the north / You just shake your head, like, where's it going to end? / this is a fairly negative experience. I guess so / you don't function well / you just don't meet your deadlines / you don't enjoy your work / you just don't want to be there anymore /

frustration for me is feeling tired, unproductive / trapped but not trapped like I felt when I was in the field / when I was knowing that it was time for me to go / when I'm frustrated, there's certainly anger, there's a quiet anger, it's not an expressed anger / it comes down to how long is my life going to be on hold here? / the only way out is to take that plane, I can only go this far before I'm in bush and I can't go any further / the isolation, after a while, I think does close in on people).

- A false belief held by many nurses that they should maintain a facade of strength and imperturbability to the world in spite of how they feel inside, causes many nurses to repress their feelings, to their own detriment (If I'm at the point where I feel like I haven't got a list in my mind anymore, then I'm getting tired / It's all part of the eye-opening part I think, you know, I've seen these things / I would say it's been more of a positive experience even though it doesn't sound like it. / I know when I was younger, when I first started nursing and stuff, I was taught the old school, nurses don't cry, nurses don't talk about what they've been through, nurses are strong, nurses are supposed to do this, this and this and be the support for everybody / it took me a long time to learn I can talk to them about what I'm going through / I think it's something I just learned along the way. I've been nursing for over 20 years, I started nursing when I was 19 and 20 and I'm 44 now, I have learned the hard way, like holding everything back).
- Emotional exhaustion - nurses lose their sense of purpose about being where they are, they end up having no life outside their job and they take any criticism extremely personally and they have very limited resources for dealing with difficult situations (Either way if you're happy with your job or you're not happy with your job, you still have to have a life / when I see nurses who will work every day and not have a life outside of their job, I know that they just can't possibly be coping / if you don't have anything going on outside your work, you're not living / if I get a complaint that's directed right at me, I take it very personally because I feel like I have not done what it is I wanted to do / I felt that I would never go back into a station / it's like you can only feel it for so long and then once you've exhausted that feeling, you can't bring it back. It's like pain / It sounds like I'm going, "God, I go home and my family is a big burden to me so if I go back to work,

I'm happy again". / My time is so limited with two little kids and a husband).

- Reduced personal accomplishment - nurses feel that there is no progress in their work and that they are so tired of dealing with clinical issues that there is no time left for prevention (I got to the point where I was so tired from doing the same thing day after day after day after day / near the end of my field work I could tell that things weren't as good as they should have been / I was tired of seeing the same thing / I was getting frustrated because things weren't getting better / so near the end I was tired, I was very tired and it stopped being fun. It became mundane and, "here we go again", / like too much of the same thing and it was getting worse / like I'm confined by the boundaries of this community / you just start to stagnate / that's when I started getting really stressed, frustrated, when I feel like I'm no longer growing).

Interpersonal / Social Issues

Non-functioning interpersonal relationships or fights between nurses, between nurses and zone officers, between nurses and support staff cause the most stress in nurses and contribute directly to burnout (it was time for me to get out otherwise I wouldn't have been able to go back if I didn't get out when I did / there was fighting in the nursing station amongst nurses and support staff / I think that was my biggest burnout, why I burned out / the first thing that comes to mind is the Rina thing and if we can use that. You know what I'm talking about. It always seem to be things that aren't really inherent in the work but it always seems to be something else, like something maybe in my personal life but not the work specifically I don't think / I've known Rina since about ten years so I consider her a fairly good friend. You know you have an attachment to that person and when you see something like that start happening, you know I guess I seen it happening but I -- here I am, I'm going to eat my own words. I said I didn't feel I could do anything about it. Like I really felt it was over my head. I just didn't know -- did a lot of (inaudible) which I see now I shouldn't have / The most stressful part was dealing with the nurses I was working with and with some of the zone officers / with those nurses, personality clashes. I felt like I was dealing with youngsters instead of mature women that are supposed to be professionals / they tended to be a bit more careful in clinic with their attitude).

Interpersonal conflict between supervisor and supervisee where competence issues and the documentation of competence issues come to the fore cause extreme negativity, stress and burnout in nurses (and the nurse in charge was just going up one side of me and down the other / I can't put a finger on it, but it's just you really got to watch your step now because if somebody complains about you, you're really going to be up shit's creek without a paddle).

The close proximity of the workplace and living quarters as well as the enforced socialisation in nursing stations lead to tremendous strain in nurses when the interpersonal relationships between various nurses become strained (I think there certainly are nurses that are narrow in their thinking or narrow in their perspective and narrow in their outlook but that's a given / a lot of that tiredness had to do with the stress of having to deal with them everyday / sort of waiting, now, what's next / what are they going to pull? / What stunt are they going to pull next? / I found that very stressful / I think most people would find it a bit stressful / It wasn't just work there was other things that were going on in the station / The nurses that worked there they're not from the community so they live and work in the same place and socialise. I don't think that's healthy).

The close proximity of nurses in the workplace and living space make nurses particularly sensitive to each others moods; this causes continuous low-level stress that easily flares up into something bigger (I don't know what the difference is between me and the other nurses / I don't think that you should have this view of coming to the north in order to make a lot of money so that you can live your life at a later time. I feel that if you're not living it while you're up here, you're never going to get satisfaction from it / I found that very stressful / you work with these people and sometimes some of the nurses that's all they see is just the people that they work with / when people are feeling kind of upset / someone's mad at you then you almost have to talk about it to carry on / when somebody's not feeling good or you think someone's a little edgy, it's not a good feeling / not in a place where you have to live together and work together / I coped, I think, with the little burnouts that I had but I had a big burnout and I had to get out).

- When there is strain between nurses exist any number of small actions, either deliberate or unintended, do snowball into the most horrendous interpersonal strife imaginable. All

nurses involved feel the stress of this confrontation at a very deep personal level with resultant tiredness, stress and fight or flight response (whispering behind people's backs / the purposeful isolating / the talking in angry tones when a simple question was asked / Just little things like that / It just built up and built up / it was once in a while and then it was like almost every day and then it was several times a day / I don't want to deal with this anymore / If I asked them how things were, they'd say things were right and fine and then I find out later it wasn't or they wouldn't even answer at all / Like they wouldn't want to discuss anything / I don't know how to deal with stuff like that / It's not that I didn't want to do my job anymore, I just didn't want to work with them / I was burned out with them).

- The time spent in a community may be marked by limited contact with other people outside the work situation. This leads to a claustrophobic among nurses reaction in that they feel that they are caught in a situation that over time will lead to notable isolation, they feel that the only solution to this is to get out of the community, but there may be obstacles in the form of expensive flight tickets, or staffing problems. Over time this causes burnout in nurses (if they got out every second weekend / if they had some kind of support system in the community, a friend in the community / someone that they can talk to and someone that they can just let loose with every once in a while / they're contained in the nursing station and they stay in the nursing station).
- The time spent in the community, without friends in the community outside of the nursing station or hospital, with the only outing being the trip to the store, and the rest of the time spent working or talking about work, day after day, leads to burnout in nurses (they work in the nursing station and the only time they really get out is to go to the store and come back / If I see a nurse doing that day after day after day, I know that they're going to burnout / nobody would listen, there was nobody there to talk to and nobody there to listen).
- A bad interpersonal experience with a drunk individual, or a rapist, or a child or person abuser, may cause nurses to generalise their negative feelings to the next patient, in order

not to do this they may experience a high level of stress in their interpersonal contact with other patients (stuff that happened in the nursing station / lots of things happened / people die and sometimes a violent death / things were getting worse and people weren't taking responsibility for charge of their lives / they always wanted you to do it for them / I was starting to hate people).

- Nurses who lose sight of the interpersonal and caring nature of their jobs and focus only on the financial remuneration aspect of it set themselves up for emotional exhaustion, depersonalisation and burnout (they're saving a lot of money / they're working for the money / the only positive thing they can see with regards to their work is the pay cheque that they're getting / I find it really hard to believe because money has never been that issue with me).
- Years of dealing with the same set of problems cause some nurses to feel an absolute inability to effect change in or for their patients, this causes nurses to start blaming their patients (I'm running into nurses who feel that after all these years, there is just nothing more that they can do / Person A would come in and you thought you had effected change and then you found you didn't at all / they were wanting, again, for you to do it for them. I just found that frustrating / looking back, generally, in my career in nursing, that's the thing that turns me off the most is people that won't take responsibility for their health care, people that expect everything to be given to them).
- Some nurses experience their families as a support, other nurses find the balancing act between family life and work life particularly stressful and personally intrusive (I've got two kids in school, now, so I can't just pick up and go like I used to / But I'm not sitting during those times when I'm not exercising, I mean I'm cleaning the house and taking care of kids / I think you're always on the balancing act between your family life and your work life / it goes right into your personal life because you can't separate the two. You're one person, you can't separate. So I feel like it's always the balancing act for the nurses / It's stressful not being away from your family / And coping, well, it's a lot easier to do it when your family is not around / I find it, anyways / Six years ago in Shamatawa I did it by

myself and then at the beginning, up to November, I was by myself. And it's a lot easier / It's stressful not being away from your family, but it's a lot -- it's more stressful having your family here because you have to bounce back and forth / You can't sit down on your break and have a break / You now have to quick, go be a mom instantly and it's very hard and I know the kids find it hard, but I find it hard / It's difficult. You have your time by yourself, you have your own time to unwind, do whatever, but I don't have that / You don't get the time to unwind and to do the things just for yourself / I guess that can be a burden because you put expectations onto yourself. I do anyways / More expectations to please everybody else, and I'm kind of left out and sometimes that's hard / So then you put yourself aside and you go back to work and you're fine and then you go back to being that, but then every now and then it pops in, "I never get anytime to do this," or whatever / But that's the most stressful part for me, it really is / my family, my own parents, sometimes I felt that they didn't understand what was happening in the station).

- Nurses find deaths of community members, especially those they had a good relationship with previously, extremely stressful (the pressure that we felt / I knew the people and it was difficult / Sometimes even when people phoned and said someone got run over by a skidoo or something, the first thing that came into my mind was my own family, whether it's them, how am I going to cope? / what am I going to do if that's my mother? / that was just briefly, you know I'd think of that just briefly and then carry on / but that's caused a lot of stress for me because I was from there and the people had died. Deaths).
- The differences in cultures and in values between nurses with a Western orientation and first-nation people cause stress in nurses (it was because the person who complained about me didn't have the facts / I've had to defend myself against Chief and Council before where they sat me down with the chart / If they don't like the way you did something or they don't like the way you told them something, or you put the responsibility where it belongs on the person, "well, this is your responsibility, you're supposed to be taking your medication", or whatever, and then they run to the Chief and say, "well, I don't like this person" / They don't understand the native people, there's very little understanding of the native people and sometimes they bring with them their own values and expect the people

to have the same values to fit into their values / and I think sometimes that's why they leave. Some stay and some leave).

The Formulated Meanings from the Extracted Significant Statements of the
Symptoms Experienced by the Individual

The five main symptoms of burnout in nursing as presented by the respondents are:

Physically Debilitated

Fatigue is the most frequently reported symptom that nurses experience, exhaustion, an all encompassing tiredness combined with sleeplessness and a lack of energy (I become quite vocal about it but how it affects me is fatigue, yes, mainly fatigue I think is the big one / lack of interest and unproductivity / I'll go home and I'll sit instead of keeping myself mobilised / I think that half the battle to staying healthy is keeping yourself mobilised / It's very, very small, it starts to invade you, tiredness at night and not sleeping / Very tired (inaudible) / you can't get out when there's only two or three of you and you're so tired you don't want to get out. You just want to go into your apartment and sleep because you're so tired because you've only had a few hours sleep / I wasn't sleeping but my body was tired / I couldn't sleep).

Nurses experience vague physical aches and pains, like stomach ache and leg pain, with headaches being the most frequently reported (I had pain sometime / leg pain / headaches, just physical pain / I had sore legs and sore head and sore other things because I wasn't coping / but at the time when I think I was burned out, maybe I didn't cope too well / I was burned out when I left the previous nursing station where I worked / I felt that I was burned out, that's why I had to leave).

Feeling physically tense and physically tired simultaneously, as well as not being able to focus and concentrate (Well, the hours and that can be very stressful, working that amount of time / you do 70 hours a week sometime and I guess that can be tiring / I go back and I can no longer go put my feet up or whatever, I have to go and attend to the needs of the kids and the husband, but I'm left out, you know -- So then you put yourself aside and you go back to work and you're

fine and then you go back to being that, but then every now and then it pops in, "I never get anytime to do this," or whatever. But that's the most stressful part for me, it really is / I was really stressed, I was really exhausted too / I was really tired, physically and mentally / I'll never let them do that to me again. I thought it was okay but I found out it wasn't. So I know better now, I've learned from that / the first time I ever left the station crying in all the time I've worked up there / of course, you get tired, but I don't remember that, I don't remember the fatigue / that feeling that you've got a problem and you can't go anywhere with it, you can't change it, you can't deal with it, it's there and that's it / And you get into that feeling too of being trapped when you feel I can't go anywhere, this is it / I knew it was time either to quit or take a leave / I had to get out).

A lack of exercise due to time constraints, a lack of concentration, not doing the things they like, a lack of physical activity that starts to invade the nurses in almost surreptitious small stages (I don't exercise / I don't stay healthy / I don't find the time for myself / I don't sit down and read a good book like I used to / I don't write letters like I used to).

In the most severe cases nurses became physically inoperative during extreme crises, crying and fearful of the situation, taking sleeping pills to sleep, not eating (I sat on a couch for seven months. I got up in the morning, I turned on TV at eight o'clock in the morning, I watched TV until five o'clock at night everyday. It was like my work schedule. That is exactly what I did / I should have been happy / I should have been happy to be in the city but I was so fried that I did nothing / All I did was get up and I watched soaps and talk shows all day long and I waited for my husband to come home and I had no money / Have you ever freaked? "Oh, I don't know what to do." And boy, did I catch shit for it. I cried about it for a week / I thought she could have died and it was all my fault and the nurse in charge was just going up one side of me and down the other).

Emotionally Overwhelmed

Emotional exhaustion with a soul, mind and body that is very, very tired, is the symptom most frequently reported by nurses (it's like you can only feel it for so long and then once you've exhausted that feeling, you can't bring it back / My family couldn't believe, they said that was the

worse they've ever seen me coming out of the north. I said, "I can't talk about it right now. You have to give me some time here." / Tired like physically tired you don't sleep very well and you're kept awake and you think).

Nurses feel stressed out and feel very frustrated, they just want to leave and sleep for days on end, when they do leave they do sleep for much longer periods than would be considered normal (I'm not taking that little bit of extra time to take care of me / I think regardless for me personally I'd still think I'd have to get out of this job every two to three years / I wasn't satisfied with the work anymore / I feel like I am homesick / I feel like I want to go home and that will probably happen to me for as long as I remain here / I have not really eroded so much yet but if I stay it will I think / I just feel I'm ready for a change. So I'm taking a six month (inaudible) the end of March / Stressed out is more like it / when I left Gibson in June I was really glad to leave / And I was just tired / I just wanted to sleep and I did sleep for about three days after that I just started getting my energy back / I've got to start making some decisions here, I think I needed that time away from them).

Some nurses become desensitised to their patients and their co-workers, having almost no emotional feelings for their patients other than anger and resentment. Some even speak of hate (I was starting to hate people / I find that very tiring and sometimes I was exhausted / I was just so fed up with what was going on. So I had to leave / I don't mind taking charge for a while but don't ask me to do it forever and don't count on me to do it for you forever, because I won't do it / I just know that that's when my frustration starts to show / it was a very devastating experience (inaudible) perspective).

At times some nurses feel emotionally overwhelmed and sad to the point of crying and becoming overinvolved in the current situation with their patients or co-workers (Hurt is the only word to use / It's like pain / when we tried to resuscitate people sometimes you go through what you did and then you think I wonder if I could have done that another way? I do anyway / There's whatever, guilt, there's anger, there's, I don't know, sadness / If I feel guilty about something, like I should have done more or I'm really angry about something / you don't have an idea of the history or the story and it's very frustrating trying to figure out, piece together what's happened

and what you're supposed to treat / The most stressful part for me is splitting myself. So it's not really work-related, it's both. It's work-related, it's family / I mean you're a minute away from home, here, and the one moment you're in the nursing station, you're a nurse, and the next minute you're out and you're a mom and there's no -- And just when you're trying to be a mom, you get called back to be a nurse and that's hard).

A high level of emotionality over time will lead nurses to feel less and less and become emotionally exhausted (that's when I started getting really stressed, frustrated / when I feel like I'm no longer growing / It was a terrible situation to be in. Terrible. There's just nobody to talk to and nobody to share it with / I just lost interest in that / Things that used to make me very, very happy, I don't do them anymore / it's because of my lack of time or my lack of ability to find the time / I find the time for all the other things but I can't find the time for myself / that's probably why I am in this two to three year cycle of burnout / I think you can go through burnout once and you might learn from it / You might learn from it and you might not / you'll likely go through it again / I think it's the second time that gets you / I think it's like getting stung by a bee / I just get so frustrated with the system / I get frustrated with the attitude of the not -- I'm frustrated with the politics / If that's burned out, then maybe I am, maybe I shouldn't be working anymore in the north, I don't know).

- Being on the verge of burnout, running just ahead of burnout, feeling tired but pushing on nevertheless, this is the position in which many nurses find themselves (My problem is more rooted in the fact that I get tired from work / I feel like I must be constantly running ahead of burnout / I feel that burnout is a very pervasive thing / "How do you stay healthy, how do you cope?" Well, I don't. Well, I obviously don't because I get burned out every two years / "I don't believe that anybody working here will not burnout." / I do not think that anybody can do this job long term, particularly nurse in charge but even community health nurse).
- Burnout creeps up on nurses without their being aware of the syndrome as a whole until something bad or traumatic happens in their lives which makes them realise that they have not been coping with the work for quite a while (Burnout is different -- It accumulates /

Burnout creeps up on you and you're not aware of it / you will become tired / then there will be an event that will shake you / It will be an assault, it will be something in your personal life / With me, when my father died, that was the event. There is always an event that will make you look and realise that you just were not coping with the job).

- Nurses come to the point where they cannot make sense of their lives and their work, it all becomes overwhelming. They may also blame other people and in general they feel very dissatisfied with their work (you have to get out and re-evaluate / you're not just re-evaluating your job, you're also re-evaluating your personal life / I just no longer could see any point to it / I was just tired / I was really bound by other people's feelings / I think that I lose sight after a while / I just get tired of all the stuff and I look for someone to blame / but I could see it going down, in retrospect, now, at the time I didn't, but in retrospect I could see that I was heading down / It was time to get out. Had I not gotten out I don't know where I would have ended up / I really don't, because I was getting tired).

Impaired Relationships

The avoidance of involvement with co-workers and people in the community is used by some nurses as a means of protecting for themselves; they only socialise superficially. Nurses feel that this protect them from the pressures created by having relationships with people (I feel that if I get to know too many people and too close to them that maybe they'll start putting pressure on me like the people did before / That's probably something I should learn, but how do you deal with people who don't want to talk and tell you what their issues are and you know you're supposed to be supporting each other in the type of work that we do).

Nurses start to have strong negative feelings towards their co-workers and especially their patients over time. If they don't get out of the community these feelings increase (I do let it out verbally, I'm quite verbal and emotional about things / there's a lot of attention-seeking with that/ Some people like it, that sick role / they misunderstood me or, I don't know, they just plain lied / we all needed a break from each other / I was starting to hate people / if I didn't get out of there I was going to hate everybody / the thing that turns me off the most is people that won't take responsibility for their health care).

Co-workers can be either an incredible support or a tremendous burden and stressor for nurses. If the relationships becomes twisted, nurses just want to leave because of all the negative symptoms associated with the twisted relationship (I run across a lot of nurses who don't recognise that we have to provide a service and that's the position that we're in / I wonder if I'm on the same track as those nurses / A lot of it was just telling her how I felt about things that she was doing / Whether I want to work with one of them in particular, that's debatable / That wasn't so much the work as the nurses who I was working with / I just couldn't handle them anymore / I didn't want to be around those nurses anymore / to tell people that somebody here is affecting us in a very negative way / But that will just make me pull my hair out and make me walk out and quit all together).

Decreased communication and repressed anger are a common occurrence for nurses who do not deal with interpersonal problems as they occur (I just couldn't handle them anymore / I didn't want to be around those nurses anymore / I was starting to hate people / if I didn't get out of there I was going to hate everybody).

Convolutd relationships, where nurses have to deal with their boss, who is a nurse and going through the same things as they are, and where nurses socialise together as equals, cause trouble over time, especially when the relationship becomes a triangle - a three-person emotional configuration - after the arrival of a new nurse (it's a strange position because your friend is your boss and you have the work part that you have to separate from the social part / And that worked up until recently and then it really got to be a problem in resolving the issue I think or for letting it go on for so long / I never felt really overwhelmed by it or anything but just sort of nagging on your mind / I'd flap off to somebody, you know, Karla was there to listen).

Family relationships add to the stress that nurses experience in the sense that they do not have enough time to spend with their family, families need to be looked after, this leads to interpersonal problems with family members (I think that you can lose sight of your family life too / I need to know that I've got a family there and I can get support from that as well / it's difficult to find the time to do that / You have to work to find the time to make a family life / I've got a life outside work, but I've got two kids to take care of, I've got a husband who I live with and

have to maintain a relationship with and it's work, it's work to maintain this family / life outside my work / I will look at that and I go well, where is the time for myself? Because there isn't any./ the actual only time that I get to myself is between twelve and one when I go home for lunch and there's no one there / It's stressful not being away from your family / it's more stressful having your family here because you have to bounce back and forth / so it is, it's more as if you're now split between family and work? / You can't sit down on your break and have a break. You now have to quick, go be a mom instantly and it's very hard and I know the kids find it hard, but I find it hard. / But to be up here and to be without family or to be single, I think it would be different. "In terms of easier?" Yes / you have your time by yourself, you have your own time to unwind, do whatever, I don't have that / you don't get the time to unwind and to do the things just for yourself, because you bounce back into spending as much time as you can with your kids and your husband).

Forced relationships with people that nurses may normally not socialise with but do out of necessity because they are in the same isolated community lead to feelings of self-alienation and frustration in some nurses (that last few months with the girls, even though I was sleeping, it wasn't a restful sleep / I'd wake up tired even though I'd go to bed early / it was just knowing I had to deal with them again the next day, it just tired me out / I was starting to hate people / if I didn't get out of there I was going to hate everybody).

Lack of relationships after hours and sexual tension further increase the stress that nurses experience as part of their daily schedule (I'll phone up a friend in Winnipeg, "oh my God," you know. They just probably sit there and listen to me spout off and not have a clue what I was really going on about / nobody would listen, there was nobody there to talk to and nobody there to listen).

Decreased Motivation

Nurses find it hard to motivate themselves to keep up a healthy lifestyle if they become tired or exhausted (I was tired of seeing the same thing / It was just too hard to get out of bed for those night calls / you don't enjoy your work / I was burned out when I left the previous nursing

station where I worked / I felt that I was burned out, that's why I had to leave / I really did feel burned out and I was burned out last year. I had to leave / I don't think I'm burned out, I just feel that I've had enough / "I keep saying that sort of like it's a litany in my head. Hang on till the end of the week, you're going to get out of here".).

Some nurses become so unmotivated that things that they used to enjoy like crafts, exercise and even eating become impossible to do or to take pleasure from (It was just too hard to get out of bed for those night calls / after a while the money didn't make any difference at all. It just didn't make up for it, for the stress / you just don't want to be there anymore / I have to do a lot of things that I don't necessarily feel like I want to do in order to stay healthy / I have to do a lot of things that I don't necessarily think are useful / keeping yourself moving and doing something / I don't know if it works for me because I -- right now, I'm not exercising, I haven't got any crafts to do. Your heart won't be in it after a while / the things you have to make yourself do until your body wants them, until your body gets into this routine / if you don't get into that routine of doing things that are going to make you healthy, then you'll just sit and you won't / it'll creep up with you in your own life).

Satisfaction in all aspects of life decreases over time, an insidious invasion that is difficult to detect until it is already leading to feelings of work evasion and strong depressive feelings (I was tired of seeing the same thing / Like I'm confined by the boundaries of this community / you just start to stagnate / When I'm frustrated, there's certainly anger, there's a quiet anger, it's not an expressed anger / I felt I was at the bottom, I guess, of burnout. It's really bad. I felt I would be ready to go back last Christmas but I went back for a while, for Christmas holidays and it was still the same there I'm not going to go back, not for a year. I'm going stay here for another year / I just didn't feel that what we were doing in the clinic at that time was going to achieve any goal / You'll be able to get all your tasks done during the day but your satisfaction will decrease and decrease / It's very, very small, it starts to invade you, tiredness at night and not sleeping / You're feeling like you don't really want to come into work that day / I don't want to come into work every day / When I wake up in the morning I'm either overwhelmed with all that I have to do / I feel like, well, there wasn't really anything I have to do / I know that if I have to look at that because there is always something to do in this job).

Listlessness, lack of enjoyment, and indifference to patients and the work in general are symptoms that nurses complain about (I got tired as I said about the not being able to see change and that started to drag me down / shuffling papers from one side of the table to the other desk / not getting the report done that you're supposed to do / focusing on the things that aren't important and you sort of think (inaudible) / That's how it manifests, and not wanting to go to work / That's not all the time, that's not as strong as I'd say on occasion, but not a lot / Usually I'm very goal directed during the day / I try and get a certain number of things done and clear my desk / I can't always do that / I think it happens probably about after three months even from starting / I know that if I don't get out in November or December, I'm going to be very, very tired).

Even getting out becomes a chore and a hardship to some nurses (I have to force myself to go outside when I don't feel like I want to go outside / but I feel better for having done it / That is actually the biggest battle is trying to get on the cycle of the things that make you feel good).

Feeling trapped in nursing and wanting to get out of nursing become a theme for nurses who are stressed out. These feelings are linked to vague feelings of unease with nursing, seldom to a specific situations and for specific reasons (but I don't know how it's going to go / Frustration for me is feeling tired, unproductive / trapped but not trapped like I felt when I was in the field when I was knowing that it was time for me to go / When I think about going back, that's what bothers me / I really feel that my life is on hold when I go back there / if I go back it would be for a year or two years or three years / I didn't want to walk out like that because I felt that I would disappoint too many people / Many times I feel I have to get out but I can't work anywhere else other than in a station / I'd like to stay in nursing).

Lack of Concentration

Nurses experience tremendous trouble in meeting deadlines and in focussing on their paperwork (you don't function well / you just don't meet your deadlines).

There is an awareness of being tired, but not of not being able to concentrate, it is only

in retrospect that the extent of the concentration loss becomes apparent (you will be aware that you are tired but you'll think that you're functioning quite well on the job / this will go on for a period of between one and two years / Well, I'll do it the best I can and I'll do it really slow because that's the only way I know I'm going to do it properly / I didn't feel at that time (that I could not cope) but when I look back now, that's probably why I couldn't sleep / I wasn't coping well).

Losing sight of your reason for being there in the first place, as well as of what you should be doing is a common occurrence for nurses (if you don't have any other supports or any other outlet, anything just for you, then you lose sight of the point to it all / The most stressful part for me is splitting myself. So it's not really work-related, it's both. It's work-related, it's family. I mean you're a minute away from home, here, and the one moment you're in the nursing station, you're a nurse, and the next minute you're out and you're a mom and there's no -- And just when you're trying to be a mom, you get called back to be a nurse and that's hard).

Tiredness and exhaustion make concentration on the task in hand very difficult for nurses (They're just too tired / they're just too tired because of the demands of the job / I mean we'd been going all day already, we were so tired / we were checking each other because we knew we were so tired that we were unsafe / But I just had to take some time to do it because I was thinking slower / If I sat there getting overwhelmed by it, it wouldn't get done. I'd be freaking / I spent a lot more time to myself. I didn't go out as much as I did before).

The Formulated Meanings from the Extracted Significant Statements on how Nurses Operationalise Salutogenic Qualities in their Lives when they Experience Burnout

The main salutogenic qualities in nurses as presented by the respondents

Comprehensibility. The stimuli deriving from one's internal and external environments in the course of living are structured, predictable, and explicable.

Northern nursing is very different from hospital nursing in the south. It carries its own

rewards in terms of being exciting and challenging, offering professional freedom and hands-on practical experience, with the nursing being very dynamic. It also has a positive side in that nurses have the opportunity of working with a culturally different people who have a wonderful sense of humour and are really in need of good service provision (Northern nursing experience is far different from what you work as a nurse when you're in a hospital / the people, they're different, the Indian people, because most of the stations are on the reserves here in Manitoba / I find northern nursing very rewarding for me / My experiences working, being a nurse in the north have been very positive right from the beginning / I've enjoyed it a lot and I've learned a lot and I have found it very dynamic / My memories of the field are very positive actually and I don't have a lot of negative memories or feelings about the work or the people / When you send them away you really do feel like you've done something / in terms of the work of being up here I like it / it's rewarding and that part of it, I guess, makes me feel good).

- Learning about nursing, becoming a better nurse, learning about a different culture, and the monetary rewards of working in the north provide the incentive to do the job and makes sense to nurses (you can do it for a while and I guess the money is a lot better too, so that pushes you a little bit too / You get a lot more money than you have where you go back to the hospital and your wage is cut in half / I found it interesting learning about the different cultural group which I really knew nothing about before / I've learned tons, made my money / That wasn't the main reason why I went up, but it helps because I would like to get into community health someday).
- Providing good nursing care and being appreciated by patients provide their own sense of satisfaction for nurses (I feel like when I'm making decisions I'm making long-term decisions that are going to affect a lot of people / If you really look closely at what you're doing and if you're finding some happiness in what it is that you're practicing / If you're happy with what it is that you're doing at that time and you're doing your best for that client / The stress of work is alleviated by enjoying the work / The majority of them appreciate when you do something nice for them or if you help them / I even had patients phone back or see me on the road there and apologise if they swore at me the night before).

- Coming from rural areas helps with the adaptation to isolated communities because these nurses know how to put up with living in a gossipy community where everybody knows everybody else's business, as well as how to entertain themselves (one reason I became a RN was to go back and work with my own people / We discussed the incident that happened and sometimes feelings would be discussed with the nurses / I feel that I couldn't do anything else except northern nursing / But I'm part of the north so maybe that's why I feel like that because I grew up in the north / I know the people and I know their lifestyle, so I think it's easier for me to stay than a girl coming from Winnipeg).
- Putting things in perspective, standing back emotionally, in a structured way as things start to happen, helps nurses to deal with stress (There's a fair amount of negative things going on here but really there isn't / if you don't see a purpose to why you're here then you should reconsider why you are here / you will never be happy up here unless you are gaining some sort of satisfaction from your daily work / when I'm not doing a good job then I need to step out of the position for a while, put it back into perspective and then start again after that / I'm trying to put this into some kind of perspective sometimes when it starts happening).
- Accepting that you as a nurse can only do so much with what you have got, understanding that the job is stressful in itself, without feeling personally responsible for situations that nurses encounter as part of their work (It's like you do the best you can with what you got / that's part of the job. I mean, shit happens. It does / You got to look on the bright side, life's too short to sit there and stew / anyways like things that you really can't control / I'm just learning now that you just can't control them / I used to get really emotional about it, but it's not worth it sometimes, you sort of just have to sit there / what am I going to do, wave a magic wand and make the weather go better? I mean I can't do it. I've got to live with what's happened).
- Bad things will cause nurses to feel bad, you cannot control everything, so you have to accept and live with things as they happen (anyways like things that you really can't control / I'm just learning now that you just can't control them / I used to get really

emotional about it, but it's not worth it sometimes, you sort of just have to sit there / what am I going to do, wave a magic wand and make the weather go better? I mean I can't do it. I've got to live with what's happened).

- Decisions made about the care of patients have long term effects on patient's lives; change occurs over a period of time, so although nurses may not see the change, they know that over time it will take place (I feel like when I'm making decisions I'm making long term decisions that are going to affect a lot of people / Any of the changes that I make, even though it seems like slow change, I know that with time a lot of it will work).
- Life as it happens continues to provide satisfaction and enjoyment to nurses (The grass roots individual, I still see the laughter / I see the sparkle and I see that sad individual / I've got goals outside of work that have absolutely nothing to do with my nursing / I leave here and I'm thinking on the way home, what am I going to make for supper tonight. I'm finding enjoyment in those things that are right in front of me).
- The work, even when it is very stressful, is basically what nurses thought it would be (The stress of work is alleviated by enjoying the work / It's basically been what I thought it would be, I don't think I let things really get to me.).
- Learning to cope and to deal with situations makes nurses stronger in the long run and makes them feel more confident about their abilities as nurses (Now at least I'll tell people (when I get tired). I think in this situation I'll tell them, if you see I'm not coping with the job then you better tell me. Don't hide it from me and make sure that within two to three years I have made a significant life change that's going to get me out of the position / up north was another experience / like I said it was maybe a bit of a stepping stone and probably opened up some doors for me. I'll never say I ever resented going up north. Never / I know you can work anywhere no matter what the conditions are if you work with someone that you enjoy, if you get along and work well together, if you get out frequently. I still believe that).

Manageability. The resources are available to meet the demands posed by the stimuli deriving from one's internal and external environments in the course of living.

The fact that nurses have to rely greatly on their own skills and decisions, while doing their own thing in terms of patient care, is experienced in a very self-affirmative manner by nurses (They make their own decisions / They just do things on their own. They don't need doctors' orders for everything / It's a reward, I guess, all in it's own as far as being able to do the things that you can't do elsewhere, except in the northern communities / The expanded role is really good / it allows you to do more than what you can do / That's my biggest thing, being able to do a lot more / I was quite happy about that because I had done the right thing by just sheer common sense and I was really proud about it and I carried that with me for a while / I feel like I'm doing what I'm good at / I'm less restricted / I'm more independent in my ability to do things/ I can deal with people on a one to one without having restrictions placed on me / I can pretty well practice in the way that I want to practice).

The fact that certain limitations and guidelines exist within which nurses function clinically adds to their sense of security and safety within the work situation (they let you think / I'm glad they have the limitations that they do / there's certain things we're not allowed to do, we're not doctors and there is guidelines and I'm glad there's the guidelines there / It just makes things a little bit more safer for the patient).

Learning how to pace yourself, learning the limits of your capacities, both as a nurse and as a human being, learning what your individual resources are, helps nurses to deal with and withstand their stressful lives (I altered my work environment / I work at it from a different angle now / I know we did everything we could / I was quite happy about that because I had done the right thing by just sheer common sense and I was really proud about it and I carried that with me for a while / where does it go? Out into outer space in that big pink ball that I hoof out there. I do that imagery thing when things really bug me. If I feel guilty about something, like I should have done more or I'm really angry about something, I do let it out verbally, I'm quite verbal and emotional about things, the way I react to things, not necessarily at that time but maybe in private. But bad feelings I try and dump as soon as I can. In my pink bubble. It's huge and sometimes I

fill and sometimes I only half fill it and sometimes I'll barely like start filling it, but once I exhaust the feeling, I hoof it and it's gone. It makes me feel better to know that I was getting rid of it, that I actually felt it and then it's gone. I can't feel angry about this anymore so I'm going to get rid of it now. Because I've felt as angry as I'm going to be. I was only angry about five minutes about this, I imagine, I'm feeling it and as I'm feeling it, it's coming out of me and I see it filling in the ball. There's whatever, guilt, there's anger, there's, I don't know, sadness. It's all in the ball because as I'm feeling it, it's going and towards the end I'm sort of going (inaudible) mad about this. Well, that's what I do. It's probably the weirdest way of handling things that you've ever heard).

- Northern nursing is experienced as making nurses better nurses and stronger individuals over time (it's made me a better and a stronger nurse / I was quite happy about that because I had done the right thing by just sheer common sense and I was really proud about it and I carried that with me for a while).
- Talking to other nurses after a traumatic event helps nurses to endure the emergencies that do occur (when something really bad happened like people died, many times the nurses would just sit together and talk about it. I think that's how we cope with those emergencies that we have).
- Not having to work in their communities of origin is an improvement for some nurses because the personal attachment issue mainly becomes a non-issue (But I don't feel the tension that I felt when I was at the previous nursing station, so it's kind of different / I guess it's because I don't know the people at the personal level / the difference for me is they're not attached to me personally).
- Some nurses feel that they can rely on themselves, their personalities, for the most part to let things roll off them, others have specific strategies that they use to deal with and withstand the pressures of the job, others find that their relationships in and with the community help them cope (when something really bad happened like people died, many times the nurses would just sit together and talk about it. I think that's how we cope with those emergencies that we have / I don't think I let things really get to me. I don't. There's

some things, but for the most part I think I tend to let things roll off of me. I'm a type B personality, I'm quite laid back. I've had that on past jobs, my performance appraisals. I have a calming effect on people. If something happens, I don't go off in a flap. I don't know why I'm like that, it's just that's me / Generally, the job is really good when you work in the clinic and stuff like that / I don't mind seeing real emergencies after hours, I don't mind it at all. People come and they're really sick, I'm just like "oh, let's do something," and that's fine / I was quite happy about that because I had done the right thing by just sheer common sense and I was really proud about it and I carried that with me for a while).

- Nurses feel that they are doing what they are good at, they are less restricted, and that in working in the community, they are working with a lot of people in order to build something for the common good of the people (I remember feeling very accepted within the environment in which I was working with the people there / Like as much as it was difficult to do that, it was still almost invigorating / And when you'd accomplished something and you had done well, which you had an abundance of, it augmented those positive feelings / I feel like I have a lot of control over what it is I want to do for the community / I feel like I have a lot of control over where I see the health care going for the community / I can use a lot of input from people I work with in terms of programs that everybody's going to be happy with / I feel like when I'm working with this community I'm working with a lot of people in order to build something / I don't feel like I'm doing it by myself / I had absolutely no preconceived ideas as to what I was going to be doing / It was all a complete surprise to me when I got up here and I liked the work from the start).

Meaningfulness. The demands imposed by the stimuli derived from one's internal and external environments in the course of living are challenges worthy of investment and engagement.

Nurses report that northern nursing is the greatest work, the most satisfying, interesting and rewarding work that nurses can do. It combines the best of what nursing could be, it embraces the full range of nursing services, from planning for health promotion, right through to acute care, from birth control counselling through pregnancy through new borns, right into old

age, across the whole family (I think that the satisfaction that I get is probably what's keeping me here) / I find it tremendously satisfying / I feel like I'm doing something / I feel like I'm doing more than I would be had I remained in the city / I'm doing what I was meant to do / I've enjoyed it a lot and I've learned a lot and I have found it very dynamic / My memories of the field are very positive actually and I don't have a lot of negative memories or feelings about the work or the people / But I just found the thing that made it so positive was the people themselves, their attitude, their tragedies, being able to reach out to people and really feel like you were making a difference / The other thing that was positive about the experience was you were growing all the time / Professionally, you were growing all the time / The expanded role is really good. Coping / in a hospital setting, you follow the doctors around. It sounds bad, but it's the nurse/doctor stigma, you follow behind. You do as you're told, what you're told and you do it when you're told, here, you're in complete control of yourself / I've enjoyed it for the most part / challenging, it's been very interesting work. I found it interesting learning about the different cultural group which I really knew nothing about before / Northern nursing experience is far different from what you work as a nurse when you're in a hospital. It's interesting and the nurse is on her own / they don't have to have, like in the morning we have to do a bed bath and feed the patient, there's nothing like that in northern nursing, it's just different / It's interesting when lots of things happen that don't happen in the hospital. Well, they do happen in the hospital but in the hospital they're all separate, but in a station it's everything / that's what makes the work interesting / I find northern nursing very rewarding for me / one reason I became an RN was to go back and work with my own people. I guess any nursing is rewarding if the people sometimes even just say thank you).

The nursing practiced in the north in general has the distinction of being the first line of defence in health care, and the nurses are right in there, making a difference, doing something and helping people help themselves (Why did I want to be a nurse because I have this idea that a nurse helps people and I wanted to be useful, I wanted to help people help themselves / And after a while I got used to it and I really enjoy it. I enjoy having, like, well, here you're doing a bit more, which is nice, and you sometimes have the time to do it / I'm not saying you shouldn't rely on other people for anything, but when it comes down to it, you know, you have to help yourself. No one else is going to. I've learned from this experience / I don't know if it's the people or if it's

the challenge. I think a lot of it has to do with the challenge of working there / I really like working there as opposed to the other stations I've been in / But I just found the thing that made it so positive was the people themselves, their attitude, their tragedies, being able to reach out to people and really feel like you were making a difference).

- The independence permitted to for nurses by this type of nursing adds greatly to their self-esteem and ability to practice independently in a focused, responsible manner (I'm getting paid for what I'm doing and I'm getting rewards on the side for what I'm doing / Right now I've got a project - I'm taking an ECLS course / It's certainly going to increase my self-esteem if I pass the course, so it's good / And part of it I'm going back because I feel like my skills are fading. I need to go back I'm not current anymore and I really want to keep my skills up and I feel like I'm going to lose them if I don't. So it's sort of for a refresher as well / my choice in the jobs I've had over the years has gradually been more positions with more and more independence / then I went into critical care where you're very independent actually and given wide open doctor's orders, it is kind of there, but you do a lot of stuff on your own. This is gone even more, you know, you're it. A lot of people say to me isn't that scary, but I've never found it that way. I don't know why because I know I can always pick up a phone and I can phone a physician somewhere and get some advice on something and you don't have that (inaudible). I guess the gradual gaining of independence, making your own decisions not relying on other people so much / I've had lots of experiences and you feel good when you've diagnosed something correctly and actually over the years it gets easier / you've seen things you can rely on past experiences more and gut feelings / it is something totally new where you're able to do someone comes in with a complaint, you have to take a history and do a physical assessment and basically come up with a diagnosis, it is not something you're taught in nursing school. That's the physician's role. I guess it must affect your self esteem / I don't think I was ever really lacking in it, but it certainly hasn't -- I mean it's definitely helped a bit more / I shouldn't say I wasn't lacking in it, but, you know, once in a while you'll have little things, "oh, can't do that, couldn't possibly do that." I don't say that so much anymore. I think it's a positive thing. I think it's good to be independent / we have more autonomy and you're allowed to think. I prefer it to working in the city. I really enjoy it).

Commitment. This term refers to the ability to believe in the truth, the importance, and the interest value of who one is and what one is doing, the tendency to involve oneself fully in the many situations of life, an overall sense of purpose.

Nurses report that nursing in the north is the greatest, the most satisfying, interesting and rewarding work that nurses can do. It combines the best of what nursing could be, it embraces the full range of nursing services (but it's a good job / Generally, the job is really good when you work in the clinic and stuff like that / I don't mind seeing real emergencies after hours, I don't mind it at all. People come and they're really sick, I'm just like "oh, let's do something," and that's fine / you can do it for awhile and I guess the money is a lot better too, so that pushes you a little bit too. You get a lot more money than you have where you go back to the hospital and your wage is cut in half / I found it interesting learning about the different cultural group which I really knew nothing about before / I've learned tons, made my money / Northern nursing experience is far different from what you work as a nurse when you're in a hospital / It's interesting and the nurse is on her own. I find northern nursing very rewarding for me).

The nurses have a feeling that they are doing something of importance for people who really need their services (I feel like I'm doing something / I feel like I'm doing more than I would be had I remained in the city / The majority of them appreciate when you do something nice for them or if you help them / I even had patients phone back or see me on the road there and apologise if they swore at me the night before / one reason I became an RN was to go back and work with my own people).

The work that nurses do is of importance to the whole community and it establishes more than just a service. There is a larger purpose behind their work, relating to the ability to help each community to become a healthy one (I can use a lot of input from people I work with in terms of programs that everybody's going to be happy with / I feel like when I'm working with this community I'm working with a lot of people in order to build something. I don't feel like I'm doing it by myself / I find the nursing personnel, I enjoy working with them. / I like them and there's a lot of good ideas out there and a lot of very strong people with really strong ideas / I like people

who a vision and I like people that can contribute and have good ideas and I think a lot of the nurses out there are like that, I mean generally speaking).

The belief that nurses have of their purpose in the community, in a higher power that helps them stay strong and help them cope with things (I'm doing what I was meant to do / I really enjoy it / I want to go back to Gibson, I like my work there. I feel like I've left something undone I don't know what it is, but I have to go back and see).

Control. Those high in control believe and act as if they can influence the events of their experience, rather than being powerless in the face of outside forces.

Nurses displayed the belief that by exercising and keeping fit and healthy, by eating a low fat diet and maintaining their weight, they can cope better with their stressful lives (I eat well / I have the usual binges, sometimes I'll have a junk food night and stuff. I try and maintain my weight so it's not too high or too low / I eat okay, I eat good and I exercise running after the kids and I like the job / I'm doing my exercise / I'm trying to lift weights and keep fit that way / I'm eating low fat diet and really proud of it).

Being permitted to practise independently and to deal with patients one-on-one without restrictions adds to a positive experience that nurses have and a feeling of being in control not only of their nursing practice, but of where the community is going in terms of health care (the more I talk about it the more I realise it, the issue is control. I couldn't handle being in a situation where I wouldn't feel like I had control of the work situation / I like having the power, control, I don't know / I don't look at it as power and control, it's having that ability just to speak out and have your views heard / we have more autonomy and you're allowed to think. I prefer it to working in the city / Being in control. Like I think that's a big thing with me because I'm almost finished here. You go to work with a smile and they'll never know that you like it / When I was in the hospital tour, I used to like being in charge. I used to like that a lot as far as charge nurse or whatever, so that's what it is then / But then if I have to go back to hospital, I give up all of this stuff. I now go back to not really having any, you have a little bit of say in stuff, but not really having any -- you're just basically following very, very strict guidelines or whatever with no ability

to expand. You just do your job and that's it / I feel like I'm doing what I'm good at / I'm less restricted / I'm more independent in my ability to do things / I can deal with people on a one to one without having restrictions placed on me / I can pretty well practice in the way that I want to practice / I feel like I have a lot of control over what it is I want to do for the community / I feel like I have a lot of control over where I see the health care going for the community).

Nurses feel that when they make decisions on behalf of the nursing station they are making long-term decisions that are going to affect a lot of people (I work at it from a different angle now / you were making a difference in a very small way, you weren't changing things in a big way, but there were times when people would leave and you felt you had touched them in some way).

- Nurses feel that they have control of their feelings and of what they allow to get to them, they have the control to let things roll off them (It's basically been what I thought it would be. / I don't think I let things really get to me. I don't. There's some things, but for the most part I think I tend to let things roll off of me. I'm a type B personality, I'm quite laid back. / I've had that on past jobs, my performance appraisals. I have a calming affect on people. If something happens, I don't go off in a flap. I don't know why I'm like that, it's just that's me / here, you're in complete control of yourself / And coping, well, it's a lot easier to do it when your family is not around. If find it, anyways).
- By discussing critical incidents nurses feel that they can control the way they cope with the incident (when something happened really bad like people died, many times the nurses would just sit together and talk about it. / I think that's how we cope with those emergencies that we have. We discussed the incident that happened and sometimes feelings would be discussed with the nurses).
- Taking responsibility for their own lives and getting lots of rest help nurses deal with stress (I went to Montana for a week and it was at a sun dance / just for me praying and just being by myself, being able to calmly think about things and being so far away from it / I just felt so much better and lighter when I go back, like I just felt good / it was something I knew I had to keep working at / I just took my time with it, like I didn't rush

it / I just thought about it and it just made me think about what I'd been through / it worked for me / I find that I need to get out every so often / I have to physically remove myself from here / I think it's like depression. I think that everybody has a propensity to be depressed and you choose not to be depressed, you choose to be happy, you choose to find something that is going to prevent you from becoming depressed / you can choose to have a healthy, mental attitude, and that comes with work. You choose to always be fending off burnout).

Challenge. Life changes are the norm rather than the exception, and those changes are anticipated as a stimulus to growth rather than as a threat to security.

The difference between nursing in the city and northern nursing is acknowledged by nurses as a stimulus to growth rather than as a threat to their security. They find the differences interesting and challenging (I think that the satisfaction that I get is probably what's keeping me here / I find it tremendously satisfying / I've enjoyed it a lot and I've learned a lot and I have found it very dynamic / Like as much as it was difficult to do that, it was still almost invigorating / And when you'd accomplished something and you had done well, which you had an abundance of, it augmented those positive feelings / as compared to hospital nursing, I hate doing bed baths, in a hospital you're doing kind of aid work / it's a continual challenge / about six years ago I did a stint in Shamatawa and I never forgot it / I loved every minute of it, and that was just after the nursing station got blown up, or shot at, or whatever / I still liked it just because of the big difference going from, I guess, hospitals to the north / it's made me a better and a stronger nurse / Northern nursing experience is far different from what you work as a nurse when you're in a hospital / it's just different. It's interesting when lots of things happen that don't happen in the hospital. Well, they do happen in the hospital but in the hospital they're all separate, but in a station it's everything).

The scope and variety of the work in the nursing station is considered a challenge for nurses, and leads to feelings of accomplishment and satisfaction (I feel like when I'm making decisions I'm making long-term decisions that are going to affect a lot of people / Any of the changes that I make, even though it seems like slow change, I know that with time a lot of it will

work / being able to reach out to people and really feel like you were making a difference / you had affected them in some way that wasn't necessarily negative all the time / The environment was dynamic, ever changing and you never knew from one minute to the next what you'd see / I've enjoyed it for the most part / challenging, it's been very interesting work / my choice in the jobs I've had over the years have gradually been more positions with more and more independence / then I went into critical care where you're very independent actually and given wide open doctor's orders, it is kind of there, but you do a lot of stuff on your own / This is gone even more, you know, you're it. A lot of people say to me isn't that scary, but I've never found it that way / I don't know why because I know I can always pick up a phone and I can phone a physician somewhere and get some advice on something and you don't have that (inaudible). I guess the gradual gaining of independence, making your own decisions not relying on other people so much / I've had lots of experiences and you feel good when you've diagnosed something correctly and actually over the years it gets easier / you've seen things you can rely on past experiences more and gut feelings / it is something totally new where you're able to do more / someone comes in with a complaint, you have to take a history and do a physical assessment and basically come up with a diagnosis / it is not something you're taught in nursing school. That's the physician's role / I guess it must affect your self-esteem. I don't think I was ever really lacking in it, but it certainly hasn't -- I mean it's definitely helped a bit more. I shouldn't say I wasn't lacking in it, but, you know, once in a while you'll have little things, "oh, can't do that, couldn't possibly do that." I don't say that so much anymore. I think it's a positive thing. I think it's good to be independent / that's what makes the work interesting / They make their own decisions / They just do things on their own. They don't need doctors' orders for everything).

In trying and critical situations nurses comfort themselves with the knowledge that they have done everything that they could possibly have done for the patient (I know we did everything we could).

Isolated communities and everything that they represent hold an allure and a challenge all their own to nurses. (Challenge and it allows you to do more than what you can do / That's my biggest thing, being able to do a lot more / You find the work stressful? Yes. I did what I liked here. I would thrive on that. I guess that's part of the thing / there's something about Gibson that

I really like and I don't know what it is / I don't know if it's the people or if it's the challenge. I think a lot of it has to do with the challenge of working there / I really like working there as opposed to the other stations I've been in / the people, they're different, the Indian people, because most of the stations are on the reserves here in Manitoba, I guess any nursing is rewarding if the people sometimes even just say thank you / How do I stay healthy? I just work. I have my own support, my own family and I talk to them and I feel that the job for me is very rewarding. I feel that. I really enjoy this type of nursing. It is a challenge for me).

The northern nursing experience is regarded as a learning experience that can be considered a stepping stone that may open other doors for nurses later in their careers (I've learned from this experience / up north was another experience like I said it was maybe a bit of a stepping stone and probably opened up some doors for me / I'll never say I ever resented going up north. Never).

Nurses feel that the few preconceived ideas they had about northern nursing vanished once they arrived and had to cope with the realities of the work as it was. They had to get used to it, and they then generally enjoyed the work (I had absolutely no preconceived ideas as to what I was going to be doing / It was all a complete surprise to me when I got up here and I liked the work from the start / after a while I got used to it and I really enjoy it / I enjoy having, like, well, here you're doing a bit more, which is nice, and you sometimes have the time to do it).

- Nurses feel that the northern nursing experience makes them stronger nurses and better nurses. It wasn't what they expected, it was a lot more than they had bargained for, but they become better people because of it (I think I might have become stronger / I think I've become very keen in my ability to recognise when I'm getting burned out. Because I look at myself now and I look at myself in say 1986, 1985, when I had a social life, I was fending off burnout then just as well as I'm doing it now, but the things that I did then was I would walk, I would write letters, I would listen to music / Of course I had no other people in my life that I was responsible to so the things that I did then were different / it's because of the way that my life has changed now that the way that I have to deal with the burnout is different / It wasn't what I expected, it was a lot more than I ever bargained for

but I think that I've become a better person because of it at times / It's kind of rounded me out a bit seeing these things because I've never seen certain things/ It's like you do the best you can with what you got that's part of the job).

- Some situations make nurses angry. In order to be in nursing for the long haul they have to be able somehow to observe the things they see, and deal effectively with the things they experience, and not allow themselves to be too deeply affected. (It's time to either make a change / Make a move in a different direction. That's probably why I change so much in what I'm doing at work / That's probably why I change what I'm doing at home too / I'm trying to avoid static, I'm trying to avoid being in one spot / I feel like if I stay in one spot and keep doing the same thing day after day after day after day after day, I'm going to get burned out, so I try to avoid that at all costs).

Self-statements / Cognitive Control. Self-statements are used to control emotional and physiological responses.

Relying on positive self-statements and positive personality traits in dealing with things enhances nurses' ability to feel comfortable about their ability to deal with things (I'm more independent in my ability to do things / I can deal with people on a one to one without having restrictions placed on me / I can pretty well practice in the way that I want to practice / I feel like I have a lot of control over what it is I want to do for the community / I feel like I have a lot of control over where I see the health care going for the community / My memories of the field are very positive actually and I don't have a lot of negative memories or feelings about the work or the people / I tend to intellectualise things a lot, I'll sit and think about it, what's going on / I've enjoyed it for the most part. It's basically been what I thought it would be / I don't think I let things really get to me. I don't. There's some things, but for the most part I think I tend to let things roll off of me. I'm a type B personality, I'm quite laid back. I've had that on past jobs, my performance appraisals. I have a calming affect on people / If something happens, I don't go off in a flap. I don't know why I'm like that, it's just that's me / I prefer it to working in the city / we have more autonomy and you're allowed to think).

Self-statements in emotionally taxing times, even with short-term goals in mind, help nurses cope ("I keep saying that sort of like it's a litany in my head. Hang on till the end of the week, you're going to get out of here". / I really enjoy it / I know we did everything we could).

Taking cognitive control over your feelings when things are not going well, or when people disappoint you, helps nurses to deal with things (But also, I wish I could have more time/ It's like you do the best you can with what you got / that's part of the job. I mean, shit happens. It does / How do you deal with that? I don't think I do anything for it. Sometimes I stick it away and, "oh, well, tomorrow," whatever / The stress of work is alleviated by enjoying the work / I know you can work anywhere no matter what the conditions are if you work with someone that you enjoy / I know you can work anywhere no matter what the conditions are if you get along and work well together / I know you can work anywhere no matter what the conditions are if you get out frequently / I still believe that).

Optimism and positive self-statements, like telling yourself that this is a learning experience and that this is tremendously satisfying are helpful in dealing with the realities of northern nursing (I think that the satisfaction that I get is probably what's keeping me here / I find it tremendously satisfying / I don't feel like I'm above anything. I mean as in work, I like it / how do you stay healthy then? A born natural, I don't know).

Reminding themselves in self-statements that they have a purpose helps nurses stay strong and cope with things (I'm doing what I was meant to do / I'm less restricted / I feel that the job for me is very rewarding / I feel that. I really enjoy this type of nursing / It is a challenge for me).

The realisation that cultural differences exist and can be interesting as well as challenging helps nurses to deal with these differences (I found the people very interesting / They were very different from people that I had known and worked with before. They had a wonderful sense of humour and there was always laughter. I remember laughter in the field / I remember feeling very accepted within the environment in which I was working with the people there they liked me, they liked me being there and I liked them / That's what makes the work interesting / The people, they're different, the Indian people, because most of the stations are on the reserves here in

Manitoba).

Taking responsibility for their own health and support systems helps nurses to function better over a longer period of time while continuing to feel that the work is rewarding and enjoyable (I have to find satisfaction in parts of my life that aren't necessarily right there / You know, like bath time with the kids, I love that / I'll take them for a walk up the road and down Saturday mornings / A lot of times I go with the flow, I think I'd like to get into community health / I think being up north has shown me that I'm not so sure if I want to live in the city, I think I might always want to live in a smaller place but not way up there in the boonies anymore / I like being out in the country, but I like to have some access to things I enjoy, like going to restaurants, maybe going to a play / How do I stay healthy? I just work. I have my own support, my own family and I talk to them and I feel that the job for me is very rewarding).

Problem Solving Strategies. The application of problem-solving strategies (planning, problem definition, evaluating alternatives, anticipation of consequences) is very important.

Developing a support system outside the nursing station, in the community, as well as just physically getting out of the nursing station, helps nurses to get away from the stress in the nursing station (I know that if you haven't got any support systems outside this Federal Government building, you cannot make it, you can't live a life just for a job / the only thing that helped me survive that friends that I had in the community plus local people / I stay healthy by trying to stay connected with the outside / I think you have to leave your workplace and sometimes even socialise outside the workplace to stay healthy / I thought that when I was there, that's what I'd do / that's why I lasted in Lost Lake as long as I did).

Having friends and elders to talk to in the community provides a sounding board for nurses as well as a chance to learn about the community (I can use a lot of input from people I work with in terms of programs that everybody's going to be happy with / I feel like when I'm working with this community I'm working with a lot of people in order to build something. I don't feel like I'm doing it by myself / I found it interesting learning about the different cultural group which I really knew nothing about before).

- Having informal debriefings after critical incidents among themselves help nurses cope better in the long run with these emergencies (I'm not afraid to say when I'm tired / talking about what I'm going through / I can talk to them without mentioning person's names and situations I've been through or I'm going through. / When something happened really bad like people died, many times the nurses would just sit together and talk about it / I think that's how we cope with those emergencies that we have / you just carry on and carry on and then clean up and then go and have some coffee and sit and talk about what had just happened / We discussed the incident that happened and sometimes feelings would be discussed with the nurses).
- Regular trips away, having spousal support, phone calls and good interpersonal relationships with other nurses all help to make the work experience worthwhile (I've got goals outside of work that have absolutely nothing to do with my nursing / I leave here and I'm thinking on the way home, what am I going to make for supper tonight / I'm finding enjoyment in those things that are right in front of me / "So how did you cope with that, you left?" Yes. Basically, I left. I think if I hadn't have -- I got out. I made plans to (inaudible) into another job for a while and to get away from it. And I haven't been back. I altered my work environment. I work at it from a different angle now / I do that imagery thing when things really bug me / how I cope with it, I find that I need to get out every so often / I have to physically remove myself from here / Do you think there are other things that keep you healthy? Yes. My kids, my family. Well, contradicting what I said before, but (inaudible) my kids and just enjoying this part of it and I guess I make plans to try and get something going, like go camping and that makes me feel good, I guess / phone calls to friends and family, watching the news, getting out frequently, like we've said this how many times, like even a weekend out in Thompson. You sort of connect again / Of course there's a lot of socialising that goes on here / I have a lot of friends that I can phone at anytime of the day or night and they'll sit and listen / I find, too, that if I can get out frequently, like every four to six weeks, it really helps. Even if it's just for a weekend or a day, even / then for me is that I would talk to David / we'd go out on holidays just to get away, and things kind of settled down in the station).

- Physical exercise and healthy eating helps nurses deal with stress, so does having diverse hobbies, from knitting and sewing to computers and netsurfing (I'm trying to avoid static / I'm trying to avoid being in one spot / I feel like if I stay in one spot and keep doing the same thing day after day after day after day after day, I'm going to get burned out, so I try to avoid that at all costs / I take my time for myself when there's no one else around / I have to find little things to do / most of it is work, it's work around the house or something like that / I'm trying to do that for myself and plus I'm bringing up all my little hobbies and stuff I bought a sewing machine, I learned how to sew, I sewed my first dress, I do my knitting and I knitted my first cap and I'm doing my exercising and stuff / when I work out I get a lot of that out too, doing something physical or I'll tear around the house, "it's time to do laundry and it's time to wash the walls I try and do something constructive with it. It makes you feel better because then afterwards you've got this sense of accomplishment I was kind of pissed off but at least I waxed the floor, I did something good with it / Or sometimes I try to sneak in a nice long hot bath or whatever and read a bit, and that's my extent of my time (inaudible) / And coming to work is almost my time, too, because I like it / I eat okay, I eat good and I exercise running after the kids and I like the job / So we were just talking about our staying healthy. Oh, and something that I -- you also exercise / I try to eat right. That's kind of hard sometimes, lack of fresh fruit and vegetables sometimes / I guess trying to do a variety of things, having interests. Like I enjoy reading, I'm doing some crafts, I love listening to music, I like getting outside on the Hondas and the snowmobiles wherever the season).

Delaying Immediate Gratification. The ability to delay immediate gratification is also important.

The whole experience of working in the north becomes gratifying in itself if viewed as a whole by nurses. There is tremendous hardships associated with northern nursing. Instead of just giving in to these hardships, nurses struggle through them because in the end they find gratification in the experience that they gain ("I keep saying that sort of like it's a litany in my head. Hang on till the end of the week, you're going to get out of here." / I'm trying to do that for myself and plus I'm bringing up all my little hobbies and stuff / I bought a sewing machine, I learned how to sew, I sewed my first dress, I do my knitting and I knitted my first cap / "You find

the work stressful?" Yes. (but) I did what I liked here. I would thrive on that. I guess that's part of the thing / up north was another experience / like I said it was maybe a bit of a stepping stone and probably opened up some doors for me. I'll never say I ever resented going up north. Never / I just felt so much better and lighter when I go back, like I just felt good / it was something I knew I had to keep working at, I just took my time with it, like I didn't rush it. I just thought about it and it just made me think about what I'd been through. It worked for me / I find northern nursing very rewarding for me).

By the same token, many of the people that nurses encounter in the course of their work really make life difficult for particular nurses at particular times, yet nurses struggle through these difficult interpersonal relationships because they find gratification in the fact that some people will be very thankful and appreciative for what is being done for them (The majority of them appreciate when you do something nice for them or if you help them / I even had patients phone back or see me on the road there and apologise if they swore at me the night before / one reason I became an RN was to go back and work with my own people / I guess any nursing is rewarding if the people sometimes even just say thank you).

Achieving financial independence over time is a great incentive for staying in the north for a time (I've learned tons, made my money. That wasn't the main reason why I went up, but it helps because I would like to get into community health someday).

Nurses expect that changes they introduce will take a long time to take effect; nurses also know that decisions they make regarding health care are long term decisions that will affect a lot of people over time (I feel like when I'm making decisions I'm making long-term decisions that are going to affect a lot of people / Any of the changes that I make, even though it seems like slow change, I know that with time a lot of it will work).

Perceived Self-efficacy. This refers to the level of self-mastery.

The fact that nurses have a lot of say in how they deal with each patient, in what they do for each patient, in diagnosing patients and in what type of medication they give each patient,

provides a tremendous sense of self-efficacy for nurses (I feel like I'm doing something / I feel like I'm doing more than I would be had I remained in the city / I was quite happy about that because I had done the right thing by just sheer common sense and I was really proud about it and I carried that with me for a while / I've had lots of experiences and you feel good when you've diagnosed something correctly and actually over the years it gets easier, you've seen things you can rely on past experiences more and gut feelings / it is something totally new where you're able to do (more) / someone comes in with a complaint, you have to take a history and do a physical assessment and basically come up with a diagnosis / it is not something you're taught in nursing school. That's the physician's role. I guess it must affect your self-esteem / I don't think I was ever really lacking in it, but it certainly hasn't -- I mean it's definitely helped a bit more. I shouldn't say I wasn't lacking in it, but, you know, once in a while you'll have little things, "oh, can't do that, couldn't possibly do that." I don't say that so much anymore / I think it's a positive thing. I think it's good to be independent).

- Nurses experience the independence of practice, the autonomy and the fact that they function mostly without doctors' orders in general as extremely positive (my choice in the jobs I've had over the years has gradually been more positions with more and more independence / then I went into critical care where you're very independent actually and given wide open doctor's orders, it is kind of there, but you do a lot of stuff on your own. This is gone even more, you know, you're it. A lot of people say to me isn't that scary, but I've never found it that way. I don't know why because I know I can always pick up a phone and I can phone a physician somewhere and get some advice on something and you don't have that (inaudible) / I guess the gradual gaining of independence, making your own decisions not relying on other people so much / They make their own decisions / They just do things on their own / They don't need doctors' orders for everything).
- Positive feedback from patients commending nurses on their skills contributes to the positive feelings nurses have about themselves and their skills (they liked me, they liked me being there and I liked them / The majority of them appreciate when you do something nice for them or if you help them / I feel that I'm a good nurse because there's a few people that have said that to me).

- Positive self-esteem, independence and the ability to help yourself and others are very important in the whole nursing experience (I feel like I'm doing something / I feel like I'm doing more than I would be had I remained in the city / I feel like I'm doing what I'm good at / I'm here because I feel that I've been doing a good job / what am I going to do, wave a magic wand and make the weather go better? I mean I can't do it. I've got to live with what's happened / If you want a second opinion, get a second opinion, but don't tell me I don't know what I'm doing / I do let it out verbally, I'm quite verbal and emotional about things, the way I react to things, not necessarily at that time but maybe in private / But bad feelings I try and dump as soon as I can / "Do you think you have a great calling to help other people?" No. I don't ever feel like that. I feel like I'm, I guess, good at my job / I'm not saying you shouldn't rely on other people for anything, but when it comes down to it, you know, you have to help yourself. No one else is going to. If you want to do something you have to do it yourself. No one else is going to / it's made me a better and a stronger nurse / It's been a nice break but I'm ready to go back to work / being able to calmly think about things and being so far away from it / I just took my time with it, like I didn't rush it. It worked for me).

This concludes the presentation of the formulated meanings from the extracted significant statements. The quantitative results will be presented next. As was stated in chapter 1 (see quantitative research design, p. 32), in this research the information gathered by means of the psychometric instruments will only be used to expand on information gathered in the unstructured interviews. The quantitative results will thus be discussed next, followed by a synthesis and an exhaustive description of all the results.

QUANTITATIVE RESULTS

The quantitative results will be covered in three sections, namely, the reporting of the results, the comparison of quantitative results with normative data and the interpretation of the results.

The Results of the Scores on the Measuring Instruments

The results reported in Table 5.1 were arrived at in the following manner. All the research participants' scores ($N = 23$) on the five measuring instruments were summed. Thus the totals represented in Table 5.1 are the sums of the 23 research participants' scores on the five measuring instruments. In order to get the mean score in each case, the total was divided by 23.

Table 5.1 Sum of scores for twenty-three research participants on each measuring instrument and the mean scores for the twenty-three participants on each measuring instrument

	Total	Mean ($n = 23$)
Sense of coherence	3198 =	139.04
Hardiness	2580 =	112.17
Learned resourcefulness	387 =	16.82
Burnout	41.01 =	1.78
Cumulative stress	627 =	27.26

The results in Table 5.2 are the scores of each research participant on the measuring battery. The research provides its own mean scores ($N = 23$) to act as cutoff points (see 4.6). Thus the sample itself determines what would be considered high scores and low scores on the measuring instruments.

Table 5.2 can be read in the following manner:

Participant #1 scored 108 on Sense of Coherence.

Participant #1 scored 114 on Hardiness.

Participant #1 scored 29 on Learned Resourcefulness.

Participant #1 scored 2.5 on the Burnout Measure.

Participant #1 scored 45 on the Cumulative Stress test.

This means that Participant #1 scores lower than the mean for this sample on Sense of Coherence. $108 < 139.04$.

This means that Participant #1 scores higher than the mean for this sample on Hardiness. $114 > 112.17$.

This means that Participant #1 scores higher than the mean for this sample on Learned Resourcefulness. $29 > 16.82$.

This means that Participant #1 scores higher than the mean for this sample on the Burnout Measure. $2.5 > 1.78$.

This means that Participant #1 scores higher than the mean for this sample on the Cumulative Stress Test. $45 > 27.26$.

The results can be interpreted in the same manner for each research participant.

Table 5.2 Participant scores on the five measuring instruments

Participant	#1	#2	#3	#4	#5	#6	#7	#8	MEAN
Sense of coherence	108	114	157	134	172	161	134	158	139.04
Hardiness	114	94	89	103	127	120	111	125	112.17
Learned resourcefulness	29	27	-4	52	40	39	01	-33	16.82
Burnout	2.5	2.04	1.5	1.9	0.8	1.01	2.3	1.03	1.78
Cumulative stress	45	30	28	22	24	21	33	18	27.26
Participant	#9	#10	#11	#12	#13	#14	#15	#16	MEAN
Sense of coherence	156	149	130	156	106	148	98	142	139.04
Hardiness	122	111	103	121	95	117	97	112	112.17
Learned resourcefulness	23	23	23	-6	29	28	3	26	16.82
Burnout	1.95	1.4	2.4	2.0	1.19	2.0	2.5	2.0	1.78
Cumulative stress	28	22	25	37	27	49	31	23	27.26
Participant	#17	#18	#19	#20	#21	#22	#23	MEAN	
Sense of coherence	165	140	143	163	153	166	145	139.04	
Hardiness	127	107	128	120	106	113	118	112.17	
Learned resourcefulness	39	-18	-30	33	11	25	27	16.82	
Burnout	1.19	2.19	1.85	1.7	1.9	1.71	1.95	1.78	
Cumulative stress	15	17	16	19	29	22	16	27.26	

Comparison of Quantitative Results with Normative Data

The mean score for sense of coherence for this research is 139.04. Normative data indicate that mean scores for different populations fall between 160.44 and 129.5. The mean score for this sample falls well within these parameters.

The mean score for hardiness for this study is 112.17. No standardised scores exist for this instrument. The highest possible score is 150.

The mean score for learned resourcefulness for this study is 16.82. Normative data indicate that mean scores for different populations fall between 23 and 27.5. The mean score for this sample falls well below the expected mean scores found in the literature.

- The mean score for burnout for this study is 1.78. This indicates the experience of little burnout overall for the sample.

The mean score for cumulative stress for this study is 27.26. A high score indicates a respondent high in cumulative stress (burnout) whereas a low score indicates a respondent low in cumulative stress (burnout). The higher the score, the more concern there should be about the respondent's potential to develop cumulative stress:

0-25 You are doing fine.

26-35 There are a few things that you should watch.

36-50 You are a candidate for cumulative stress.

51-65 You are well into cumulative stress.

Overall this indicates that there are some things that the respondents in this sample should watch and failing to do so may result in the development of burnout.

Interpretation of the Results

The goal for the quantitative results (from chapter 1) was that information gathered from the psychometric instruments will be used to divide the research participants into high burnout prone individuals and low burnout prone individuals as well as to find out whether each individual scores high on salutogenic properties or low on salutogenic properties. The reason for this is that one would expect, from a quantitative perspective, an individual who scores high on burnout to score low on salutogenic properties and an individual who scores low on burnout to score high on salutogenic properties. The expectation is that the salutogenic properties act as generalised resistance resources and have buffering effects on stress and burnout. It was stated in chapter 1 that the possibility exists, however, that the mere presence or absence of burnout symptoms (or a high or low score on the burnout measures) is not enough to explain an individual's functioning.

Seven research participants can be considered **high burnout prone** individuals as measured by the Burnout Measure and the Cumulative Stress Test.

Participant # 1	Burnout	2.5 > 1.78
	Cumulative stress	45 > 27.26
Participant # 2	Burnout	2.04 > 1.78
	Cumulative stress	30 > 27.26
Participant # 7	Burnout	2.3 > 1.78
	Cumulative stress	33 > 27.26
Participant # 9	Burnout	1.95 > 1.78
	Cumulative stress	28 > 27.26
Participant # 12	Burnout	2.0 > 1.78
	Cumulative stress	37 > 27.26
Participant # 14	Burnout	2.0 > 1.78
	Cumulative stress	49 > 27.26
Participant # 15	Burnout	2.5 > 1.78
	Cumulative stress	31 > 27.26

Of these seven, only two participants (participants #7 and #15) scored high on burnout and low on all the salutogenic measures. The rest all scored high on some salutogenic measures and low on others.

Participant # 1	Burnout	2.5 > 1.78	Sense of coherence	108 < 139.04
	Cumulative stress	45 > 27.26	Hardiness	114 > 112.17
	Learned resourcefulness	29 > 16.82		

High on the burnout measures. Low on sense of coherence. High on hardiness and learned resourcefulness.

Participant # 2	Burnout	2.04 > 1.78	Sense of coherence	114 < 139.04
	Cumulative stress	30 > 27.26	Hardiness	94 < 112.17
	Learned resourcefulness	27 > 16.82		

High on the burnout measures. Low on sense of coherence and hardiness. High on learned resourcefulness.

Participant # 7	Burnout	2.3 > 1.78	Sense of coherence	134 < 139.04
	Cumulative stress	33 > 27.26	Hardiness	111 < 112.17
	Learned resourcefulness	01 < 16.82		

High on the burnout measures. Low on the salutogenic measures.

Participant # 9	Burnout	1.95 > 1.78	Sense of coherence	156 > 139.04
	Cumulative stress	28 > 27.26	Hardiness	122 > 112.17
	Learned resourcefulness	23 > 16.82		

High on the burnout measures. High on the salutogenic measures.

Participant # 12	Burnout	2.0 > 1.78	Sense of coherence	156 > 139.04
	Cumulative stress	37 > 27.26	Hardiness	121 > 112.17
	Learned resourcefulness	-6 < 16.82		

High on the burnout measures. High on sense of coherence and hardiness. Low on learned resourcefulness.

Participant # 14	Burnout	2.0 > 1.78	Sense of coherence	148 > 139.04
	Cumulative stress	49 > 27.26	Hardiness	117 > 112.17
	Learned resourcefulness	28 > 16.82		

High on the burnout measures. High on the salutogenic measures.

Participant # 15	Burnout	2.5 > 1.78	Sense of coherence	98 < 139.04
	Cumulative stress	31 > 27.26	Hardiness	97 < 112.17
	Learned resourcefulness	3 < 16.82		

High on the burnout measures. Low on the salutogenic measures.

These results indicate that a high score on the burnout measures is **not** indicative of where the person finds himself or herself on the salutogenic measures. A high score on the burnout measures reflected low salutogenic qualities in only 8.7 percent (participants #7 and #15) of the research participants. A high score on the burnout measures also reflected high salutogenic qualities in 8.7 percent (participant #9 and #14) of the research participants. A high score on the burnout measure is not indicative of salutogenic qualities that individuals may or may not have.

Eight research participants can be considered **low burnout prone individuals** as measured by the Burnout Measure and the Cumulative Stress Test.

Participant # 5	Burnout	0.8	< 1.78
	Cumulative stress	24	< 27.26
Participant # 6	Burnout	1.01	< 1.78
	Cumulative stress	21	< 27.26
Participant # 8	Burnout	1.03	< 1.78
	Cumulative stress	18	< 27.26
Participant # 10	Burnout	1.4	< 1.78
	Cumulative stress	22	< 27.26
Participant # 13	Burnout	1.19	< 1.78
	Cumulative stress	27.0	< 27.26
Participant # 17	Burnout	1.19	< 1.78
	Cumulative stress	15	< 27.26
Participant # 20	Burnout	1.7	< 1.78
	Cumulative stress	19	< 27.26
Participant # 22	Burnout	1.71	< 1.78

Cumulative stress 22 < 27.26

Of these eight, five participants (participants #5, #6, #17, #20 and #22) scored low on burnout and high on all the salutogenic measures. The rest all scored high on some salutogenic measures and low on others.

Participant # 5	Burnout	0.8 < 1.78	Sense of coherence	172 > 139.04
	Cumulative stress	24 < 27.26	Hardiness	127 > 112.17
	Learned resourcefulness	40 > 16.82		

Low on the burnout measures. High on the salutogenic measures.

Participant # 6	Burnout	1.01 < 1.78	Sense of coherence	161 > 139.04
	Cumulative stress	21 < 27.26	Hardiness	120 > 112.17
	Learned resourcefulness	39 > 16.82		

Low on the burnout measures. High on the salutogenic measures.

Participant # 8	Burnout	1.03 < 1.78	Sense of coherence	158 > 139.04
	Cumulative stress	18 < 27.26	Hardiness	125 > 112.17
	Learned resourcefulness	-33 < 16.82		

Low on the burnout measures. High on sense of coherence and hardiness. Low on learned resourcefulness.

Participant # 10	Burnout	1.4 < 1.78	Sense of coherence	149 > 139.04
	Cumulative stress	22 < 27.26	Hardiness	111 < 112.17
	Learned resourcefulness	23 > 16.82		

Low on the burnout measures. High on sense of coherence and learned resourcefulness.
Low on hardiness.

302

Participant # 13	Burnout	1.19 < 1.78	Sense of coherence	106 < 139.04
	Cumulative stress	27.0 < 27.26	Hardiness	95 < 112.17
	Learned resourcefulness	29 > 16.82		

Low on the burnout measures. High on learned resourcefulness. Low on sense of coherence and hardiness.

Participant # 17	Burnout	1.19 < 1.78	Sense of coherence	165 > 139.04
	Cumulative stress	15 < 27.26	Hardiness	127 > 112.17
	Learned resourcefulness	39 > 16.82		

Low on the burnout measures. High on the salutogenic measures.

Participant # 20	Burnout	1.7 < 1.78	Sense of coherence	163 > 139.04
	Cumulative stress	19 < 27.26	Hardiness	120 > 112.17
	Learned resourcefulness	33 > 16.82		

Low on the burnout measures. High on the salutogenic measures.

Participant # 22	Burnout	1.71 < 1.78	Sense of coherence	166 > 139.04
	Cumulative stress	22 < 27.26	Hardiness	113 > 112.17
	Learned resourcefulness	25 > 16.82		

Low on the burnout measures. High on the salutogenic measures.

These results indicate that a low score on the burnout measures is **not** indicative of where the person finds himself or herself on the salutogenic measures, although it is more indicative than a high score on the burnout measures is of where the person finds himself or herself on the salutogenic measures. A low score on the burnout measures did reflect high salutogenic qualities in 21.74 percent (participants # 5, #6, #17, #20 and #22) of the research participants. From a quantitative perspective this means that the five research participants who presented with high

salutogenic qualities on the research instruments will be better able to deal with the stresses and strains of life. This would lead to lower burnout scores. But this was only true for 21.74 percent of the respondents. A low score on the burnout measure is thus not necessarily indicative of salutogenic qualities that individuals may or may not have.

As was stated in chapter 1, the expectation was that an individual who scores high on the burnout measures would score low on salutogenic measures and an individual who scores low on burnout measures would score high on salutogenic measures. It was expected that the salutogenic properties would act as generalised resistance resources and have buffering effects on stress and burnout. This is neither proved or disproved by the current results. It was further stated in chapter 1 that the possibility exists, however, that the mere presence or absence of burnout symptoms (or a high or low score on the burnout measures) is not enough to explain the individual's functioning. This has been borne out by the results presented above. It seems that entering the life world of the individual proves much more informative than relying on quantitative measures alone.

Exhaustive Description

A synthesis and an exhaustive description of all the results, including both the qualitative and the quantitative results, an integration of the theme clusters and their formulated meanings into an exhaustive description of nurses' lived experience of the causes of burnout, the symptoms of burnout that they experience, and how they stay healthy, are presented next.

Nurses' Lived Experience of the Causes of Burnout

Burnout, over time, is caused by various factors. Although the quantitative results indicated a low experience of burnout overall for the sample, all the research participants connoted many causes of burnout in their daily lives. The amount of work, too much going on, the fast pace in the work place, basically **the work itself**, starts it off. This is further convoluted by a workload which may be difficult and heavy, possibly strained interpersonal relationships, lack of sleep, and at times bad weather that influences medivacs or causes telephone lines to go dead.

This all contributes to nurses' experiencing extremely high stress levels and feeling very tired. It is an environment conducive to the development of burnout in a very short time. All nurses, both those scoring high on the burnout measures (participants #1, #2, #7, #9 and #15) and those scoring low on the burnout measures (participants #8 and #10) reported this information. This leads to an acceptance by nurses that the busy nursing lifestyle will eventually cause burnout. Nurses who experience a lot of deaths - among young or old people, violent or medical deaths, and trauma-related deaths - hangings, gunshot wounds, accidents, sexual abuse and alcohol-related trauma, some of it really bad, carry an abundance of emotionally taxing baggage and stress. Furthermore, the experience of living on a reservation, isolated in the north, living in the nursing station, which can be a fairly closed environment, and operating in the nurse practitioner role, are all sources of both negative and positive feelings. Over time the negative feelings seem to conquer and crush a lot of the positive feelings. The isolated and confined communities, the lack of roads in or out of communities in some instances, the inability to go away over weekends, the staffing shortages and at times extreme staffing shortages, the whole lifestyle of being so closely tied to nursing and the nursing station add up and cause tremendous feelings of tiredness and burnout in nurses over time. The never ending return of patients and seeing the same patients with the same problems over and over are further causes of stress. Nurses in nursing stations are always on call for emergencies, even during their time off, and this causes a predilection not to relax. Limited information and history about emergency cases arriving for treatment can lead to a great deal of frustration and stress. Feelings of not getting paid enough as well as not being appreciated by patients add to the sense that nurses have of not being sufficiently valued for their efforts.

Perceived lack of support from **the organisation** for which the nurses work causes burnout. In most instances perceived lack of support from Medical Services Branch Zone Office or from Chief and Council as experienced by the nurses cause an immense amount of stress and burnout. Zone office, its perceived bureaucracy and lack of support for nurses in the field, its policies, its staffing policies, the lack of a consistent supply of relief nurses, the lack of action in support of nurses, the way the Zone Nursing Officers (ZNO's) treat nurses in the field, the experience of nurses that Zone Office sees nurses in the field as a problem instead of it's reason for existence, all cause considerable negativism and eventual burnout in nurses. The bureaucratic

system, which is seen as a very powerful system for controlling the nurses and what is going on in the field, is experienced as being largely ignorant of the realities of working in the field and over time nurses get the feeling that they just do not matter to anyone. The organisational setup of the nursing stations, the inadequacy of the facilities and the staffing in terms of the number of people served, the amount of on-call duty, the lack of physician availability, all add to an increase in dissenting feelings in nurses over time. Some nurses contribute to their eventual feelings of burnout by not attending to and taking responsibility for their personal wellbeing; instead, they blame their tiredness on the lack of organisational support and being short staffed. Although many nurses express qualified support of the Critical Incident Stress Management Services (CISMS) program, it is generally rated as a bandaid solution by Medical Services (in this sense, the whole bureaucracy somewhere out there), to a much deeper and continuous problem of bad management and lack of support of the nurses in the field, overall. CISMS is seen by nurses as too little too late, the symbolic representation that this is a solution by Medical Services (again, in this sense, the whole bureaucracy somewhere out there) to much greater, deeper and continuous problems of bad management, instead of the perception that CISMS is there to address critical incidents in order that nurses should not suffer from the long term effects of these incidents. This view to which most nurses subscribe of CISMS even in the face of consistent explanations by CISMS staff as to what their program is about, points to a deep and persistent frustration that nurses in the field have with the organisation, with Medical Services, with Zone Office, and their management policies, to the extent that any intervention presented to and for the nurses will be viewed with deep suspicion as just another band-aid solution. On the other side of the coin ZNO's and their personal perception of the nurses in the field, as well as of burnout and its management, and of the time nurses should spend in nursing stations, and turnover of nurses, add to organisational fracturing.

The hardships endured by the members of **the community** are obviously not lost on the nurses. The painful realities of existence in the community cause much emotional circumstantiality in the midst of which the nurses must continue to function. The many roles of the nurse as caregiver, as a public health professional, as a clinician, as the first responder to emergencies and violent situations, as the representative of Medical Services, as a health specialist in the community, as a person responsible for attending meetings with and for Chief and Council in the

role of nursing administrator, all these roles and their permeable nature become a very heavy load for nurses to carry. Murders in the community, physical violence, alcohol and drug abuse, threats and violent danger to nurses from community members become overwhelming for nurses at times. Some nurses appear to become desensitised or hardened to acts of violence, in order to protect themselves. Issues that are called "political" which nurses have to deal with at all times add tremendously to nurses' feeling stressed out and becoming burned out. A political issue can be considered interference by Chief and Council in the assessment of patients and/or the treatment planned for a patient by a nurse. This interference usually follows after an emotional reaction by a patient and/or family members based on dislike, anger, perceptual urgency, feelings that assessment and treatment are inadequate, the family's standing in the community, or on any other reason that Chief and Council feel gives them the right to interfere. Political issues are usually based on inadequate information, impulsive emotional reactions, racism, different perceptions of issues, or years of repressed anger. These issues that trouble community members may then become a huge political issue with its resultant negative influence on the nurses. Nurses experience resentment for the Orwellian notion that Chief and Council are always out there as a big brother and are used extensively by community members to threaten, coerce, and manipulate them. Lack of proper use of avenues of communication and a proper discussion forum for dealing with mutual misunderstandings in the community contribute to burnout. Lack of knowledge in some instances of basic personal care, first aid, and personal responsibility among community members contributes to feelings of resentment in nurses. Misuse and overuse of the nursing station as a general clinic at all hours of the night, with the expectation that misuse like that is a right of community members, cause many feelings of negativity in nurses. Nurses easily become the focus of a repressed dislike of white people shared by some community members because they represent an organisation and/or a government that for years has yielded tremendous power over the community members. This causes nurses to feel they are the target of reversed discrimination and racism. Nurses' motives for being in the community are always questioned, and on numerous occasions they are deemed uncaring money hungry mercenaries by community members, which leads to extraordinary negativity in nurses because of the inherent catch-22 properties of the argument. One bad political incident is enough to cause nurses to feel resentful towards community members who are perceived as bitter and angry towards the nurses. In these cases words like "racist", "prejudiced" and "racism" seem to be used as a matter of course by most

individuals involved. This adds more pain to an already inflamed situation. The fact that even after years of devoted service to the community nurses never become fully accepted by community members because of the transient nature of their position in the community leads to frustration and stress in nurses. Although nurses individually usually provide the best service possible to the community, this may not be sufficient to fulfil community needs. The nursing station as a physical institution may not be sufficient to fulfil community needs. In these instances nurses in their individual capacity easily get blamed for not being able to provide appropriate care and they may be castigated as being no good. This places nurses under extreme and unfair stress. An added component may be lack of knowledge of the cultural differences between nurses and patients. The hiatus between what exists in the reservation setting and conditions in the world outside the reservation causes many feelings of unreality and fragmentation in nurses which over time become quite disconcerting to nurses. Some nurses who work in their communities of birth found that addition stress and demands made by community members in the form of invasion of their privacy after hours, expecting privileged treatment from the nurses and acting as if the nurses were on duty at all times.

Intrapsychic factors that cause burnout also exist. Some nurses who feel that they have burned out in the past because they did not see the signs and were not aware of the problem as it happened to them until after the event, now feel more prone to burnout. The qualitative results indicated that overall there are some things that should be watched by this sample and that failing to do so may result in the development of burnout. Overwork, overextension and lack of knowledge of their own limitations seem to be contributing factors to burnout in nursing. Negative self-talk, sleep disturbances, unhealthy eating habits and smoking seem to be the prevalent behaviour pattern in nurses who feel overwhelmed by their jobs. Extreme negativity towards patients, an inadequate level of functioning as assessed by the nurses themselves, feeling as if they are spitting in the wind, as well as not meeting deadlines, lack of enjoyment of their work, a sense of isolation, and a profound sense of wanting to leave have been reported by a number of nurses. A false belief held by many nurses that they should present a strong and imperturbable facade to the world in spite of how they feel inside, causes many nurses to repress their feelings, to their own detriment. Emotional exhaustion and reduced personal accomplishment then follow. Nurses lose their sense of purpose about being where they are, they

end up having no life outside their job and they take any criticism extremely personally. They also have very limited resources for dealing with difficult situations. Nurses also feel that there is no progress in their work and that they are so tired of dealing with clinical issues that there is no time left for prevention.

Non-functioning interpersonal relationships or fights between nurses, between nurses and zone officers, between nurses and support staff, cause the most stress in nurses and contribute directly to burnout. Interpersonal conflict between supervisor and supervisee where competence issues and the documentation of competence issues come to the fore cause extreme negativity, stress and burnout in nurses. The close proximity of the workplace to their living quarters as well as the enforced socialisation in nursing stations lead to tremendous strain among nurses when the interpersonal relationships between various nurses become strained. The close proximity of nurses to each other not only in the workplace, but also in their living space, makes nurses particularly sensitive to each other's moods. This causes a continuous low level of stress that easily flares up into something bigger. When strain between nurses exists, any number of small actions, either deliberate or unintended, do snowball into the most horrendous interpersonal strife imaginable. All nurses involved feel the stress of this confrontation at a very deep personal level, with resultant tiredness, stress and a fight or flight response. The time spent in a community may be marked by limited contact with other people outside the work situation. This leads to a claustrophobic among nurses in that they feel they are caught in a situation that over time will lead to notable isolation. They feel that the only solution to this is to get out of the community, but there might be obstacles in the shape of expensive air tickets or staffing problems. The time spent in the community, without friends in the community outside the nursing station or the hospital, with the only outing being the trip to the store, and the rest of the time spent working or talking about work, day after day, leads to burnout in nurses. A bad interpersonal experience with a drunk individual, or a rapist, or a child or person abuser, may cause nurses to generalise their negative feelings to the next patient. In order not to do this they may experience a high level of stress in their interpersonal contact with other patients. Nurses who lose sight of the interpersonal and caring nature of their jobs and focus only on the financial remuneration aspect of it set themselves up for emotional exhaustion, depersonalisation and burnout. Years of dealing with the same set of problems causes some nurses to feel an absolute inability to effect change in or for their patients. This causes

nurses to start blaming their patients. Some nurses experience their families as a support, other nurses find the balancing act between family life and work life particularly stressful and personally intrusive. Also, nurses found deaths of community members, especially those they formerly had a good relationship with, extremely stressful. In conclusion it should also be noted that the differences in cultures and in values between nurses with a Western orientation and first nation people, and a lack of understanding of these differences, causes stress in some nurses.

Nurses' Lived Experience of the Symptoms of Burnout that they Experience

As a result of the burnout, **physically debilitating symptoms** are sometimes experienced by some nurses. Exhaustion and fatigue are the most commonly reported symptoms. The exhaustion is described as an all encompassing tiredness combined with sleeplessness and a lack of energy. Overall nurses experience vague physical aches and pains, like stomach aches and leg pains, with headaches being the most frequently reported. Feeling physically tense and physically tired simultaneously, as well as not being able to focus and concentrate, are further symptoms reported. A lack of exercise owing to time constraints, a lack of concentration, not being able to do the things they like, and a lack of physical activity that starts to invade the nurses in almost imperceptible small steps. In the most severe cases some nurses became physically inoperative during extreme crises. In these instances they report that they cried and became fearful of the situation, they had to take sleeping pills to sleep, and had no appetite.

Emotional exhaustion, with a soul, mind and body that is very, very tired, is the symptom most reported by nurses. Nurses feel stressed out and feel very frustrated. They just want to leave and sleep for days on end. When they do leave they do sleep for considerably longer periods than would be considered normal sleep. Some nurses become desensitised to their patients and their co-workers, having almost no emotional feelings for their patients other than anger and resentment, some even say hate. At times some nurses feel emotionally overwhelmed and sad to the point of crying and become overinvolved in the current situation with their patients or co-workers. A high level of emotionality over time will lead nurses to feel less and less and become emotionally exhausted. Being on the verge of burnout, running just ahead of burnout, feeling tired but pushing on nevertheless, this is the position in which many nurses find themselves. Burnout creeps up on nurses without their being aware of the syndrome as a whole until something bad

or traumatic happens in their lives which makes them realise that they have not been coping with the work for quite a while. Nurses reach the point where they cannot make sense of their lives and their work, it all becomes overwhelming, they may also blame other people and in general they feel very dissatisfied with their work.

Burnout impairs relationships at times. Avoiding involvement with co-workers and people in the community is a device used by some nurses as a protection for themselves, they only socialise superficially. Nurses feel that this protects them from the pressure created by having relationships with people. Nurses start to have strong negative feelings towards their co-workers and especially their patients over time. If they don't get out of the community these feelings increase. Co-workers can be either an incredible support or a tremendous burden and stressor for nurses. If a relationship becomes twisted, nurses just want to leave because of all the negative symptoms associated with the twisted relationship. Decreased communication and repressed anger are a common occurrence for nurses who do not deal with interpersonal problems as they occur. Convoluted relationships, where nurses have to deal with their boss, who is a nurse and going through the same things as they are, and where nurses socialise together as equals, cause trouble over time, especially when the relationship is turned into a triangle - a three-person emotional configuration, by the arrival of a new nurse. Family relationships add to the stress that nurses experience in the sense that they do not have enough time to spend with their family. Families need to be looked after, and the nurse's lack of time leads to interpersonal problems with family members. Forced relationships with people with nurses might not otherwise have socialised with but whom they now socialise because out of necessity because they are in the same isolated community lead to feelings of self-alienation and frustration in some nurses. Lack of relationships after hours and sexual tension further increase the stress that nurses experience as part of their daily schedule.

Nurses find it hard to motivate themselves to keep up a healthy lifestyle if they are becoming tired and exhausted. Some nurses become so unmotivated that things that they use to enjoy like crafts, exercise and even eating, become impossible to do or to take pleasure from. Satisfaction in all spheres of life decreases over time; there is an insidious decline that is difficult to detect until it has begun to lead to feelings of work evasion and strong depressive feelings.

Listlessness, lack of enjoyment, and indifference to patients and the work in general are symptoms that nurses complain about. Even getting out becomes a chore and a hardship to some nurses. Feeling trapped in nursing and wanting to get out of nursing becomes a theme for nurses who are stressed out. These feelings are linked to a vague sense of unease with nursing, but seldom to specific situations and specific reasons.

Nurses experience tremendous trouble in meeting deadlines and in focusing on their paperwork owing to **loss of concentration**. There is an awareness of being tired, but not of not being liable to concentrate. It is only in retrospect that the extent of the concentration loss becomes apparent. Losing sight of your reason for being there in the first place, as well as of what you should be doing, is a common occurrence for nurses. Tiredness and exhaustion make concentration on the task on hand very difficult for nurses. Some nurses feel that although they never considered themselves a danger to their patients, they thought that some Zone Officers might have considered them to be dangerous to their patients at times of high stress or tiredness.

Nurses' Lived Experience of How They Stay Healthy

Both nurses scoring high on the burnout measures and those scoring low on the burnout measures exhibited salutogenic qualities. All nurses say that northern nursing is very different from hospital nursing in the south, it carries its own rewards in terms of being exciting and challenging, and offering professional freedom and hands-on practical experience. The nursing practised is very dynamic and there is also the positive side of working with a culturally different people who have a wonderful sense of humor and are really in need of good service provision. Learning about nursing, becoming a better nurse, learning about a different culture, and the monetary rewards of working in the north provide the incentives for doing the job. These things makes sense to nurses, and help to place things in perspective. Such incentives make the effort **comprehensible**. They make the experience structured, predictable and explicable. Providing good nursing care and being appreciated by patients give nurse a sense of satisfaction. Coming from rural areas helps with the adaptation to isolated communities because these nurses know how to put up with living in a gossipy community where everybody knows everybody else's business, as well as how to entertain themselves. Putting things in perspective in a structured way as they start to happen (achieving emotional distance), helps nurses to deal with stress. To accept that they as nurses can only do

so much with what they have and to understand that the job is stressful in itself, without feeling personally responsible for situations that nurses encounter as part of their work, also help nurses deal with stress. Nurses learn that bad things will cause nurses to feel bad, and that certain things are beyond their control. That is why nurses learn to accept and live with things as they happen. Decisions made in the care of patients have long-term effects on patients' lives, change occurs over a period of time, so although nurses may not see the change, they know that over time it will take place. Life as it happens is a continuing source of satisfaction and enjoyment to nurses. The work, even when it is very stressful, is basically what nurses thought it would be. Learning to cope and to deal with situations makes nurses stronger in the long run and makes them feel more confident about their ability as nurses.

The fact that nurses have to rely greatly on their own skills and take their own decisions, while being autonomous in terms of patient care, is experienced in a very self-affirmative manner by nurses. The resources required to meet demands are contributed by the nurse. This makes the work and effort **manageable**. The fact that certain limitations and guidelines exist within which nurses function clinically, adds to their sense of security and safety within the work situation. Learning how to pace yourself, learning the limits of your capacities, both as a nurse and as a human being, learning what your individual resources are, helps nurses to manage, deal with and withstand their stressful lives. Northern nursing is experienced as turning nurses into better nurses and stronger individuals over time. Talking to other nurses after a traumatic event helps nurses to endure the emergencies that do occur. Not having to work in their communities of origin is preferable for some nurses because the personal attachment issue becomes mostly a non-issue. Some nurses feel that they can rely on themselves, on their personalities, or for the most part of their ability to let things roll off them in order to manage as nurses. Others have specific strategies that they use to deal with and withstand the pressures of the job. Still others find that their relationships in and with the community help them to cope. Nurses feel that they are doing what they are good at, they are less restricted, and that in working in the community, they are working with a lot of people in order to build something for the common good of the people.

In describing the **meaningfulness** of their work nurses report that northern nursing is the greatest work, the most satisfying, interesting and rewarding work that nurses can do; it combines the best of what nursing could be; it encompasses full range of nursing attitudes, from

planning for health promotion, right through to acute care, from birth control counselling through pregnancy through newborns, right into old age across the whole family. The nursing practised in the north in general has the great distinction of being the first line of defence in health care, and the nurses are right in there, making a difference, doing something and helping people to help themselves. The independence this type of nursing allows nurses largely, adds to their self-esteem and ability to practice independently in a focused, responsible manner. There is also the element of freedom of choice that nurses have - you choose to be happy, and choose to have a healthy mental attitude, fighting burnout. Nurses can likewise choose not to be depressed.

There are several other factors that come into play which offset the negative experience of northern nursing. The feeling exists among nurses that they are doing something of importance for people who really need their services, make nursing a **commitment** worthy of investment. The work that nurses do is of importance to the whole community and it involves more than just a service. There is a greater purpose behind their work, the ability to help each community to become a healthy one. There is a further belief that some nurses have concerning their purpose in the community, namely that a higher power helps them stay strong and them cope with things.

Nurses believe that by exercising and keeping fit and healthy, by eating a low fat diet and maintaining their weight, they can remain in **control** and cope better with their stressful lives. The independence of practice which allows them to deal with patients one on one without the restrictions that nurses in general hospitals face adds to a positive experience that nurses have and contributes to a feeling of being in control. This feeling of control extends beyond nursing practice, into where the community is going in terms of health care. Nurses feel that when they make decisions on behalf of the nursing station they are making long term decisions that are going to affect a lot of people. Some nurses feel that they have control of their feelings and of what they allow to get to them, they have the control to let things roll off them. By discussing critical incidents nurses feel that they can control the way they cope with the incident. Taking responsibility for their own lives and getting lots of rest help nurses deal with stress.

The difference between nursing in the city and northern nursing is acknowledged by nurses as a stimulus to growth rather than as a threat to their security. They find the differences interesting and **challenging**. The breadth and amplitude of the work in the nursing station are

considered a challenge for nurses, and lead to feelings of accomplishment and satisfaction. In trying and critical situations nurses comfort themselves with the knowledge that they have done everything that they possibly could have done for the patient. Isolated communities and everything that they represent, has an allure and a challenge all their own for nurses. The northern nursing experience is regarded as a learning experience that can be considered a stepping stone that could open other doors for nurses later in their careers. Nurses feel that what little preconceived ideas they had about northern nursing vanishes once they arrive and they have to cope with the realities of the work as it occurs. They have to get use to it, and they then generally enjoy the work. Nurses feel that the northern nursing experience makes them stronger and better nurses. In most cases it wasn't what they expected, it was a lot more than they bargained for, but they become better persons because of it. Some situations make nurses angry, in order to be in nursing for the long haul they have to be able to somehow observe the things they see, and deal effectively with the things they have to deal with, and not let them get to their souls.

Relying on **positive self-statements** and positive personality traits in dealing with things enhances nurses' abilities to feel comfortable about their propensity for dealing with things. Self-statements in emotionally taxing times, even with shortterm goals in mind, help nurses cope. Taking cognitive control of their feelings when things are not going well, or when people disappoint them, helps nurses to deal with things. Optimism and positive self-statements, like telling yourself that this is a learning experience and that this is tremendously satisfying, are helpful in dealing with the realities of northern nursing. Reminding themselves in self-statements that they have a purpose helps nurses stay strong and cope with things. The realisation that cultural differences exist and can be interesting as well as challenging helps nurses to deal with these differences. Taking responsibility for your own health and support systems helps nurses to function better over a longer period of time while continuing to feel that the work is rewarding and enjoyable.

Developing a support system outside the nursing station, in the community, as well as just physically getting out of the nursing station, helps nurses to get away from the stress in the nursing station. It is a good **problem-solving** strategy. Having friends and elders to talk to in the community provide a sounding board for nurses as well as a chance to learn about the community. Another problem-solving strategy is to have an informal debriefing among themselves after critical

incidents. This helps nurses cope better in the long run with these emergencies. Regular trips away, having the support of a spouse, phone calls and good interpersonal relationships with other nurses, all help to make the work experience worthwhile. Physical exercise and healthy eating helps nurses deal with stress so does having diverse hobbies, from knitting and sewing to computers and netsurfing. The introduction of suites for individual nurses a few years ago in nursing stations helped a lot to reduce interpersonal strife.

The whole experience of working in the north becomes gratifying in itself if viewed as a whole by nurses. The understanding that nursing is a difficult and hard job in the north, but that some people will be very thankful and appreciative makes the job worthwhile. Achieving financial independence over time is a great incentive for staying in the north for a time. Nurses expect that changes they introduce will take a long time to take effect, nurses also know that decisions they make regarding health care are long-term decisions that will affect a lot of people over time. In a sense this becomes an exercise in **delayed gratification**, much like boot camp "I am glad I did it, but I never want to do it again."

The fact that nurses have a big say in how they deal with each patient, in what they do for each patient, in diagnosing patients and in what type of medication they give each patient, provides a tremendous sense of **self-efficacy** for nurses. Nurses experience the independence of practice, the autonomy and the fact that they function mostly without doctors' orders in general as extremely positive. Positive feedback from patients commending nurses on their skills contributes to positive feelings nurses have about themselves and their skills. Positive self-esteem and the necessary independence to help yourself and others are very important in the whole nursing experience.

Discussion

Results of this phenomenological study show the incredible richness of information gathered by the phenomenological method. In chapter one it was stated that the manner in which and the reasons why certain nurses suffer from burnout should be investigated. It was further stated that the focus should be on how individuals use their personality traits in terms of their subjective constructions of reality. Put differently, the emphasis should be on how personality traits find expression in behaviour. These objectives, as well as the objective of receiving answers to the questions formulated in the sub aims have been more than adequately achieved by the results. The quantitative results proved to be unhelpful in determining whether high burnout prone individuals and low burnout prone individuals differ in their presentation of salutogenic qualities.

This concludes step seven of the phenomenological and empirical research. A phenomenological praxis adds to our understanding of the individual operationalisation of resistance resources and it has implications for the treatment and prevention of burnout in nurses. This in turn might have positive implications for the individual nurse and for the organisation.

Chapter Summary

The qualitative and quantitative results of this research were described in this chapter. Each of the seven transcribed interviews were presented and the central themes and theme clusters were extracted from the significant statements. From these central themes and theme clusters the following questions were answered: What causes burnout in the nursing profession? What are the symptoms experienced by the individual? How do nurses operationalise salutogenic qualities in their lives when they experience burnout?

The qualitative results indicated that **neither** a low score on the burnout measures **nor** a high score on the burnout measures is indicative of where the person finds himself or herself on the salutogenic measures, or of whether a person presents with the salutogenic qualities in his or her personality. The quantitative results proved unhelpful in determining whether high burnout prone individuals and low burnout prone individuals differ in their presentation of salutogenic

qualities.

In the next chapter the conclusions and restrictions of the research will be formulated. The formulation of recommendations will conclude this research.

CONCLUSIONS, RESTRICTIONS AND RECOMMENDATIONS

In this chapter the conclusions, restrictions and recommendations for this research will be given. This will take the form of an evaluation of the research in terms of the aims put forward in chapter one. Step 8 of the phenomenological and empirical research, namely the formulation of conclusions, will be performed first.

Conclusions

The general aim of this research was to generate a synthesis of burnout in the nursing profession from the perspective of the salutogenic paradigm, in order not only to integrate the existing knowledge but to contribute to the scientific paradigm. In order to achieve this, two aims for the literature survey were formulated:

- **Aim 1:** To present and integrate the existing literature on burnout with a specific focus on the experience of burnout in the nursing profession.

A synthesis of the burnout literature with a specific focus on the experience of burnout in the nursing profession was achieved in chapter 2 in the following manner. The concept of burnout was discussed. The discussion included a definition of burnout, the very important diagnostic criteria that would allow burnout to be identified within an individual, and the differential diagnosis. The antecedents and consequences of burnout as well as different coping strategies utilised to combat burnout were further discussed, as was the manifestation of the burnout concept in the nursing literature. The chapter was concluded with a discussion of the restrictions in the burnout concept.

It was stated that burnout is not a simple, uni-dimensional problem, but a complex issue

that is best explained within the confines of the human services professions. It was also stated that burnout is a unique type of stress phenomenon that is always the end-result of a gradual process of disillusionment in the quest to derive a sense of existential significance from work. Greater clarity on the burnout concept, its character, and its costs has thus been attained.

Aim 1 of the research has thus been achieved.

- **Aim 2:** To present and integrate the existing literature on salutogenesis with a specific focus on the role of salutogenesis and salutogenic constructs in burnout in the nursing profession.

A synthesis of the salutogenic literature, with a specific focus on the role of salutogenesis and salutogenic constructs in burnout in the nursing profession was achieved in chapter 3 . The conceptualisation of salutogenesis offered a critical and comprehensive perspective on how the individual manages to stay well intrapsychically, socially and in the organisational setting. The study of the strengths that individuals exhibit in order to manage the tension and stress in their lives and not to succumb to illness, proved to be a sound and descriptive paradigm with great possibilities for utilisation. Three answers to the salutogenic question, namely sense of coherence, hardiness and learned resourcefulness, were presented in great detail.

It was stated that salutogenesis opens the way to increasing our understanding of coping but that there is not necessarily a single correct answer to the complex salutogenic question.

Aim 2 of the research has thus been achieved.

As was stated at the beginning of this section, the general aim of this research was to generate a synthesis of burnout in the nursing profession from the perspective of the salutogenic paradigm in order not only to integrate existing knowledge but also to contribute to the scientific paradigm. To help to achieve this, the following empirical aims were formulated:

- **Aim 1:** To study the influence of salutogenic constructs on burnout from a

phenomenological point of view. In order to achieve this, three sub aims were formulated:

- * Sub-aim 1: To conduct a phenomenological study of the causes of burnout in the individual nurse.

A synthesis and an exhaustive description of nurses' lived experience of the causes of burnout were presented in chapter 5 in the following sections. Burnout caused by the work itself, by the engulfing demands and the daily realities that nurses function under. Burnout caused by the organisation, the rampant bureaucracy and the lack of organisational support. Burnout caused by the community, by consumer expectations and demands. Burnout caused by intrapsychic factors like reduced personal accomplishment, emotional exhaustion and depersonalisation. In the last place, burnout caused by interpersonal and social issues.

It was stated that burnout over time is caused by various factors that are individual and personal and therefore not easily discovered by methods other than the phenomenological method, where the life world of each individual is described.

Sub-aim 1 of the research has thus been achieved.

- * Sub-aim 2: To carry out a phenomenological determination of the symptoms of burnout in the individual nurse.

A synthesis and an exhaustive description of nurses' lived experience of the symptoms of burnout that they experience was presented in chapter 5 in the following manner: Physically debilitating symptoms experienced by the individual nurse and symptoms of being emotionally overwhelmed were presented in detail. Burnout that causes relationships to suffer and further causes intrapsychic symptoms of decreased motivation and lack of concentration was also presented.

It was stated that nurses report symptoms of exhaustion and fatigue the most frequently, while emotional exhaustion presents as a soul, mind and body that is very tired. This leads to

much frustration, a lack of motivation and a loss of concentration. The acceptance by nurses in general that burnout and its symptoms are an irrevocable and expected part of the nursing profession is galling.

Sub-aim 2 of the research has thus been achieved.

- * Sub-aim 3: To make a phenomenological study of the influence of salutogenic constructs, as operationalised by the individual nurse, on the experience of burnout.

A synthesis and an exhaustive description of nurses' lived experience of how they stay healthy was presented in chapter 5 in the following manner: Nurses experienced their lives and work as comprehensible, manageable and meaningful. There was also, for most nurses, a sense of commitment, control and challenge involved in their lives and work. They presented with self statements that showed cognitive control, problem solving strategies, the ability to delay immediate gratification and a sense of perceived self-efficacy.

It was stated that the nursing practised is both exciting and challenging, with a lot of professional freedom and hands on practical experience. This is experienced in a very self-affirmative manner by nurses.

Sub-aim 3 of the research has thus been achieved.

This research has been effective in achieving the general aim of generating a synthesis of burnout in the nursing profession, and also in arriving at a synthesis of burnout in nursing from the perspective of the salutogenic paradigm. Existing knowledge from the literature was consolidated and integrated, and "new knowledge" of the phenomenological experience of the causes and symptoms of burnout and how nurses stay healthy, was presented. In the last section of this chapter, the recommendations, it will further be shown how this new knowledge can enrich nursing training and practice.

Step 8 of the phenomenological and empirical research, namely the formulation of conclusions, has thus been completed.

Restrictions

In chapter 1 it was stated that step 9 of the phenomenological and empirical research would consist of a formulation of the restrictions of the research. These restrictions are presented next.

In the first place the restrictions for this research regarding burnout (p. 94) and the restrictions for this research regarding salutogenesis (p.139) should be noted. Two pertinent restrictions remain: (1) The fact that burnout has generally been studied from the pathogenic perspective means that to re-conceptualise the construct into the salutogenic paradigm remains difficult. (2) The phenomenological research method did reveal more generalised resistance resources than those covered by the known salutogenic literature in this research. This caused a somewhat forced categorising of the operationalisation of salutogenic qualities into known categories.

A further shortcoming is the fact that nurses practising in northern Manitoba were used exclusively. The cultural differences that exist in the north, as well as the isolation experienced by the nurses, mean that caution should be exercised when generalising the results to the nursing population in the south. The small sample size likewise means that generalisations to the general nursing population should be approached with caution and individual differences should not be overlooked. Using nurses from both rural and city locations may have alleviated this restriction.

It may be argued that one interview per respondent may not be sufficient to gather adequate information regarding the respondent's life world. It should be noted that the researcher lived in the same northern environment for five years and knew most of the nurses for at least two to three years prior to conducting the study. Nevertheless, more time spent on more interviews per respondent might have yielded even richer information. The already time-consuming nature of the research process would not be alleviated by this. But the gains in information might offset

this restriction.

This concludes step 9 of the phenomenological and empirical research.

Recommendations

The last step, step 10 of the phenomenological research method, will be presented next. This synchronises with an, as yet unaddressed aim presented in chapter 1. In chapter 1 the last aim for this research was formulated as follows:

- **Aim 2:** Based on the results, to make recommendations for the individual nurse and the nursing profession.

The recommendations will be made for industrial and clinical psychological practice, health psychology, individual nurses and the nursing profession and research.

Industrial and Clinical Psychological Practice

The physical and psychological health of the employee is of the utmost importance for both industrial and clinical psychological practice and the **prevalence and incidence of burnout should therefore be examined in more detail**. It is recommended that industrial and clinical psychologists take note of the diagnostic criteria that allow burnout to be identified within an individual as well as the differential diagnosis that exists for burnout.

In this research the phenomenological perspective indicated that individual nurses experienced burnout idiosyncratically. It is therefore important that the psychologist should **focus on the individual factors** that play a role in the experience of burnout. As the results indicated that the individual operationalises different salutogenic characteristics when faced with stressful working conditions, the positive and negative factors should be taken into consideration in the selection of intervention strategies.

The results also indicated that salutogenesis is a valuable alternative to the restrictive pathogenic paradigm. Strümpher (1995) indicates that the construct “salutogenesis” can be extended to a concept “fortigenesis”, which refers to strength in general. This **specific salutogenic characteristic should therefore be stimulated and accommodated**. If the salutogenic characteristics enable individuals to negotiate stressful events more effectively, this could have a direct influence on the cost of health care.

More specifically, recommendations could be formulated for the sub-field of occupational mental health. It is recommended that **salutogenesis be introduced** at the instructional level. The industrial and clinical psychologist should be aware of the impact of salutogenic constructs as well as salutogenesis as a paradigm in order to identify these stress-resistant resources in times of crises. In this research it became evident that the qualitative / phenomenological approach to research has benefits for the understanding of the individual suffering from burnout. It is therefore recommended that psychologists become more aware of the value and benefits of phenomenological research. Results obtained by means of phenomenological research can be utilised on a practical level by psychologists trying to alleviate the symptoms of burnout.

Health Psychology

In health psychology as a subject **more emphasis should be placed on salutogenesis and the salutogenic construct**. As the salutogenic paradigm has been used and operationalised for a while, it has shown that it can produce valid results that can be used to further existing knowledge. Positive focus on salutogenesis opens the way for the researcher to look at people suffering from stress and burnout as individuals who have certain characteristics that can help them to combat stress and burnout. It is therefore recommended that the salutogenic paradigm be used when dealing with burnout as a clinical entity. This recommendation has the following implications:

Antonovsky (1987) remarked that a salutogenic focus forces the practitioner to focus on the whole person rather than on a specific illness. Therefore the dichotomy of health and disease is not an absolute. All factors that aid movement toward the one or the other end of the

continuum should be examined in order to protect and improve physical and/or psychological health.

When the individual becomes the unit of analysis the emphasis may be placed on individual weaknesses and strengths which can promote health. It is therefore recommended that health psychology be aware of the fact that not all individuals and cultures manifest health in the same way. But there are various salutogenic personality qualities within the individual that can be strengthened, reinforced and enabled.

The results obtained in this research further indicate that there are interdependent factors that contribute to burnout. It is therefore recommended that organisations should be aware of these factors and that programs should be implemented to change the working environment in order to facilitate health. In this specific group, the results also indicated that there are various individual factors that contribute to the inception of burnout. As these results, obtained phenomenologically, also indicated that individuals differ in regard to their ability to deal with stress and burnout, it is recommended that more phenomenological research on burnout be done. This is in line with Kobasa's (1979) lament that there is not sufficient focus on the individual and the intrapsychic processes. The more complex the interplay between the individual and the various stressors related to burnout, the more valuable a phenomenological perspective can be. This would allow health psychology as a field of study to better predict and counter the prevalence of burnout. It would also lead to the expansion of theory in the field of health psychology.

The Individual Nurse and Nursing Practice

The phenomenologically obtained research results clearly indicated that some nurses are prone to burnout. This proneness is the result of work-related factors, organisational factors, consumer demands, intrapsychic factors and interpersonal factors. It is recommended that **individual nurses and the nursing profession in general** be made aware of: (1) the existence of burnout, (2) the factors that contribute to burnout, (3) the various manifestations of burnout at work and in the organisation, and (4) the coping strategies available to counter this problem in a positive and salutogenic manner. The phenomenological results of this research revealed a

number of issues that have implications for both the prevention and treatment of burnout in nurses. The results especially established how nurses can operationalise their inherent salutogenic qualities. Specific salutogenic coping strategies that emerged via the respondents were the following:

- **Placing things in perspective** (It's like you do the best you can with what you got, that's part of the job / life's too short to sit there and stew, anyways like things that you really can't control.), **work enjoyment** (it's rewarding and that part of it, I guess, makes me feel good), **recognising the added monetary reward**.
- **Coping with added responsibility in an expanded role brings satisfaction.** (It's a reward, I guess, all in it's own as far as being able to do the things that you can't do elsewhere, except in the northern communities)
- **Being in control** (here, you're in complete control of yourself / I'm doing what I was meant to do)
- **Commitment** (I feel like when I'm working with this community I'm working with a lot of people in order to build something)
- **Freedom of choice** (you choose to find something that is going to prevent you from becoming depressed / you can choose to have a healthy, mental attitude, and that comes with work), **being in charge** (we have more autonomy and you're allowed to think).
- **Challenge** (it's a continual challenge / it allows you to do more than what you can do).
- **Problem-solving strategies: staying active** (I'm trying to avoid static, I'm trying to avoid being in one spot / I have to find little things to do), **use of imagery** (I do that imagery thing when things really bug me), **relying on other people** (I know that if you haven't got any support systems outside this Federal Government building, you cannot make it, you can't live a life just for a job), **outside interests** (I'm bringing up all my little hobbies and

stuff / I bought a sewing machine, I learned how to sew, I sewed my first dress, I do my knitting and I knitted my first cap), **physical activity** (when I work out I get a lot of that out too, doing something physical), **using common sense** (I had done the right thing by just sheer common sense and I was really proud about it and I carried that with me for a while), **pampering self** (like go camping and that makes me feel good / Or sometimes I try to sneak in a nice long hot bath or whatever and read a bit), **exercise** (I'm doing my exercising and stuff / and I exercise), **healthy eating habits** (I eat okay, I eat good), **close friendships** (I have a lot of friends that I can phone at anytime of the day or night and they'll sit and listen), **frequent breaks** (I find that I need to get out every so often / I have to physically remove myself from here / if I can get out frequently, like every four to six weeks, it really helps. Even if it's just for a weekend or a day, even), **spontaneous debriefings** (when something happened really bad like people died, many times the nurses would just sit together and talk about it. I think that's how we cope with those emergencies that we have), **learning** (learning about the different cultural group which I really knew nothing about before).

- **Work is stressful, but success in the work situation, despite the stress, gives gratification.** ("You find the work stressful?" Yes, (but) I did what I liked here. I would thrive on that. I guess that's part of the thing).
- **Skill enhancement over time** (I've had lots of experiences and you feel good when you've diagnosed something correctly and actually over the years it gets easier, you've seen things you can rely on past experiences more and gut feelings).

It is furthermore recommended that in **the training of nurses** the concept of burnout, the antecedents of burnout, the consequences of burnout **and the coping strategies available** to counter burnout should be introduced, discussed, taught and be part of the training armour supplied to nurses.

The results also indicated that certain nurses are more successful in the operationalisation of salutogenic strategies and various characteristics that can help to combat stress and burnout.

The strength and weaknesses of individual nurses could be assessed and coping strategies could be taught. It is furthermore recommended that Medical Services Branch (MSB) be made aware of the fact that nurses working in northern communities have to deal with extra ordinary amount of stress which can lead to burnout. Once a nurse is suffering from burnout she becomes less effective and productive and if this continues without care, such nurses will leave the field and sometimes leave nursing altogether. This is extremely costly to the organisation. In order to keep nurses functional, it is recommended **that structures are initiated where nurses dealing with the effects of burnout can be helped**. This should be separate from the established Critical Incident Stress Management Services (CISMS) and should be an ongoing forum focusing on the physical and mental health of the individual nurse. It is recommended that individual nurses be made aware of their characteristic ways of coping that are not helpful to them, and be coached and prompted through various incentives to establish a healthier lifestyle within the restrictions of working in the north. This could empower the individual nurse by giving him or her a sense of control. Knowledge of salutogenic characteristics and how these are operationalised can furthermore be used to help nurses identify helpful coping mechanisms. In the long run this approach will save MSB a tremendous amount of money in recruitment fees and in the training of new nurses to replace the nurses they lose.

In the last place it is recommended that future research on the salutogenic perspective of burnout in the nursing profession should focus on the difference in the experience of causes of burnout, the symptoms of burnout and the salutogenic qualities exhibited between nurses in rural areas (north and south) and those in the city (bigger hospital settings). It is expected that the context may differ, but that their experiences might reflect similar themes.

The last step, step 10 of the phenomenological and empirical research method, has thus been completed. This also means that Aim 2 of the research, namely, to make recommendations for the individual nurse and the nursing profession, based on the results, has been achieved.

In summary: This research took a broad view of personality in health research. It studied the psychological processes underlying the observed connections between psychological variables and health outcomes. In order to study the operationalisation of these processes, a

phenomenological, person-based approach was followed. The study focused on health phenomena and the individual was retained as the unit of analysis. This approach represented a movement away from a fragmented science, infatuated with technology and linked to a singular epistemology, towards a focus on the process and dynamics of personal experience.

REFERENCES

- Abramson, L.Y., Seligman, M.E.P. & Teasdale, J.D. (1978). Learned helplessness in humans: Critique and reformulation. *Journal of Abnormal Psychology, 87*, 49-74.
- Allport, G.W. (1955). *Becoming: Basic considerations for a psychology of personality*. New Haven: Yale University Press.
- American Psychiatric Association. (1987). *Diagnostic and statistical manual of mental disorders* (3rd ed., revised). Washington: American Psychiatric Press.
- American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* 4th ed.). Washington: American Psychiatric Association.
- Anson, O., Carmel, S., Levenson, A. Bonney, D.Y. & Maoz, B. (1993). Coping with recent life events: The interplay of personal and collective resources. *Behavioral Medicine, 18*(4), 159-166.
- Antoni, M. (1985). Temporal relationship between life events and two illness measures: A cross-lagged panel analysis. *Journal of Human Stress, 11*, 21-25.
- Antonovsky, A. (1972). Breakdown: A needed fourth step in the conceptual armamentarium of modern medicine. *Social Science and Medicine, 6*, 537-544.
- Antonovsky, A. (1979). *Health, stress, and coping: New perspectives on mental and physical well-being*. San Francisco: Jossey-Bass.
- Antonovsky, A. (1983). *The sense of coherence: Development of a research instrument*. (Newsletter and Research Reports, 1, 1-11). Tel Aviv: Tel Aviv University, W.S. Schwartz Research Center for Behavioral Medicine.

- Antonovsky, A. (1984). The sense of coherence as a determinant of health. In J.D. Matarazzo, S.M. Weiss, J.A. Herd, M.E. Miller & S.M. Weiss (Eds.), *Behavioral health: A handbook of health enhancement and disease prevention*. New York: Wiley-Interscience.
- Antonovsky, A. (1985). The life cycle, mental health, and the sense of coherence. *Israel Journal of Psychiatry and Related Sciences*, 22, 273-280.
- Antonovsky, A. (1987). *Unraveling the mystery of health*. San Francisco: Jossey-Bass.
- Antonovsky, A. (1995). The moral and the healthy: Identical, overlapping or orthogonal? *Israeli Journal of Psychiatry Related Sciences*, 32, 1, 5-13.
- Antonovsky, A., Adler, I., Sagy, S. & Visel, R. (1990). Attitudes toward retirement in an Israeli cohort. *International Journal of Aging Human Development*, 31, 57-77.
- Antonovsky, A. & Bernstein, J. (1986). Pathogenesis and salutogenesis in war and other crises: Who studies the successful copier? In N.A. Milgram (Ed.), *Stress and coping in time of war: Generalizations from the Israeli experience*. New York: Brunner/Mazel.
- Antonovsky, H. & Sagy, S. (1986). The development of a sense of coherence and its impact on responses to stress situations. *Journal of Social Psychology*, 126, 213-225.
- Armstrong-Stassen, M., al-Ma'Aitah, R., Cameron, S & Horsburgh, M. (1994). Determinants and consequences of burnout: a cross-cultural comparison of Canadian and Jordanian nurses. *Health Care Women International*, 15(5), 413-421.
- Arnold, M. (1984). *Memory and the brain*. Hillsdale: Erlbaum.

- Ashworth, P.D. (1987). The descriptive adequacy of qualitative findings. *The Humanistic Psychologist, 15*(1), 38-49.
- Averill, J.R. (1973). Personal control over aversive stimuli and its relationship to stress. *Psychological Bulletin, 80*, 286-303.
- Bailey, K.D. (1987). *Methods of social research*. New York: The Free Press.
- Bandura, A. (1982). Self-efficacy mechanism in human agency. *American Psychologist, 37*, 122-147.
- Bandura, A. (1989). Human agency in social cognitive theory. *American psychologist, 44*, 1175-1184.
- Barlow, D.H. (1988). *Anxiety and its disorders: The nature and treatment of anxiety and panic*. New York: Guilford Press.
- Barlow, D.H. & Craske, M.G. (1989). *Mastery of your anxiety and panic*. New York: Graywind Publications.
- Bart, C.A. (1992). *Personality, cognitive appraisal and adjustment in lung transplant recipients*. Unpublished PH.D. dissertation. York University. York.
- Bartone, P.T. (1989). Predictors of stress-related illness in city bus drivers. *Journal of Occupational Medicine, 31*, 857-863.
- Bauman, K.E. & Udry, J.R. (1972). Powerlessness and regularity of contraception in an urban Negro male sample: A research note. *Journal of Marriage and the Family, 34*, 112-114.

- Beck, C.L. & Gargiulo, R.M. (1983). Burnout in teachers of retarded and non-retarded children. *Journal of Educational Research*, 73(3), 169-173.
- Beck, C.T. (1990). Qualitative research: Methodologies and use in paediatric nursing. *Issues in Comprehensive Paediatric Nursing*, 13, 193-201.
- Beck, C.T. (1995). Burnout in undergraduate nursing students. *Nurse Education*, 20(4), 19-23.
- Bedian, A., Armenakis, A. & Curran, L. (1981). The relationship between role stress and job-related, interpersonal, and organizational climate factors. *Journal of Social Psychology*, 22(2), 246-260.
- Belcastro, P.A. & Gold, R.S. (1983). Teacher stress and burnout: Implications for school health personnel. *Journal of School Health*, 53(7), 10-15.
- Belcastro, P. & Hayes, L. (1983). Ergophilia ... ergophobia ... ergo ... burnout? *Professional Psychological Research*, 15, 260-270.
- Ben-Sira, Z. (1985). Potency: A stress-buffering link in the coping-stress-disease relationship. *Social Science and Medicine*, 21, 397-406.
- Berg, A., Hansson, U.W. & Hallberg, I.R. (1994). Nurses' creativity, tedium and burnout during 1 year of clinical supervision and implementation of individually planned nurse care: comparisons between a ward for severely demented patients and a similar control ward. *Journal of Advanced Nursing*, 20(4), 742-749.
- Bernard, L.C. & Belinsky, D. (1993). Hardiness, stress and maladjustment: Effects of self-reported retrospective health problems and prospective health center visits. *Journal of Social Behavior and Personality*, 8(6), 97-110.

- Bibeau, G., Dussault, G., Larouche, L.M., Lippel, K., Saucier, J.F., Vezina, M. & Vidal, J.M. (1989). *Certains aspects culturels, diagnostiques et juridiques de burnout* [Some cultural diagnostic and juridical aspects of burnout]. Paper presented at the Annual Convention of the Confederation des Syndicats Nationaux, Montreal.
- Boss-Victoria, R.G. (1992). *Generalized resistance resources of informal caregivers: A study of demands for care, competing demands, perception of burden and cognitive stress (caregiver burden, care demands)*. Unpublished doctoral dissertation. University of Texas, Houston.
- Boyce, W.T., Schaefer, C. & Uitti, C. (1985). Permanence and change: Psychosocial factors in the outcome of adolescent pregnancy. *Social Science and Medicine*, 21, 1279-1287.
- Boyle, A., Grap, M.J., Younger, J. & Thornby, D. (1991). Personality hardiness, ways of coping, social support and burnout in critical care nurses. *Journal of Advanced Nursing*, 16(7), 850-857.
- Breed, M. (1988). *'n Ondersoek na die wenslikheid van psigologiese hulpverlening aan onluspolisiermanne as krisiswerkers*. [An investigation into the desirability of psychological and giving to riot police as crisis workers]. Unpublished M. A. thesis. Potchefstroom: Potchefstroom University for Christian Higher Education.
- Brill, P.L. (1984). The need for and operational definition of burnout. *Family and Community Health*, 6, 143-150.
- Bromley, D.B. (1986). *The case-study method in psychology and related disciplines*. Chichester: Wiley.
- Bryant, E. (1994). When the going gets tough. *Canadian Nurse*, 90(2), 36-39.
- * Burgess, A.W. (1980). Stress and burnout. *Abstract, Carrier Foundation Letter*, 64.

* Burisch, M. (1993). In search of theory: Some ruminations on the nature and etiology of burnout. In W. B. Schaufeli, C. Maslach & T. Marek (Eds), *Professional burnout*. Washington: Taylor & Francis.

Burke, R.J. (1987). Issues and implications for health care delivery systems: A Canadian perspective. In J. C. Quick, J.D. Quick, R. S. Bhagat, and J. E. Dalton (Eds), *Work stress: Health care systems in the workplace*, New York: Praeger Publishers.

Caccese, C.F. & Mayerberg, C.K. (1984). Gender differences in perceived burnout of college coaches. *Journal of Sport Psychology*, 6, 279-288.

Cahoon, A.R. & Rowney, J.I. (1984). Managerial burnout: A comparison by sex and level of responsibility. *Journal of Health and Human Resources Administration*, 7, 249-263.

Cameron, S.J., Horsburgh, M.E. & Armstrong-Stassen, M. (1994). Job satisfaction, propensity to leave and burnout in RN's and RNA's: A multivariate perspective. *Canadian Journal of Nursing Administration*, 7(3), 43 -64.

Campbell, J.M., Amerikaner, M., Swank, P. & Vincent, K. (1989). The relationship between the hardiness test and the personal orientation inventory. *Journal of Research in Personality*, 23, 373-380.

Cannon, W.B. (1932). *The wisdom of the body*. New York: Norton.

Capel, S.A., Sisley, B.L. & Desertrain, G.S. (1987). The relationship of role conflict and role ambiguity to burnout in high school basketball coaches. *Journal of Sport Psychology*, 9, 106-117.

Caplan, G. (1964). *Principles of preventive psychiatry*. New York: Basic Books.

Carlson, R. (1984). What's social about social psychology? Where's the person in personality research? *Journal of Personality and Social Psychology*, 47, 1304-1309.

Carmel, S. & Bernstein, J. (1990). Trait anxiety, sense of coherence and medical school stressors: Observations at 3 stages. *Anxiety Research*, 3, 51-60.

Cedoline, A.J. (1982) *Job burnout in public education*. New York: Teachers College Press.

Ceslowitz, S. (1989). Burnout among hospital staff nurses. *Journal of Advanced Nursing*, 14(7), 553-558.

Cherniss, C. (1980a). *Staff burnout: Job stress in the human services*. Beverly Hills: Sage Publications.

* Cherniss, C. (1980b). *Professional burnout in human service organizations*. New York: Praeger Publishers.

* Cherniss, C. (1995). *Beyond burnout*. New York: Routledge.

Cilliers, F.V.N. (1991). *Die veranderende rol van die bedryfsielkunde in Suid-Afrika*. [The changing role of Industrial Psychology in South Africa]. Inaugural address. Pretoria: Department of Industrial Psychology, University of South Africa.

Clanton, L.D., Rude, S.S & Taylor, C. (1992). Learned resourcefulness as a moderator of burnout in a sample of rehabilitation providers. *Rehabilitation Psychology*, 37(2), 131-140.

Cleaver, G. (1988). A phenomenological analysis of victimization. The experience of having one's house attacked and damaged. *South African Journal of Psychology*, 18(3), 76-83.

- Clum, G.A. (1990). *Coping with panic: A drug-free approach to dealing with anxiety attacks*. Pacific Grove: Brooks/Cole Publishing Company.
- Cobb, S. (1976). Social support as a moderator of life stress. *Psychosomatic Medicine*, 5(38), 300-317.
- Coe, R.M., Miller, D.K. & Flaherty, J.H. (1991). Sense of coherence and perception of caregiving burden. *Behavior, Health, and Aging*, 2(2), 93-99.
- Coe, R.M., Romeis, J.C., Tang, B. & Wolinsky, F.D. (1990). Correlates of a measure of coping in older veterans: A preliminary report. *Journal of Community Health*, 15, 287-296.
- Cohen, F. (1984). Coping. In J.D. Matarazzo and others (Eds.), *Behavioral health: A handbook of health enhancement and disease prevention*. New York: Wiley.
- Cohen, S. (1980). Aftereffects of stress on human performance and social behavior. *Psychological Bulletin*, 88, 82-108.
- Colaizzi, P. (1978). Psychological research as the phenomenologists views it. In: Valle, R. & King, M. (Eds). *Existential phenomenological alternative for psychology*. New York: Oxford University Press.
- Colerick, E.J. (1985). Stamina in later life. *Social Science and Medicine*, 21, 997-1006.
- Consolvo, C. A., Brownwell, V. & Distefano, S.M. (1989). Profile of the hardy NICU nurse. *Perinatol*, 9(3), 334-337.
- Cooper, C.L. (1981). *Executive families under stress*. Englewood Cliffs: Prentice-Hall.

- Cordes, C.L. & Dougherty, T.W. (1993). A review and integration of research on job burnout. *Academy of Management Review*, 18(4), 621-656.
- Coyne, J.C. & Lazarus, R.S. (1980). Cognitive style, stress perception, and coping. In I. L. Kutash & L. B. Schlesinger (Eds.), *Handbook on stress and anxiety*. San Francisco: Jossey-Bass.
- Cox, T. (1978). *Stress*. Baltimore: University Park Press.
- Cox, T. (1985). The nature and measurement of stress. *Ergonomics*, 28, 1155-1163.
- Cox, T. (1990). The nature and recognition of stress: Conceptual and methodological issues. In E. N. Corlett & J. Wilson (Eds.), *Evaluation of human work*, London: Taylor & Francis.
- Cox, T. & Ferguson, E. (1991). Individual differences, stress and coping. In C. L. Cooper & R. Payne (Eds.), *Personality and stress: Individual differences in the stress process*. Chichester: John Wiley & Sons.
- Dahlin, L., Cederblad, M., Antonovsky, A. & Hagnell, O. (1990). Childhood vulnerability and adult invincibility. *Acta Scandinavica Psychiatry*, 82, 228-232.
- Dakof, G.A. & Mendelsohn, G.A. (1986). Parkinson's disease: The psychological aspects of a chronic illness. *Psychological Bulletin*, 99, 375-387.
- Dana, R.H., Hoffman T., Armstrong B. & Wilson J. (1985). *Sense of coherence: Examination of the construct*. Poster session presented at the Southwestern Psychological Association, Austin.
- De Charms, R. (1968). *Personal causation: The internal affective determinants of behavior*. New York: Academic Press.

- Dermatis, H. (1989). *Hardiness in nurses: Relation to stress, social support, coping and illness*. Unpublished PH. D. dissertation. City University of New York, New York.
- De Wet, C.F. (1985). *Huweliksterapie met verwysing na gesinne van oorsprong*. [Marital therapy with reference to families of origin]. Unpublished M. A. thesis. Potchefstroom: Potchefstroom University for Christian Higher Education.
- De Wet, C.F. (1987). *Die sielkundige ontlonting van stres in die oorlogsituasie: Teorie en praktyk*. [The psychological debriefing of stress in a war situation]. Paper presented at the Annual Convention of the Psychological Association of South Africa, Cape Town.
- De Wet, C.F. (1993). *Culture and care: Beyond theory in aboriginal care*. Paper presented at the Annual Convention of the Canadian Psychological Association, Montreal.
- Duquette, A., Kerouac, S., Sandhu, B.K. & Beaudet, L. (1994). Factors related to nursing burnout: A review of empirical knowledge. *Issues in Mental Health Nursing*, 15(4), 337-358.
- Eckstein, H. (1975). Case study and theory in political science. In F.I. Greenstein & N.W. Polsby (Eds.), *Handbook of political science, (Vol.7): Strategies of enquiry*. Reading: Addison-Wesley.
- Edelwich, J. & Brodsky, A. (1980). *Burnout: Stages of disillusionment in the helping professions*. New York: Human Sciences Press.
- Edwards, D.J.A. (1991). Duquesne phenomenological research method as a special class of case study research method. In R. van Vuuren (Ed.), *Dialogue beyond polemics*. Pretoria: Human Sciences Research Council.

Edwards, J.R. (1991). The measurement of type A behavior pattern: An assessment of criterion-oriented validity, content validity, and construct validity. In C. L. Cooper & R. Payne (Eds.), *Personality and stress: Individual differences in the stress process*. Chichester: John Wiley & Sons.

Enevoldsen Bowsher, J. & Keep, D. (1995). Toward an understanding of three control constructs: Personal control, self-efficacy and hardiness. *Issues in Mental Health Nursing*, 16, 33-50.

Entin, A.D. (1989). Foreword. In D.T. Wessells, Jr., A.H. Kutscher, I.B. Seeland, F.E. Selder, D.J. Cherico, & E.J. Clark (Eds.), *Professional burnout in medicine and the helping professions*. New York: Haworth Press.

Etzion, D., Kafrey, D. & Pines, A. (1982). Tedium among managers: A cross-cultural comparison between Israelis and Americans. *Journal of Psychology and Judaism*, 7, 30-41.

Everly, G.S. (1989). *A clinical guide to the treatment of the human stress response*. New York: Plenum.

Everly, G.S. & Lating, J. (1994). *Psychotraumatology*. New York: Plenum.

* Farber, B.A. (1983). Introduction: A critical perspective on burnout. In B. A. Farber (Ed.), *Stress and burnout in the human service profession*, New York: Pergamon Press.

Farrington, A. (1995). Stress and nursing. *British Journal of Nursing*, 4(10), 574-578.

Fender, L.K. (1989). Athlete burnout: Potential for research and intervention strategies. *Sport Psychologist*, 3, 63-71.

- Figley, C.R., Burgess, A. & Mitchell, J.T. (1994). *Compassion fatigue: The stress of caring too much*. Panama City: Visionary Productions.
- Fiorentino, L.M. (1986). Stress: The high cost to industry. *Occupational Health Nursing*, 34, 217-220.
- Fischer, C.T. & Wertz, F.J. (1979). Empirical phenomenological analyses of being criminally victimized. In A. Giorgi, R. Knowles & D. L. Smith (Eds.), *Duquesne studies in phenomenological psychology* (Vol 3). Pittsburgh: Duquesne University Press.
- Fischer, H.J. (1983). A psychoanalytic view of burnout. In B. A. Farber (Ed.), *Stress and burnout in the human service profession*. New York: Pergamon Press.
- Flannery, R.B. & Flannery G.J. (1990). Sense of coherence, life stress, and psychological distress: A prospective methodological inquiry. *Journal of Clinical Psychology*, 46(4), 415-420.
- Forney, D.S., Wallace-Schutzman, F. & Wiggers, T. (1982). Burnout among career development professionals: Preliminary findings and implications. *Personnel and Guidance Journal*, 60(7), 435-439.
- Frankl, V.E. (1959). *Man's search for meaning*. New York: Washington Square Press.
- Freudenberger, H.J. (1974). Staff burnout. *Journal of Social Issues*, 30, 159-165.
- Freudenberger, H.J. (1975). The staff burnout syndrome in alternative institutions. *Psychotherapy: Theory, Research and Practice*, 12(1), 73-82.
- Freudenberger, H.J. (1981). *Burnout: Contemporary issues and trends*. Paper presented at the National Conference on Stress and Burnout, New York.

- Freudenberger, H.J. (1982). Coping with job burnout. *Law and Order*, 30(5), 5-10.
- Freudenberger, H.J. (1983). Burnout: Contemporary issues, trends and concerns. In B. A. Farber (Ed.), *Stress and burnout in the human service profession*, New York: Pergamon Press.
- Freudenberger, H.J. (1985). Impaired clinicians: Coping with burnout. In P. A. Keller & R. H. L. G. (Eds.), *Innovations in clinical practice: A source book 3*. Sarasota: Professional Resource Exchange.
- Freudenberger, H.J. (1989). Burnout: Past, present and future concerns. In D. T. Wessells, Jr., A. H. Kutscher, I. B. Seeland, F. E. Selder, D. J. Cherico, & E. J. Clark (Eds.), *Professional burnout in medicine and the helping professions*. New York: Haworth Press.
- Freudenberger, H.J. & Richelson, G. (1980). *Burnout: How to beat the high cost of high achievement*. New York: Doubleday.
- Friedman, H.S. (Ed.) (1990). *Personality and Disease*. New York: John Wiley.
- Fromm, E. (1947). *Man for himself*. New York: Holt, Rinehart, & Winston.
- Funk, S.C. (1992). Hardiness: A review of theory and research. *Health Psychology*, 11(5), 335-345.
- Funk, S.C. & Houston, B.K. (1987). A critical analysis of the Hardiness Scale's validity and utility. *Journal of Personality and Social Psychology*, 53 (3), 572-578.
- Galdston, I. (Ed.) (1954). *Beyond the germ theory: The roles of deprivation and stress in health and disease*. New York: Health Education Council.

- Gallagher, T.J., Wagenfeld, M.O., Baro, F. & Haepers, K. (1994). Sense of coherence, coping and caregiver role overload. *Social Science and Medicine*, 39(12), 1615-1622.
- Ganster, D.C. & Schaubroeck J. (1991). Work, stress and employee health. *Journal of Management*, 17, 235-271.
- Garber, J., Miller, S.M. & Abramson, L.Y. (1980). On the distinction between anxiety states and depression: Perceived control, certainty, and probability of goal attainment. In J. Garber & M. E. P. Seligman (Eds.), *Human helplessness: Theory and applications*. New York: Academic Press.
- Garden, A.M. (1987). Depersonalization: A valid dimension of burnout? *Human Relations*, 40, 545-560.
- Gellhorn, E. (1967). *Principles of automatic-somatic integrations*. Minneapolis: University of Minnesota Press.
- Gibson, J.L., Ivancevich, J.M. & Donnelly (Jr.), J.H. (1991). *Organizations: Behavior, structure, processes* (7th edition). Boston: Irwin.
- Gillmore, V.L. (1990). *Workplace variables and experienced occupational hazards as predictors of health of speciality nurses*. Unpublished PH.D. dissertation. University of Maryland at Baltimore, Baltimore.
- Gintner, G.G., West, J.D. & Zarski, J.J. (1989). Learned resourcefulness and situation-specific coping with stress. *Journal of Psychology*, 123(3), 295-304.
- Giorgi, A. (1975). An application of phenomenological method in psychology. In A. Giorgi, C. T. Fischer & E. L. Murray (Eds.), *Duquesne studies in phenomenological psychology* (Vol. 2). Pittsburgh: Duquesne University Press.

- Giorgi, A. (1985). *Phenomenology and psychological research*. Pittsburgh: Duquesne University Press.
- Giorgi, A. (1986). Theoretical justification for the use of description in psychological research. In P. Ashworth, A. Giorgi & de Koning, A.J.J. (Eds.), *Qualitative research in psychology* (pp. 3-22). Pittsburgh: Duquesne University Press.
- Giorgi, A. (1986b). The "Context of discovery/context of verification" distinction and descriptive human science. *Journal of Phenomenological Psychology*, 17, 151-166.
- Golembiewski, R.T. & Munzenrider, R.F. (1988). *Phases of burnout: Developments in concepts and applications*. New York: Praeger.
-  Golembiewski, R.T., Munzenrider, R.F. & Stevenson, J.G. (1986). *Stress in organizations*. New York: Praeger.
- Gomes, M.E. & Maslach, C. (1991). *Commitment and burnout among political activists: An in-depth study*. Paper presented at the International Society of Political Psychology, Helsinki.
- Gray, J. (1982). *The neuropsychology of anxiety*. New York: Oxford University Press.
- Greef, M. (1991). *'n Model vir psigiatriese verpleegkundige begeleiding van die pasient met geestesongemak* [A model for psychiatric nursing help to the patient with mental discomfort]. Unpublished doctoral dissertation. Rand Afrikaans University, Johannesburg.
- Gruber, V.A. & Wildman, B.G. (1987). The impact of dysmenorrhea on daily activities. *Behavior Research and Therapy*, 25, 123-128.

- Hallberg, I.R. (1994). Systematic clinical supervision in a child psychiatric ward: Satisfaction with nursing care, tedium, burnout, and the nurses' own report on the effects of it. *Arch Psychiatric Nursing*, 8(1), 44-52.
- Hallsten, L. (1993). Burning out: A framework. In W. B. Schaufeli, C. Maslach & T. Marek (Eds.), *Professional burnout*. Washington: Taylor & Francis.
- Handy, J. (1990). *Occupational stress in a caring profession: The social context of psychiatric nursing*. Aldershot: Avebury.
- Harrison, W.D. (1983). A social competence model of burnout. In B. A. Farber (Ed.), *Stress and burnout in the human service profession*. New York: Pergamon Press.
- Hart, K.E. Hittner, J.B. & Paras, K.C. (1991). Sense of coherence, trait anxiety, and the perceived ability of social support. *Journal of Research in Personality*, 25(2), 137-145.
- Hartrick, G.A. & Hills, M.D. (1993). Staff nurse perceptions of stressors and support needs in their workplace. *Canadian Journal of Nursing*, 25(1), 23-31.
- Hayes, H. (1988). The causative factors of stress among operating room nurses in Los Angeles and Orange counties (Master's thesis, California State University). *Masters Abstracts International*, 27(1), 96.
- Heidegger, M. (1962). *Being and time*. New York: Harper and Row.
- Heifetz, L.J. & Bersani, H.A. (1983). Disrupting the cybernetics of personal growth: Toward a unified theory of burnout in the human services. In B. A. Farber (Ed.), *Stress and burnout in the human service profession*. New York: Pergamon Press.

- Herman, J. & Van der Kolk, B. (1987). Traumatic antecedents of borderline personality disorder. In B. van der Kolk (Ed.), *Psychological trauma*. Washington: American Psychiatric Press.
- Hinshaw, A., Smeltzer, C. & Atwood, J. (1987). Innovative retention strategies for nursing staff. *Journal of Nursing Administration*, 17(6), 8-16.
- Holmes, T.H. & Masuda, M. (1974). Life change and illness susceptibility. In Dohrenwend, B. S. & Dohrenwend, B. P. (Eds.), *Stressful life events: Their nature and effects*. New York: Wiley.
- Huang, C. (1995). Hardiness and stress: A critical review. *Maternal Child Nursing Journal*, 23(3), 82-89.
- Huysamen, G.K. (1993). *Metodologie vir die sosiale en gedragwetenskappe* [Methodology for the social and behaviour sciences]. Halfway House: Southern Book Publishers.
- Jackson, S.E. (1982). *Burnout: A concept in need of refinement*. Paper presented at the Annual Convention of the American Psychological Association.
- Jackson, S.E., Schwab, R.L. & Schuler, R.S. (1986). Toward an understanding of the burnout phenomenon. *Journal of Applied Psychology*, 71, 630-640.
- Jacobi, J.S. (1968). *The psychology of C. C. Jung*. London: Yale University Press.
- James, W. (1911). The energies of men. In H. James (Ed.), *Memories and studies*. New York: Longmans Green & Company.
- Jennings, B.M. & Staggars, N. (1994). A critical analysis of hardiness. *Nursing Research*, 43(5), 274-281.

- Jones, J. (Ed.).(1981). *The burnout syndrome: Current research, theory, interventions*. Park Ridge: London House Press.
- Jones, P.S. (1991). Adaptibility: A personal resource for health. *Scholarly Inquiry for Nursing Practice*, 5(2), 95-108.
- Jung, C.G. (1960). *Psychological Types* (Vol. 6, collected works). Princeton: Princeton University Press.
- Kadushin, A. (1974). *Child welfare services*. New York: Macmillan.
- Kahn, R.L. (1978). Job burnout: Prevention and remedies. *Public Welfare*, 16, 61-63.
- Kalimo, R. & Vuori, J. (1990). Work and sense of coherence: Resources for competence and life satisfaction. *Behavioral Medicine*, 16, 76-89.
- Kalimo, R. & Vuori, J. (1991). Work factors and health: The predictive role of pre-employment experiences. *Journal of Occupational Psychology*, 62(2), 97-115.
- Kaplan, A. (1964). *The conduct of inquiry*. San Fransico: Chandler Publication Company.
- Kaplan, G.A. (1985). Psychosocial aspects of chronic illness: Direct and indirect associations with ischemic heart disease mortality. In R. M. Kaplan and M. H. Criqui (Eds.), *Behavioral epidemiology and disease prevention*. New York: Plenum.
- Kaplan, H.I. & Sadock, B.J. (1991). *Synopsis of psychiatry: Behavioral sciences clinical psychiatry* (6th ed.). Baltimore: Williams & Wilkins.
- Kaufman, F. (1944). *Methodology of the social sciences*. New Jersey: Humanities Press.

- Kearns, J.D. (1973). *Stress in industry*. London: Priory Press.
- Kempe, C.H. (1978). *Child protection services: Where have we been? What are we now and where are we going? Child abuse and neglect: Issues on implementation and innovation* (DHEW Publication No. 78-30147, vol 5). Washington: U. S. Government Printing Office.
- Kriska, G.W. (1964). *The disorganized personality*. New York: McGraw-Hill.
- Kobasa, S.C. (1979). Stressful life events, personality, and health: An inquiry into hardiness. *Journal of Personality and Social Psychology*, 37, 1-11.
- Kobasa, S.C. (1982). The hardy personality: Toward a social psychology of stress and health. In G.S. Sanders & J. Suls (Eds.), *Social psychology of health and illness* (pp. 3-32). Hillsdale: Erlbaum.
- Kobasa, S.C. & Maddi, S.R. (1977). Existential personality theory. In Corsini (ed.), *Current personality theory*, Itasca: Peacock.
- Kobasa, S.C., Maddi, S.R. & Kahn, S. (1982). Hardiness and health: A prospective study. *Journal of Personality and Social Psychology*, 42, 168-177.
- Kobasa, S.C., Maddi, S.R. & Puccetti, M.C. (1982). Personality and exercise as buffers in the stress-illness relationship. *Journal of Behavioral Medicine*, 5, 391-404.
- Kohn, M.L. (1985). *Unresolved interpretive issues in the relationship between work and personality*. Address delivered at the American Sociological Association, Washington.
- Kohn, M.L. & Schooler, C. (1983). *Work and personality: An enquiry into the impact of social stratification*. Norwood: Ablex.

- Kramer, M. (1974). *Reality shock*, St. Louis: Mosby.
- Kruger, D. (1986). Fenomenologie en die grondslae van die psigologie [Phenomenology and the foundation of psychology]. *Suid-Afrikaanse Tydskrif vir Sielkunde*, 16(4), 109-116.
- Kuhn, T.S. (1970). *The structure of scientific revolutions*. Chicago: The University of Chicago Press.
- Kvale, S. (1987). Interpretation of the qualitative research interview. In F.J. van Zuuren, F. J. Wertz & B. Mook (Eds.), *Advances in qualitative psycholgy: Themes and variations*. Berwyn: Swets North America Inc.
- Kvale, S. (1990). *Ten standard responses to qualitative research interviews*. Paper presented at the Annual Convention of the Canadian Psychological Association, Quebec.
- Lambert, C.E. (1991). *The relationship among psychological hardiness, faculty practice involvement, and perception of role stress of nurse educators*. Unpublished doctoral dissertation. University of Maryland at Balitmore, Balitmore.
- Lambert, C.E. & Lambert, V.A. (1987). Hardiness: Its development and relevance to nursing. *Image: Journal of Nursing Scholarship*, 19(2), 92-95.
- Lang, P.J. (1984). Cognition in emotion: Concept and action. In C. Izard, J. Kagan & R. Zajonc (Eds.), *Emotions, cognitions and behavior*. New York: Cambridge University Press.
- Lang, P.J. (1985). The cognitive psychophysiology of emotion: Fear and anxiety. In A. H. Tuma & J. D. Maser (Eds.), *Anxiety and the anxiety disorders*. Hillsdale: Erlbaum.
- Langemo, D.K. (1990). Impact of work stress on female nurse educators. *Image: Journal of Nursing Scholarship*, 22, 159-173.

- Larsson, G. & Setterlind, S. (1990). Work load/work control and health: Moderating effects of heredity, self-image, coping and health behavior. *International Journal of Health Science*, 1, 79-88.
- Lazarus, R.S. (1967). Cognitive and personality factors underlying threat and coping. In M. H. Appley & R. Trumbull (Eds.), *Psychology of stress*. New York: Appleton-Century-Crofts.
- Lazarus, R.S. (1974). Psychological stress and coping in adaptation to illness. *International Journal of Psychiatry in Medicine*, 5, 321-332.
- Lazarus, R.S. (1976). *Patterns of adjustment* (3rd ed.). New York: McGraw-Hill.
- Lazarus, R.S. (1978). A strategy for research on psychological and social factors in hypertension. *Journal of Human Stress*, September, 35-40.
- Lazarus, R.S., Averill, J.R. & Opton, E.M., Jr. (1970). Toward a cognitive theory of emotion. In M.B. Arnold (Ed.), *Feelings and emotions*. New York: Academic Press.
- Lazarus, R.S., Cohen, J.B. & Folkman, S. (1980). Psychological stress and adaptation: Some unresolved issues. In H. Selye (Ed.), *Selye's guide to stress research* (Vol. 1). New York: Van Nostrand Reinhold.
- Lazarus, R.S. & Folkman, S. (1984). *Stress appraisal and coping*. New York: Springer.
- Lazarus, R.S. & Launier, R. (1978). Stress-related transactions between person and environment. In L. A. Pervin & M. Lewis (Eds.), *Perspectives in interactional psychology*. New York: Plenum Press.

- Lee, R.T. & Ashforth, B.E. (1993). A further examination of managerial burnout: Toward an integrated model. *Journal of Organizational Behavior*, 14, 3-20.
- Lefcourt, H.M. (1980). Locus of control and coping with life's events. In E. Staub (Ed.), *Personality: Basic issues and current research*, Englewood Cliffs: Prentice-Hall.
- Lempp, H. (1995). Burnout associated with caring for people living with HIV/AIDS. *Nursing Times*, 91(18), 34-35.
- Leon, G.R. & Rosenthal, B.S. (1984). Prognostic indicators of success or relapse in weight reduction. *International Journal of Eating Disorders*, 3, 15-24.
- Levi, L. (1989). Occupational stressors, biological stress and workers' health (Abstract). *Sangyo Ika Daigaku Zasshi*, 11(2), 229-245.
- Lewis, S.L., Campbell, M.A., Beckett, P.J., Cooper, C.L., Bonner, P.M. & Hunt, W.C. (1992). Work stress, burnout, and sense of coherence among dialysis nurses. *American Nephrology Nurses Association Journal*, 19(6), 545-554.
- Libassi, M.F. & Muluccio, A. (1986). Competence-centered social work: Prevention in action. *Journal of Primary Prevention*, 6, 168-180.
- Lief, H.I. & Fox, D. C. (1963). Training for "detached concern" in medical students. In H.I. Lief, V. F. Lief & N. R. Lief (Eds.), *The psychological basis of medical practice*. New York: McGraw-Hill.
- Lin, N. (1976). *Foundation of social research*. New York: McGraw Hill.

Lyall, A. (1989). The prevention and treatment of professional burnout. In D. T. Wessells, Jr., A. H. Kutscher, I. B. Seeland, F. E. Selder, D. J. Cherico, & E. J. Clark (Eds.), *Professional burnout in medicine and the helping professions*. New York: Haworth Press.

Lynn, R. (1989). Burnout in the professional care giver: Does the Phoenix have to burn or why can't Icarus stay aloft? In D. T. Wessells, Jr., A. H. Kutscher, I. B. Seeland, F. E. Selder, D. J. Cherico, & E. J. Clark (Eds.), *Professional burnout in medicine and the helping professions*. New York: Haworth Press.

Lysaught, J.P. (1970) *An abstract for action. National commission for the study of nursing and nursing education*. New York: McGraw-Hill.

Maddi, S.R. & Khoshaba, D.M. (1994). Hardiness and mental health. *Journal of Personality Assessment*, 63(2), 265-274.

Manning, G. (1988). *Stress without distress: Rx for burnout*. Cincinnati: Vista Systems.

Manning, M.R., Williams, R.F. & Wolfe, D.M. (1988). Hardiness and the relationship between stressors and outcomes. *Work and stress*, 2(3), 205-216.

* Maslach, C. (1976). Burned-out. *Human Behavior*, 5(9), 16-22.

* Maslach, C. (1978). How people cope. *Public Welfare*, 16, 56-58.

* Maslach, C. (1978). The client role in staff burn-out. *Journal of Social Issues*, 34, 111-124.

* Maslach, C. & Jackson, S.E. (1977). Lawyer burnout. *Barrister*, 5(2), 52-54.

- Maslach, C. & Jackson, S.E. (1981). The measurement of experienced burnout. *Journal of Occupational Behavior*, 2, 99-113.
- Maslach, C. & Jackson, S.E. (1982a). *Maslach burnout inventory*. Palo Alto: Consulting Psychologists Press.
- Maslach, C. & Jackson, S.E. (1982b). Burnout in the health professions: A social psychological analysis. In Sanders, G. S. & Suls, J. (Eds.), *Social psychology of health and illness*. New Jersey: Lawrence Erlbaum Associates.
- Maslach, C. & Jackson, S.E. (1984). Burnout in organizational settings. In S. Oskamp (Ed.), *Applied social psychology annual: Applications in organizational settings* (Vol. 5, pp. 133-153). Beverly Hills: Sage.
- Maslach, C. & Schaufeli, W.B. (1993). Historical and conceptual development of burnout. In W. B. Schaufeli, C. Maslach & T. Marek (Eds.), *Professional burnout*. Washington: Taylor & Francis.
- Maslow, A.H. (1954). *Motivation and personality*, New York: Harper & Row.
- Mason, J.W. (1975). A historical view of the stress field (Part 1). *Journal of Human Stress*, March, 6-12.
- Matarazzo, J.D. (1980). Behavioral health and behavioral medicine: Frontiers for a new health psychology. *American Psychologist*, 35, 807-817.
- Matarazzo, J.D. (1982). Behavioral health's challenge to academic, scientific and professional psychology. *American Psychologist*, 37, 1-14.

- Matthews, K.A. (1982). Psychological perspectives on the type A behavior pattern. *Psychological Bulletin*, 91, 293-323.
- McAbee, R. (1994). Job stress and coping strategies among nurses: Results of a self report survey. *American Occupational Health Nursing Journal*, 42(10), 483-487.
- McCarthy, M. (1989). Burnout: What price care giving? In D.T. Wessells, Jr., A.H. Kutscher, I.B. Seeland, F.E. Selder, D.J. Cherico, & E.J. Clark (Eds.), *Professional burnout in medicine and the helping professions*. New York: Haworth Press.
- McCracken, G. (1988). *The long interview*. Newbury Park: Sage.
- McCranie, E.W., Lambert, V.A. & Lambert, C.E. (1987). Work stress, hardiness, and burnout among hospital staff nurses. *Nursing Research*, 36(6), 374-378
- McGrath, A., Reid, N. & Boore, J. (1989). Occupational stress in nursing. *International Journal of Nursing Studies*, 26(4), 343-358.
- McSherry, W.C. & Holm, J.E. (1994). Sense of coherence: Its effects on psychological and physiological processes prior to, during, and after a stressful situation. *Journal of clinical psychology*, 50(7), 476-487.
- Meichenbaum, D. (1977). *Cognitive-behavior modification: An integrative approach*. New York: Plenum.
- Meichenbaum, D. (1985). *Stress inoculation training*. New York: Pergamon Press.
- Meyer, W.F., Moore, C. & Viljoen, H.G. (1989). *Personality theories - from Freud to Frankl*. Johannesburg: Lexicon Publishers.

- Mineka, S. (1985). The frightful complexity of the origins of fears. In F. Brush & J. Overmier (Eds.), *Affect, conditioning, and cognition: Essays on the determinants of behavior*. Hillsdale: Erlbaum.
- Mineka, S. & Kelly, K.A. (1989). The relationship between anxiety, lack of control and loss of control. In A. Steptoe & A. Appels (Eds.), *Stress, personal control and health*. Chichester: John Wiley & Sons.
- Minirth, F.B. (1986). *How to beat burnout*. Chicago: Moody Press.
- Mitchell, J.T. (1985). Healing the helper. In B. Green (Ed.), *Role stressors and supports for emergency workers*. Washington: Center for Mental Health Studies of Emergencies, U. S. Department of Health and Human Services.
- Mitchell, J.T. (1986). Critical incident stress management. *Response*, Sept./Oct., 24-25.
- Mitchell, J.T. (1993). Comprehensive traumatic stress management in the emergency department. *Emergency Nurses Association Monograph Series*, 1(8), 3-13.
- * Mitchell, J.T. & Bray, G.P. (1990). *Emergency services stress: Guidelines for preserving the health and careers of emergency services personnel*. Englewood Cliffs: Brady.
- Mitchell, J.T. & Everly, G.S. (1993). *Critical incident stress debriefing: An operations manual for the prevention of traumatic stress among emergency services and disaster workers*. Ellicott City: Chevron Publishing Corporation.
- Mitchell, J.T. & Resnick, H.L.P. (1981). *Emergency response to crisis*. Maryland: Robert J. Brady.

- Moos, R.H. (1984). Context and coping: Toward a unifying conceptual framework. *American Journal of Community Psychology*, 12, 5-25.
- Monat, A. & Lazarus, R.S. (1977). Stress and coping: Some current issues and controversies. In A. Monat & R. S. Lazarus (Eds.), *Stress and coping: An anthology*. New York: Columbia University Press.
- Moore, C. (1989). The humanistic approach. In W.F. Meyer, C. Moore & H.G. Viljoen (Eds.). *Personality theories - from Freud to Frankl*. Johannesburg: Lexicon Publishers.
- Morano, J. (1993). The relationship of workplace social support to perceived work-related stress among staff nurses. *Journal of Post Anesthesia Nursing*. 8(6), 395-402.
- Mouton, J. & Marais, H.C. (1990). *Basic concepts in the methodology of the social sciences*. Pretoria: Human Sciences Research Council.
- * Muldary, T.W. (1983). *Burnout among health professionals: Manifestations and management*. Norwalk: Appleton-Century-Crofts.
- Naisberg-Fennig, S., Fennig, S., Keinan, G. & Elizur, A. (1991). Personality characteristics and proneness to burnout: A study among psychiatrists. *Stress Medicine*, 7(4), 201-205.
- Neimeyer, R.A. (1994). The role of client-generated narratives in psychotherapy. Special section: Narrative theory and therapy. *Journal of Constructivist Psychology*, 7(4), 229-242.
- Noble, J.E. (1993). *Examination of hardiness as a predictor of nurse retention*. Unpublished PH.D. dissertation. The Union Institute.

- Nolan, P., Cushway, D. & Taylor, P. (1995). A measurement tool for assessing stress among mental health nurses. *Nursing Standard*, 9(46), 36-39.
- Norbeck, J. (1985). Perceived job stress, job satisfaction, and psychological symptoms in critical care nursing. *Research in Nursing and Health*, 8, 253-259.
- Norman, E. & Getek, D. (1988). Post-traumatic stress in victims of physical trauma (Abstract). *Proceedings of the 15th Annual National Teaching Institute of the American Association of Critical Care Nurses*. Newport Beach: American Association of Critical Care Nurses.
- Norrie, P. (1995). Do intensive care staff suffer more stress than staff in other care environments? A discussion. *Intensive Critical Care Nursing*, 11(5), 293-297.
- Oehler, J.M. & Davidson, M.G. (1992). Job stress and burnout in acute and nonacute pediatric nurses. *American Journal of Critical Care*, 1(2), 81-90.
- Oettgen, H.T. (1977). Immunotherapy of cancer. *New England Journal of Medicine*, 297, 484-491.
- Oken, D. (1978). The unknown factor: The doctor and how he does his doctoring. *Frontiers of Psychiatry*, June 15, 12.
- Okun, M.A., Zantra, A.J. & Robinson, S.E. (1988). Hardiness and health among women with rheumatoid arthritis. *Personality and Individual Differences*, 9, 101-107.
- O'Leary, A. (1985). Self-efficacy and health. *Behavior Research and Therapy*, 23, 437-451.
- Onega, L.L. (1991). A theoretical framework for psychiatric nursing practice. *Journal of Advanced Nursing*, 16(1), 68-73.

- Oosthuizen, M. (1994). *Stressimptomatologie by nooddienpersoneel* [Stress symptomology in emergency personnel]. Unpublished M. A. thesis. Pretoria: University of South Africa.
- Orcutt, T.L. & Prell, J.R. (1994). *Integrative paradigms of psychotherapy*. Boston: Allyn and Bacon.
- Ormel, J. & Sanderman, R. (1989). Life events, personal control and depression. In A. Steptoe & A. Appels (Eds.), *Stress, personal control and health*. Chichester: John Wiley & Sons.
- Oswin, M. (1978). *Children living in long stay hospitals*. London: Heinemann.
- Ouellette Kobassa, S.C. (1990). Lessons from history: How to find the person in health psychology. In H. S. Friedman (Ed.), *Personality and Disease*. New York: John Wiley.
- Pagana, K.D. (1990). The relationship of hardiness and social support to student appraisal of stress in an initial clinical nursing situation. *Journal of Nursing Education*, 29, 255-261.
- Papadatou, D., Anagnostopoulos, F. & Monos, D. (1994). Factors contributing to the development of burnout in oncology nursing. *British Journal of Medical Psychology*, 67(part 2), 187-199.
- Parkes, K.R. (1994). Personality and coping as moderators of work stress processes: Models, methods and measures. *Work and Stress*, 8(2), 110-129.
- Parkes, K.R. & Rendall, D. (1988). The hardy personality and its relationship to extraversion and neuroticism. *Personality and Individual Differences*, 9, 785-790.
- Payne, L. (1982). *Sense of coherence: A measure of health status*. Unpublished master's thesis. Edmonton: School of Nursing, University of Alberta.

- Payne, R. (1988). Individual differences in the study of occupational stress. In C. L. Cooper & R. Payne (Eds.), *Causes, coping, and consequences of stress at work*, Chichester: John Wiley & Sons.
- Pearlin, L.I., Meneghan, E.G., Lieberman, M.A. & Mullan, J. T. (1981). The stress process. *Journal of Health and Social Behavior*, 22, 337-356.
- Pearlin, L.J. & Schooler, C. (1978). The structure of coping. *Journal of Health and Social Behavior*, 19, 2-21.
- Pelsma, D.M., Roland, B., Tollefson, N. & Wigington, H. (1989). Parent burnout: Validation of the MBI with a sample of mothers. *Measurement and Evaluation in Counseling and Development*, 22, 81-87.
- Petrie, K. & Azariah, R. (1990). Health-promoting variables as predictors of response to a brief pain management program. *Clinical Journal of Pain*, 6, 43-46.
- Pettegrew, L., Costello, R., Wolf, G., Lennox, S. & Thomas, S. (1980). Job related stress in a medical centre organization: Management of communication issues. In D. Nimmo (Ed.), *Communication Yearbook IV*. New Brunswick: Transaction, Inc.
- Phares, E.J. (1979). *Clinical psychology: Concepts, methods, and profession*. Homewood: The Dorsey Press.
- Pines, A. (1983). On burnout and the buffering effects of social support. In B. A. Farber (Ed.), *Stress and burnout in the human service profession*. New York: Pergamon Press.
- Pines, A.M. (1988). *Keeping the spark alive: Preventing burnout in love and marriage*. New York: St. Martin's Press.

Pines, A.M. (1993). Burnout: An existential perspective. In W. B. Schaufeli, C. Maslach & T. Marek (Eds.), *Professional burnout*. Washington: Taylor & Francis.

* Pines, A.M. & Aronson, E. (1981). *Burnout: From tedium to personal growth*. New York: Free Press.

* Pines, A.M. & Aronson, E. (1988). *Career burnout: Causes and cures*. New York: Free Press.

Pines, A. & Maslach, C. (1978). Characteristics of staff burnout in mental health settings. *Hospital and Community Psychiatry*, 29, 233-237.

Plug, C., Meyer, W.F., Louw, D.A. & Gouws, L.A. (1986). *Psigologiewoordeboek* (2nd ed.) [Psychology dictionary]. Johannesburg: McGraw-Hill.

Polkinghorne, D.E. (1994). Reaction to special section on qualitative research in counselling process and outcome. *Journal of Counselling Psychology*, 41(4), 510-512.

Pollack, S.E. & Duffy, M.E. (1990). The health related hardiness scale: Development and Psychometric analysis. *Nursing Research*, 39, 218-222.

Post, R. & Ballenger, J. (1981). Kindling models for the progressive development of psychopathology. In H. van Pragg (Ed.), *Handbook of biological psychiatry* (pp. 609-651). New York: Marcel Dekker.

Pruyser, P.W. (1984). Existential impact of professional exposure to life-threatening or terminal illness (Abstract). *Bulletin of the Menninger Clinic*, 48(4).

Rabkin, J.G. & Struening, E.L. (1976). Life events, stress and illness. *Science*, 194, 1013-1020.

- Radmacher, S.A. & Sheridan, C.L. (1989). The global inventory of stress: A comprehensive approach to stress assessment. *Medical Psychotherapist*, 2, 183-188.
- Redden, E.M., Tucker, R.K. & Young, L. (1983). Psychometric properties of the Resenbaum Schedule for Assessing Self-control. *The Psychological Record*, 33, 77-86.
- Regelson, W. (1989). Physician "burnout". In D. T. Wessells, Jr., A. H. Kutscher, I. B. Seeland, F. E. Selder, D. J. Cherico, & E. J. Clark (Eds.), *Professional burnout in medicine and the helping professions*. New York: Haworth Press.
- Reiss, D. (1981). *The family's construction of reality*. Cambridge: Harvard University Press.
- Rich, V.L. (1991). *The use of personal, organizational, and coping resources in the prevention of staff nurse burnout: a test of a model*. Unpublished PH. D. dissertation. University of Pittsburgh, Pittsburgh.
- Roach, B.L. (1994). Burnout and the nursing profession. *Health Care Supervisor*, 12(4), 41-47.
- Rogers, C.R. (1959). A theory of therapy, personality, and interpersonal relationships, as developed in the client-centered framework. In S. Koch (Ed.), *Psychology: A study of a science* (Vol. 3, pp. 184-256). New York: McGraw Hill.
- Roseman, I. (1984). Cognitive determinants of emotion. In P. Shaver (Ed.), *Human Stress*. New York: AMS Press.
- Rosenbaum, M. (1980). A schedule for assessing self-control behaviors: Preliminary findings. *Behavior Therapy*, 11, 109-121.

- Rosenbaum, M. (1983). Learned resourcefulness as a behavioral repertoire for the self-regulation of internal events: Issues and speculations. In M. Rosenbaum, C.M. Franks & Y. Jaffe (Eds.), *Perspectives on behavior therapy in the eighties*. New York: Springer.
- Rosenbaum, M. (1988). Learned resourcefulness, stress and self-regulation. In S. Fisher & J. Reason (Eds.), *Handbook of life-stress, cognition and health* (pp. 483-496). Chichester: Wiley.
- Rosenbaum, M. (1989). Self-control under stress: The role of learned resourcefulness. Special issue: The role of individual differences in stress and stress management. *Advances in Behavior Research and Therapy*, 11(4), 249-258.
- Rosenbaum, M. & Ben-Ari, K. (1985). Learned helplessness and learned resourcefulness: Effects of noncontingent success and failure on individuals differing in self-control skills. *Journal of Personality and Social Psychology*, 48, 198-215.
- Rosenbaum, M. & Palmon, N. (1984). Helplessness and resourcefulness in coping with epilepsy. *Journal of Consulting and Clinical Psychology*, 52(2), 244-253.
- Rosenberg, M.J. (1990). *Predictors of healthy lifestyles among professional nurses*. Unpublished ED. D. dissertation. Northern Illinois University, Illinois.
- Ross, L. (1977). The intuitive psychologist and his shortcomings: Distortions in the attribution process. In L. Berkowitz (Ed.), *Advances in experimental social psychology* (Vol. 10). New York: Academic Press.
- Rotter, J.B. (1954). *Social learning and clinical psychology*. Englewood Cliffs: Prentice-Hall.
- Rotter, J.B. (1966). Generalized expectancies for internal versus external control of reinforcement. *Psychological Monographs*, 80 (1, Whole No. 609).

- Rotter, J.B. (1975). Some problems and misconceptions related to the construct of internal versus external reinforcement. *Journal of Consulting and Clinical Psychology, 43*, 56-67.
- Rummel, C.B. (1991). *The relationship of health value and hardiness to health-promoting behavior in nurses*. Unpublished PH. D. dissertation. New York University, New York.
- Ryland, E. & Greenfeld, S. (1991). Work stress and well being: An investigation on Antonovsky's sense of coherence model. *Journal of Social Behavior and Personality, 6*(7), 39-54.
- Sagy, S. & Antonovsky, A. (1990). Coping with retirement: Does the sense of coherence matter less in the kibbutz? *International Journal of Health Sciences, 1*, 233-242.
- Sagy, S., Antonovsky, A. & Adler, I. (1990). Explaining life satisfaction in later life: The sense of coherence model and activity theory. *Behavioral Health Aging, 1*, 11-25.
- Sandelowski, M. (1986). The problem of rigor in qualitative research. *Advances Nursing Science, 8*(3), 27-37.
- Sarason, S. (1977). *Work, aging, and social change*, New York: Free Press.
- Sartre, J.P. (1956). *Being and nothingness*. New York: Philosophical Library.
- Schaufeli, W.B. , Enzmann, D. & Girault, N. (1993). Measurement of burnout: A review. In W. B. Schaufeli, C. Maslach & T. Marek (Eds.), *Professional burnout*. Washington: Taylor & Francis.
- Schaufeli, W.B. & Peeters, M.C.M. (1990). *The measurement of burnout*. Paper presented at the ENOP Conference on Professional Burnout, . Krakow.

- Schwab, R.L. & Iwanicki, E.F. (1982). Perceived role conflict, role ambiguity, and teacher burnout. *Educational Administration Quarterly*, 18, 60-74.
- Schwartz, G.E. (1979). The brain as a health care system. In G. C. Stone, F. Cohen, N. E. Adler (Eds.), *Health psychology* (pp. 549 - 573). San Francisco: Jossey - Bass.
- Segal, R.D. (1996). *The early adult life structure of urban black men*. Unpublished doctoral dissertation. University of South Africa, Pretoria.
- Selder, F.E. & Paustian, A. (1989). Burnout: Absence of vision. In D. T. Wessells, Jr., A. H. Kutscher, I. B. Seeland, F. E. Selder, D. J. Cherico, & E. J. Clark (Eds.), *Professional burnout in medicine and the helping professions*. New York: Haworth Press.
- Seligman, M.E.P. (1975). *Helplessness: On depression, development and death*. San Francisco: W. H. Freeman.
- Seligman, M.E.P. (1990). *Learned optimism: How to change your mind and your life*. New York: Pocket Books.
- Seligman, M.E.P. (1993). *What you can change and what you can't*. Toronto: Random House.
- Selye, H. (1936). A syndrome produced by diverse nocuous agents. *Nature*. July 4.
- Selye, H. (1950). *Stress*. Montreal: Acta.
- Selye, H. (1956). *The stress of life*. New York: McGraw Hill.
- Selye, H. (1974). *Stress without distress*. Philadelphia: J. B. Lippincott.

- Selye, H. (1976). *Stress in health and disease*. Boston: Butterworth.
- Senge, P.M. (1990). *The fifth discipline: The art and practice of the learning organization*. New York: Doubleday.
- Shaffer, G.W. & Lazarus, R.S. (1952). *Fundamental concepts in clinical psychology*. New York: McGraw-Hill.
- Shirom, A. (1989). Burnout in work organizations. In C. L. Cooper & I. Robertson (Eds.), *International review of industrial and organizational psychology* (pp. 25-48). New York: Wiley.
- Slater, J. & Depue, R.A. (1981). The contribution of environmental events and social support to serious suicide attempts in primary depressive disorder. *Journal of Abnormal Psychology*, 59, 275-285.
- Smith, K.J. & Everly, G.S. (1992). *A structural model and configural analysis of the relationship between stressors and disease among accountants*. Paper presented at the NIOSH/APA Conference on Occupational Stress, Washington.
- Sorokin, P.A. (1959). *Social and cultural mobility*. New York: Free Press.
- Staats, A.W. (1975). *Social behaviorism*. Homewood: Dorsey.
- Stechmiller, J.K. & Yarandi, H.N. (1992). Job satisfaction among critical care nurses. *American Journal of Critical Care*, 1(3), 37-44.
- Steptoe, A. & Appels, A. (Eds.), (1989). *Stress, personal control and health*. Chichester: John Wiley & Sons.

- Stewart, M.J. & Arklie, M. (1994). Work satisfaction, stressors and support experienced by community health nurses. *Canadian Journal for Public Health*, 85(3), 180-184.
- Stones, C.R. (1986). Phenomenological praxis: A constructive alternative in research in psychology. *South African Journal of Psychology*, 16, 117-121.
- Stones, C.R. (1988). Research: Toward a phenomenological praxis. In D. Kruger (Ed.), *An introduction to phenomenological psychology*. Cape Town: Juta.
- Stout, J.K. & Williams, J.M. (1983). Comparison of two measures of burnout. *Psychological Reports*, 53, 283-289.
- Strasser, S. (1963). *Phenomenology and the human sciences*. Pittsburgh: Duquesne University Press.
- Strümpher, D.J.W. (1990). Salutogenesis: A new paradigm. *South African Journal of Psychology*, 20(4), 265-276.
- Strümpher, D.J.W. (1995). The origins of health and strength: from 'salutogenesis' to 'fortigenesis'. *South African Journal of Psychology*, 25(2), 81-89.
- Strümpher, D.J.W. & Louw, D.A. (1989). *Stress among farmworkers in Western Cape agribusiness organization*. Paper presented at the Annual Convention of the Psychological Association of South African, Durban.
- Sullivan, G.C. (1989). Evaluating Antonovsky's salutogenic model for its adaptability to nursing. *Journal of Advanced Nursing*, 4, 14(4), 336-342.

- Sullivan, G.C. (1993). Towards clarification of convergent concepts: sense of coherence, will to meaning, locus of control, learned helplessness and hardiness. *Journal of Advanced Nursing*, 18(11), 1772-1778.
- Super, D.E. (1955). Transition: From vocational guidance to counselling psychology. *Journal of Counselling Psychology*, 2, 3-9.
- Swede, S.A. & Jaffe, S.S. (1987). *The panic attack recovery book*. New York: New American Library.
- Sykes, W. (1991). Taking stock: Issues from the literature on validity and reliability in qualitative research. *Journal of the Market Research Society*, 33(1), 3-12.
- Syme, S.L. (1989). Control and health: A personal perspective. In A. Steptoe & A. Appels (Eds.), *Stress, personal control and health*. Chichester: John Wiley.
- Tarolli-Jager, K. (1994). Personal hardiness: Your buffer against burnout. *American Journal of Nursing*, 94(2), 71-72.
- Tartasky, D.S. (1993). Hardiness: Conceptual and methodological issues. *Image: Journal of Nursing Scholarship*, 25(3), 225-229.
- Taylor, H. & Cooper, C.L. (1989). The stress-prone personality: A review of the research in the context of occupational stress. *Stress Medicine*, 5(1), 17-27.
- Taylor, S.J. & Bogdan, R. (1984). *Introduction to qualitative research methods: The search for meanings* (2nd ed.). New York: Wiley.
- Thomas, C.B. (1981). Stamina: The thread of human life. *Journal of Chronic Diseases*, 34, 41-44.

- Tishelman, C., Taube, A. & Sachs, L. (1991). Self-reported symptom distress in cancer patients: reflections of disease, illness or sickness? *Social Science Medicine*, 33(11), 1229-1240.
- Todres, L.A. (1986). The experience of human finitude: A phenomenological investigation. *South African Journal of Psychology*, 16, 122-125.
- Topf, M. (1989). Personality hardiness, occupational stress, and burnout in critical care nurses. *Research in Nursing and Health*, 12(3), 179-186.
- Towers, J.F. (1984). *A meta-analysis of the relationships among stress, social supports, and illness and their implications for health profession education*. Unpublished doctoral dissertation. University of Pennsylvania.
- Turner, R.J. (1981). Social support as a contingency in psychological well-being. *Journal of Health and Social Behavior*, 22, 357-367.
- Tyler, P.A. & Ellison, R.N. (1994). Sources of stress and psychological well-being in high-dependency nursing. *Journal for Advanced Nursing*, 19(3), 469-476.
- Vachon, M.L. (1995). Staff stress in hospice/palliative care: A review. *Palliative Medicine*, 9(2), 91-122.
- Van Servellen, G. & Leake, B. (1993). Burnout in hospital nurses: A comparison of acquired immunodeficiency syndrome, oncology, general medical, and intensive care unit nurse samples. *Journal of Professional Nursing*, 9(3), 169-177.
- Van Vuuren, R.J. (1989). An exploration of the role of description in psychology as a descriptive science. *South African Journal of Psychology*, 19(2), 65-74.

Van Vuuren, R.J. (1991). *Dialogue beyond polemics*. Pretoria: Human Sciences Research Council.

Van Vuuren, R.J. & Ladikos, A. (1991). Strafbelewenis: 'n empiries-fenomenologiese studie van die gevangene se belewenis van straf [Doing time: An empirical - phenomenological study of the inmate's experience of punishment]. *Suid-Afrikaanse Tydskrif vir Strafregepleging*, 4, 298-317.

* Veninga, R.L. & Spradley, J.P. (1981). *The work stress connection: How to cope with job burnout*. Boston: Little, Brown.

Vines, W. (1991). *Psychological stress reaction, coping strategies, and health promotion lifestyles among hospital nurses*. Unpublished doctoral dissertation. University of Alabama, Birmingham.

Wallston, K.A. & Wallston, B.S. (1982). Who is responsible for your health? The construct of health locus of control. In Sanders, G. S. & Suls, J. (Eds.), *Social psychology of health and illness*. New Jersey: Lawrence Erlbaum Associates.

Warr, P.B. (1987). *Work, unemployment and mental health*. Oxford: Clarendon Press.

Watzlawick, P. (1984). Self-fulfilling prophecies. In P. Watzlawick (Ed.), *The invented reality*. New York: W.W. Norton & Company.

Watzlawick, P. (1990). *Münchhausen's pigtail or psychotherapy and "reality"*. New York: W.W. Norton and Company.

Weiman, C. (1977). A study of occupational stressors and the incidence of disease/risk. *Journal of Occupational Medicine*, 19, 119-122.

Werner, E.E. & Smith, R.S. (1982). *Vulnerable but invincible: A study of resilient children*. New York: McGraw-Hill.

- Wertz, F.J. (1985). Method and findings in a phenomenological psychological study of a complex event: Being criminally victimized. In A. Giorgi (Ed.), *Phenomenology and psychological research*. Pittsburgh: Duquesne University Press.
- Wessells, D.T. (1989). The etiology of job stress. In D.T. Wessells, Jr., A.H. Kutscher, I.B. Seeland, F.E. Selder, D.J. Cherico, & E.J. Clark (Eds.), *Professional burnout in medicine and the helping professions*. New York: Haworth Press.
- Wheaton, B. (1985). Models for the stress-buffering functions of coping resources. *Journal of Health and Social Behavior*, 26, 12, 352-364.
- White, R.W. (1959). Motivation reconsidered: The concept of competence. *Psychological Review*, 66, 297-333.
- Williams, S.J. (1990). The relationship among stress, hardiness, sense of coherence, and illness in critical care nurses. *Medical Psychotherapy*, 3, 171-186.
- Wolman, B.B. (1965). *Handbook of clinical psychology*. New York: McGraw-Hill.
- Wright, T.F., Blache, C.F., Ralph, J. & Luterman, A. (1993). Hardiness, stress, and burnout among intensive care nurses. *Journal of Burn Care and Rehabilitation*, 14(3), 376-381.
- Yarborough, T.E. (1989). A day with our feelings. In D.T. Wessells, Jr., A.H. Kutscher, I.B. Seeland, F.E. Selder, D.J. Cherico, & E.J. Clark (Eds.), *Professional burnout in medicine and the helping professions*. New York: Haworth Press.
- Yin, R.K. (1984). *Case study research: Design and methods*. Beverly Hills: Sage.

Yia-kee, C. & Tang, C.S. (1995). Existential correlates of burnout among mental health professionals in Hong Kong. *Journal of Mental Health Counseling, 17*(2), 220-229.

Zauszniewski, J.A. (1995). Theoretical and empirical considerations of resourcefulness. *Image: Journal of Nursing Scholarship, 27*(3), 177-180.

APPENDIX A

RESPONDENT #1

Me: I would like you to tell me about the experience of working as a nurse in the north, tell me how it's affecting you and how it makes you feel. I would like to know whether you find it stressful and whether you feel burned out sometimes. I would also like to know how you cope with this, or to put it differently, how you stay healthy. Take your time and you can start whenever you like, wherever you like.

#1: Wherever I like? My feelings about being a nurse in the north. I enjoy the work, I find it tremendously satisfying, I feel like I'm doing something, I feel like I'm doing more than I would be had I remained in the city, so I feel like and I feel like I'm doing what I'm good at. So I think that the satisfaction that I get is probably what's keeping me here so far. Burn out

--

Me: Before you get to that, just being a nurse in the north, how is it different for you than being a nurse somewhere else?

#1: I'm less restricted and I'm more independent in my ability to do things. I can deal with people on a one to one without having restrictions placed on me by a hospital or a public health centre. I can pretty well practice in the way that I want to practice. That's just by virtue of my position, though. You know I'm sure that the others don't have as much of that opportunity. But I feel like I have a lot of control over what it is I want to do and where I see the health care going for the community. I feel like I'm part of this community. I feel like when I'm making decisions I'm making long term decisions that are going to affect a lot of people and I'm going to be able to see them through because I'm going to be here for a long time. So any of the changes that I make, even though it seems like slow change, I know that with time a lot of it will work and I'm making the decisions with stuff like that in mind. I'm

not using a lot of my training in that respect because when I was in training I felt restricted by feelings and practices which we were taught and then were told to abide by. Straight nursing rules, I always stick with them because they're the core for what I need to practice, but beyond that in terms of designing programs and stuff that are fit for this community, I can use a lot of input from people I work with in terms of programs that everybody's going to be happy with. So I feel like when I'm working with this community I'm working with a lot of people in order to build something. I don't feel like I'm doing it by myself and when I start to feel like I'm doing it by myself, that's when I know I'm getting burned out when I feel like I'm the only one who is doing anything or when I feel like I'm isolated then I know that I'm starting to get fried and it's time to either make a change or make a move in a different direction. So that's probably why I change so much in what I'm doing at work and what I'm doing at home too I suppose because I'm trying to avoid static, I'm trying to avoid being in one spot because I feel like if I stay in one spot and keep doing the same thing day after day after day after day after day, I'm going to get burned out, so I try to avoid that at all costs. I try to look at the work I'm doing and see the positive affects of the work instead of the negative affects of the work because there's a fair amount of negative things going on here but really there isn't, you know, if you really look closely at what you're doing and if you're finding some happiness in what it is that you're practicing, if you're happy with what it is that you're doing at that time and you're doing your best for that client, then when you send them away you really do feel like you've done something. And a lot of the nurses that I talk with now and just previously, they don't feel like they're doing anything. They feel like they're just spitting into the wind and nothing is happening with regards to their work and that there's always a lot of patients that's going to keep coming every day, and it is going to keep coming every day because it's a very sick community and we have to provide a service and that's the position that we're in. We're in a service position and we have to do what we have to do and I recognize that and I run across a lot of nurses who don't recognize that and I wonder if I'm on the same track as those nurses.

Me: In terms of that you see a goal, that's what you're saying to me and you think a lot of them

don't see a goal.

#1: I think that a lot of them, particularly the ones that have been here a while or been around a while, do not see any purpose to their being in the north, and my reply to them is that if you don't see a purpose to why you're here then you should reconsider why you are here and you should look at that because I don't think that you should have this view of coming to the north in order to make a lot of money so that you can live your life at a later time. I feel that if you're not living it while you're up here, you're never going to get satisfaction from it and you will never be happy up here unless you are gaining some sort of satisfaction from your daily work and I am convinced of that after the years I've been up here, and I'm running into nurses who feel that after all these years, there is just nothing more that they can do.

Me: How many years?

#1: Ten.

Me: Now, it's just because it came up in a previous interview that I asked how long because most people are here a year or two, one or two years, maybe five. So you've been here ten?

#1: Yes. And the thing is I don't know what the difference is between me and the other nurses. I came up here as a fresh grad in 19-- and I had a lot of notions about nursing but I didn't have any notions about living in the north, living on a reserve. I had absolutely no preconceived ideas as to what I was going to be doing. So it was all a complete surprise to me when I got up here and I liked the work from the start. I liked it from the start and when I left in '87 I left because I knew it was time to leave this community. I was just tired and I felt that if I didn't get out of the community I wouldn't be able to stay in the community long term (inaudible) at a later date. I felt that I would never go back into a station because I got to the point where I was so tired from doing the same thing day after day after day after day, that I just no longer could see any point to it and I was really, really constricted by my

supervisors and what it was they were telling me I had to do and what I knew that I wanted to do. I was really bound by other people's feelings and I just didn't feel that what we were doing in the clinic at that time was going to achieve any goal. So I can see how other nurses can end up like that because they are working in a set of rules and they look at it and what their idea of what they should be doing is different from the person that they're working under. So I designed this (inaudible) program and I tell the other nurses that I know it works, I'm getting satisfaction from it and if they aren't getting satisfaction, well, that's too bad. I know that I know in my heart that it will work because I've been around for a while in this community and I'm getting support from the community in what I'm trying to do, but I can see how nurses end up.

Me: What like?

#1: Like they aren't doing any good.

Me: Hmm-hmm. End up on dead end street. "I'm living for when I leave here."

#1: Yes. And they're saving a lot of money, they're working for the money.

Me: But if you do that you work for one day you don't work for now.

#1: Hmm-hmm.

Me: I mean that's exactly what you said earlier.

#1: Yes. And when nurses are up here and the only positive thing they can see with regards to their work is the pay cheque that they're getting. I find it really hard to believe because money has never been that issue with me. The pay cheques are fine and I've never had to worry about money because of my job. I never had to worry about it. I've always been able

to spend and not have too much difficulty, but I don't see it as being the most important thing. The money -- you cannot get paid enough money to do this job as far as I'm concerned because the work we do deserves probably twice the amount of pay for what we're doing.

Me: Because it's an investment in people.

#1: Yes. Yes. And we're in a service industry and service industries, except for physicians, are always very underpaid people. We have lost control of where we've been and what we're doing and I don't think that we're getting paid enough. But it's not an issue to me because I get my pay cheque every two weeks, I'm getting paid for what I'm doing and I'm getting rewards on the side for what I'm doing. But I know now that I have to get out of the position about every two to three years and take a good break from it in order to not fry myself because I think that I lose sight after a while.

Me: Let's talk about getting fried. You've mentioned burn out, you've mentioned getting fried.

#1: Okay. I just get tired of all the stuff and I look for someone to blame. I can't blame myself because I know that I'm working hard so I never look at myself when I'm getting burned out, I always seem to look outward and try and look for something else, the cause of that. But when it gets right down to it, what's happened is you do it for so long day after day, coming in here and working, and if you don't have any other supports or any other outlet, anything just for you, then you lose sight of the point to it all and it starts to build up. I find it a very, very (inaudible). It's very, very small, it starts to invade you, you know, which is tiredness at night and not sleeping. You're feeling like you don't really want to come into work that day because I don't want to come into work every day but I usually wake up knowing that I've got things that I want to do and when I wake up in the morning and I'm either overwhelmed with all that I have to do or I feel like, well, there wasn't really anything I have to do, then I know that if I have to look at that because there is always something to do in this job. If I'm at the point where I feel like I haven't got a list in my mind anymore, then I'm getting tired and

I'm losing sight of what it is that I should be doing because usually I'm very goal directed during the day and I try and get a certain number of things done and clear my desk after at the end of the day and start (inaudible) the next day. And I can't always do that and I think it happens probably about after three months even from starting -- like I'm starting from a week now and I know that if I don't get out in November or December, I'm going to be very, very tired. I have to see my only family twice a year back home, and if I don't see them twice a year I feel that. I feel like I am homesick, I feel like I want to go home and that will probably happen to me for as long as I remain in xyz, that's going to happen to me that I'm going to feel like if I don't get home twice a year that I have not seen my family. So I have to do that twice a year and then I have to have time for myself on top of that. And that gets very difficult to arrange. It's hard to do. You can't leave all the time, you can't be gone all the time. So I know that I have to plan to get out of this clinic at least every three or four months for a minor time period, even if it's a weekend in pkm or Winnipeg, and that's something that Medical Services doesn't (inaudible). I have become very, very cynical about the Federal Government and it's ability to provide for the nurses. We've got an upper echelon in Medical Services that they're here working for us so we've got all these field nurses, say one hundred field nurses out there doing their job and we've got this bureaucratic system above us that is working because we are out there. The only reason that they have jobs is because we are working here, and yet the attitude that we get from the upper echelons is that they are the ones who are supposed to create the rules, they are the ones who have the complete power over what's going on in the field when it's supposed to be the other way around and it's taking me a long time to come to that conclusion about Medical Services because I used to feel that they were working for us, but I don't anymore. I think that most of those people have not seen a nursing station, they don't know what it is we're doing here and when they start questioning what it is we're doing here and saying that they know better, then they shouldn't be doing it anymore. They're making a lot of attempts to put Native involvement in Medical Services but it's not doing any good because the bureaucratic (inaudible) is just going to keep (inaudible). And it's actually holding back a lot of what's going on. A lot of what we should be doing is being held back by the bureaucracy and I think

that that in itself is contributing to burn out, that nurses are getting the feeling that they just don't matter to anyone after a while.

Me: Do you think burn out is prevalent, do you think burn out is -- I don't want to put words in your mouth. I would like you to tell me what your thoughts on burn out are because you've been around quite a while and you talk about it as if it's something that you are almost comfortable with or familiar with in a sense that, "I know I get tired. I know I get burned out. I have to leave." Tell me a bit about your thoughts on --

#1: To me it's part of the job and if you think that you are going to come to the north and not get tired of the job after a specific period of time, then you're kidding yourself and that's what I tell the nurses who are coming in that as soon as they come in I tell them to make sure they're planning a break in about four months time because they will get tired. I don't know what it is that's causing it. I think that there's a lot of pressures on the nurses to do a lot of things that they just don't feel are working after a while, or they're just too tired, they're just too tired because of the demands of the job and they can't get what they need. If they got out every second weekend or if they had some kind of support system in the community, a friend in the community, someone that they can talk to and someone that they can just let loose with every once in a while, but I find that what's going on with a lot of the nurses now is they're contained in the nursing station and they stay in the nursing station, they work in the nursing station and the only time they really get out is to go to the store and come back. And if I see a nurse doing that day after day after day, I know that they're going to burn out because I know that if you haven't got any support systems outside this Federal Government building, you cannot make it because you can't live a life just for a job. You can't. It's not human. I don't think it's human. I think that people are supposed to do a job, they're supposed to be happy with their job, but some people aren't. Some people, they work eight thirty to five and they have a life outside their job and if the life is (inaudible). You know so either way if you're happy with your job or your not happy with your job, you still have to have a life, and when I see nurses who will work every day and not have a life outside of their job, I know

that they just can't possibly be coping because it doesn't matter where they are, if you don't have anything going on outside your work, you're not living to me, you're just not, and I don't see how people can do that. I don't think you can come particularly into the north and work day after day after day after day, and live your life every four months on the vacations. I don't think that you can do that.

Me: Hmm-hmm.

#1: I think that you have to find some sort of a happiness on a daily basis up here, something outside of your work.

Me: I agree. Do you think burn out, that's tiredness which we equate, which you know, we say that is burn out?

#1: No. I think tiredness contributes to the burn out.

Me: Contributes to burn out. Okay. Do you think burn out is something that you have today, tomorrow you rest and then the next day you are fine? I would like your thoughts on that. I don't expect you to --

#1: I don't know. I think it's something that always has a potential for being there and all you need is the right environment for it to flourish. I think it's like depression. I think that everybody has a propensity to be depressed and you choose not to be depressed, you choose to be happy, you choose to find something that is going to prevent you from becoming depressed. You choose it. It's just like you choose to be thin, you choose to be fat, you can choose certain things and you can choose to have a healthy, mental attitude, and that comes with work. You choose to always be fending off burn out because I don't think that you can get out of here and not be burned out. I think that there is just too much going on with the job. There is too much. You've got the Federal Government who thinks that they're there

and you're non-existent when in fact the only reason that they are there is because you're working, and they are providing absolutely no support. They're supposed to be giving all these things to these nursing stations and they're not, and they don't give you what you feel you need to practice as a nurse. You're not getting all the staff that you need to practice as a nurse, and if nurses were to look at what it is they're doing in their practice and their own practical nursing training, they'd realize that they're not practicing correctly but it's because of the constraints of the Federal Government that they're not doing it. So you've got the Federal Government contributing to your burn out in your practice and your own life and then you've got a community who, for the most part, knows that you're here for money, they know that you're here because it's a job and you're getting paid well to do the job and they put expectations on you to perform and you get one bad apple who will colour your view of the community for everyone else, and even someone who is nice to you, you can't see it because all you've seen is people who are bitter and angry that you happen to be there. And again, it's particularly if you're white and it becomes even a greater issue. It happens to the Native nurses as well but particularly if you're white. Your reason for being there will always be questioned and then when you stay, your reason for staying will be questioned. "Why are you staying here? Do you really like us, or are you just going to leave in ten years?"

Me: As an expert or as one that is living this, how do you really -- you mentioned two things. You mentioned the Federal Government, fighting the Federal Government and then fighting the people, or not really fighting, but these are the things that make you tired, --

#1: Yes.

Me: -- dealing with the people. So my question is, in the community how do you find the community, how do you -- you have more or less (inaudible) the community.

#1: Yes. I like this community. (some personal information deleted) So we've chosen to live in xyz because it's an area where he can work and I can work. We made an economic decision

when we chose to come back here and for working at the nursing station, I can take it or leave it. I don't have to stay here but I know that if I lived in this community and I watched this nursing station being run by somebody else, I know that they can't do it as good as me. I know that they can't. I know that -- and that's not every nurse. Maybe a nurse will come along but the community will run better and will be able to run this place better than me, and that can happen when I get burned out. That is when that will start to happen. So that's why I know that I need to get out of this position every two years so I don't lose sight of why it is I'm here. I'm here because I feel that I've been doing a good job and when I'm not doing a good job then I need to step out of the position for a while, put it back into perspective and then start again after that. I think that that is what I have to do because there's pressure on the community to perform and you feel like for me being from this community, I feel like I have personally disappointed someone if I'm not what it is they wanted me to do. I take it very personally and I try not to because that can affect me long term. I'm here to do a job, but I know that if I didn't have that personalized attitude towards the work, I don't think I'd be able to cope.

Me: Okay. But you mentioned earlier that you do not take things so personally, that you try to stay goal directed but now you do say that you --

#1: No. I stay goal directed in my daily tasks.

Me: But what you mentioned was, "I don't get burned out because of how I feel in terms of how I work because I work very hard," those were your words but, "I get burned out because of the other stresses and strains." But now you do say there is a personal investment for you?

#1: Yes. The reason that I'm happy with this job is because I get satisfaction from it and when I send someone out of the clinic room, it doesn't matter what I've seen them for, if I've seen them for an ingrown toenail or if I've seen them because of spousal assault or they're grieving because they lost someone years previous, I see these people and I know them. I know either

them, personally, or I know their families or I know something that has happened to them in the past that connects me up with them. So I see them and I see them for their ailment and I send them away satisfied. I will try and send them away satisfied and if I get a complaint that's directed right at me, I take it very personally because I feel like I have not done what it is I wanted to do. It adds up with me because I'm living here in the community too, and if I start not satisfying a lot of people then people aren't going to like me in the community either and that will stretch out into my home life, and I don't want that. I want them to see me as a nurse who is working at the clinic and I want them to see me as a person who happens to live here in the community as well. So I try and separate myself from that but I can't really do it. And I've basically been told by the community that they know that I'm here and they know that I do a good job at the nursing station. When I'm not there they ask when I'm going to go back, but I'll always be seen as a nurse. I won't be able to separate myself from that role that I can do that with my own family, my own family life, you know, I'm a person, I'm a mother, I'm a wife and I can do that with my own life. I have to try and find something that's satisfaction that is outside of this work and if I don't do that then I just can't cope with the job significantly at the time. It usually takes about two years and what always happens is there has to be an event that will cause it. That's what I think will always contribute to the burn out crisis because burnout, I feel that burn out is a very pervasive thing, it creeps up on you and you're not aware of it and you will become tired and you will be aware that you are tired but you'll think that you're functioning quite well on the job and this will go on for a period of between one and two years and you'll continue, and you'll be doing very well at your job but you'll start doing it by (inaudible). Your heart won't be in it after a while. You'll be able to get all your tasks done during the day but your satisfaction will decrease and decrease and then there will be an event that will shake you. It will be an assault, it will be something in your personal life. With me, when my father died, that was the event. There is always an event that will make you look and realize that you just were not coping with the job and you have to get out and re-evaluate. And you're not just re-evaluating your job, you're also re-evaluating your personal life.

Me: So burn out for you is a very real thing, it's not just a word.

#1: It's not a theory.

Me: Yes. It's not a theory. Okay.

#1: And I do not feel that any nurse can come in here and not get burned out. I don't think that they are being realistic if they can't burn out and I don't think that they're being at all realistic about their lives at all if they come up here and they don't have a life outside of their work on a daily basis. What I see here because we had eight nurses at the station is nurses who don't have a life.

Me: Hmm-hmm. Sorry. I just want to change this. -(Side A ends) -So and that's basically how you say people stay healthy. What you've just given is you've given this sort of your views on why people or how people can stay healthy, but how do you stay healthy, how do you cope? You've mentioned that sort of --

#1: Well, I don't. Well, I obviously don't because I get burned out every two years, so I'm --

Me: But you've also just mentioned that you see that as inheriting part of this job.

#1: Yes. It's a natural process. Yes.

Me: Yes. You said, "I don't believe that anybody working here will not burn out."

#1: Well, and I probably perfected the ability to recognize burn out. Yes. Maybe that's what it is.

Me: In yourself.

#1: I don't stay healthy, I just know when it's time to get the hell out. Maybe that's it, I don't know because I know that when you're in training and they do the lectures on burn out and they say well, you know you have to be doing things, you have to have something for yourself. And me, I've got a life outside work, but I've got two kids to take care of, I've got a husband who I live with and have to maintain a relationship with and it's work, it's work to maintain this family life outside my work and I will look at that and I go well, where is the time for myself? Because there isn't any. I get up in the morning, I have to make sure that I've got two kids out the door to school, a babysitter to make sure that she's doing what she needs to be doing during the day and the actual only time that I get to myself is between twelve and one when I go home for lunch and there's no one there. Or after eleven o'clock at night when everyone's in bed and I have become my mother's daughter because that is what my mother used to say. She'd get up at seven o'clock in the morning and she would work all day until eleven o'clock at night and when everyone was in bed, that was when she took her time. And that is exactly what I'm doing. I take my time for myself when there's no one else around and I have to find little things to do and most of it is work, it's work around the house or something like that. But what I know that I need to do is I need to exercise, I need to get outdoors, I need to have a project that's going to provide me with something at the end like a craft, something that's going to give me something at the end, and as yet, I have not been able to fit those extra things into my schedule and I have to find a way to fit those things into my schedule so that I can increase my time, really.

Me: In order to have something going --

#1: For myself.

Me: -- for yourself in order to stay healthy.

#1: Yes. And now I haven't got that. I haven't got the time to exercise yet, because I haven't found a time of day when I feel like I can do that so I have to do that and it's on my daily list

of when is going to be the best time, and then I know that I want to just have time for me to do something that I choose to do, and I haven't got that yet. But my problem is more rooted in the fact that I get tired from work and I'll go home and I'll sit instead of keeping myself mobilized and I think that half the battle to staying healthy is keeping yourself mobilized and keeping yourself moving and doing something, just something that's going to give you --

Me: But isn't that in itself a --

#1: That's a light burn out. Yes.

Me: Yes. Isn't that in itself sort of rushed, so in order not to stagnate, in order not to die, in order not to burn out, I have to be constantly moving.

#1: Yes. Yes. Like I feel like I must be constantly running ahead of burn out. You know and I feel like if --

Me: But that's how you stay healthy.

#1: Yes.

Me: I mean it's valid if it works for you.

#1: Yes. I don't know if it works for me because I -- right now, I'm not exercising, I haven't got any crafts to do. Right now I've got a project I'm taking an ECLS course, but that's something that I feel that I have to take, so it's not a project for anything that I would have had as a list of goals, but in terms of my career it's something very, very good, you know it's something I've always wanted to do but it's not something that's for me personally what it's going to do for me, personally. Well, it's certainly going to increase my self esteem if I pass the course, so it's good. And I have to do a lot of things that I don't necessarily feel like I

want to do in order to stay healthy. I have to do a lot of things that I don't necessarily think are useful.

Me: Like what?

#1: Studying for an ECLS course for one thing, or I have to force myself to go outside when I don't feel like I want to go outside, but I feel better for having done it and that is actually the biggest battle is trying to get on the cycle of the things that make you feel good are the things you have to make yourself do until your body wants them, until your body gets into this routine, and if you don't get into that routine of doing things that are going to make you healthy, then you'll just sit and you won't -- it'll creep up with you in your own life. Nurses are doing that, they're doing that with their work and they're doing that with their own life. We've got nurses who might exercise here but if they don't exercise for a week (inaudible) by the end of the week and they know that but they were tired and they chose not to exercise. And this is what I do, I get tired and I choose not to exercise. But I'm not sitting during those times when I'm not exercising, I mean I'm cleaning the house and taking care of kids. And I have to find satisfaction in parts of my life that aren't necessarily right there. You know, like bath time with the kids, I love that. I'll have a whirlpool. We have a whirlpool bathtub so I'll run a bath. The three of us will get into the bathtub and it's probably the best thing I can do for myself every week. So I'll do stuff like that. I'll take them for a walk up the road and down Saturday mornings and those are the things that are really (inaudible) because I think that you can lose sight of your family life too and I need to know that I've got a family there and I can get support from that as well and I have a responsibility to these children. I brought them into the world. My husband has a responsibility to the family. I'm responsible. We're all this unit and we're responsible to keep each other together and doing things as a family. And it's difficult to find the time to do that. You have to work to find the time to make a family life, so I've got goals outside of work that have absolutely nothing to do with my nursing. I leave here and I'm thinking on the way home, what am I going to make for supper tonight. I'll talk to the kids about how they did at school and if I don't connect up with them

about school, I feel like I haven't enjoyed part of the day looking at their drawings. So I'm finding enjoyment in those things that are right in front of me. I shouldn't have to look very far. That's what they say about having kids, you don't have to look very far. It's right there. You're just not seeing it. I practice that with work and I practice that at home. But I know that with regards to me personally and taking care of myself, that is where I'm worst. I don't exercise, I don't find the time for myself, I don't sit down and read a good book like I used to. I don't write letters like I used to. Things that used to make me very, very happy, I don't do them anymore and it's because of my lack of time or my lack of ability to find the time. I find the time for all the other things but I can't find the time for myself. And that's probably why I am in this two to three year cycle of burn out because I'm not taking that little bit of extra time to take care of me. But I think regardless for me personally I'd still think I'd have to get out of this job every two to three years. I do. I left here in 1999 after two and a half years feeling like I had to get out of a job because there's a lot of community pressures, relationships, things going on, I wasn't satisfied with the work anymore, and I sat on a couch for seven months. I got up in the morning, I turned on T.V. at eight o'clock in the morning, I watched T.V. until five o'clock at night everyday. It was like my work schedule. That is exactly what I did. I lived in rtttzz. I should have been happy. I should have been happy to be in the city but I was so fried that I did nothing. All I did was get up and I watched soaps and talk shows all day long and I waited for my husband to come home and I had no money. After I left here, I felt like I had no money. So I went up to the (other region) and I worked there for three years and I started in one position just as a community health nurse and then found a job doing a special project on (whatever). And I got a lot of rewards for that. I really enjoyed that. I designed my own position and got a lot of satisfaction from it. I got a lot of people to take their pills in the community where it was the epidemic area, two hundred people on medications, I brought it down to three. I could see that my work had results and it worked out really, really well for me being up there. But I ended up leaving there because my family life was suffering. We couldn't survive financially like that. So I think you're always on the balancing act between your family life and your work life and the only thing that pushes you over the edge with regards to being a nurse for Medical Services

is, Medical Services and the community has the ability to (inaudible) nurses. If they don't support their nurses they don't let them know that they are doing something, you are doing something of value here and you have to find that. Nobody else can tell them that, but it helps to be told from the outside. It helps. But if they don't see that they're doing anything then the balance gets tipped and you end up being fried as a nurse and then it goes right into your personal life because you can't separate the two. You're one person, you can't separate. So I feel like it's always the balancing act for the nurses. And me as a supervisor, when I'm watching nurses, I tell them when they're doing well, I comment when they're doing well and I provide constructive criticism when they're not doing well. I try and make it as constructive as possible. I won't rake somebody over the coals unless I know that they're trying to do something that they really shouldn't be doing. But I try and always make it a learning environment. I always try and tell them when they are doing well because I think that people need that, I think they need to know that. And I'll tell nurses, "boy, that patient really likes you. It's obvious you've got a good rapport with them," and I tell nurses that all the time. And I'll try and connect patients up with nurses that they have a rapport with because they'll get more satisfaction from that. You get more from that than you will from anything else because you sure as hell won't get support from Medical Services. You will not get it. You know what Medical Services, now, they've designed a critical incident stress program that pulls nurses out of the community and sends them on talks to someone and they'll pay for the first five sessions which is very gallant, but five sessions doesn't cut it, so they put this band aid on an entire problem that isn't going to be solved. They aren't talking to the nurses and they aren't saying what can we do for them on a daily basis that's going to help them? But maybe we should make sure they have adequate numbers of staff every day so they don't get tired at work. Maybe we should provide them some positive feedback for what they're doing and you do not get that from Medical Services.

Me: Which is much more organizational development thing than a critical incident.

#1: Yes. Yes. And all they're doing -- all they have done with regards to burn out is they've got

this band aid on for when the event happens.

Me: But that's a crisis, I mean --

#1: Yes.

Me: -- we know that burn out doesn't come from that.

#1: No. No.

Me: Burn out doesn't come from the crisis.

#1: No. But it's the crisis that will make them recognize the burn out.

Me: Sure.

#1: It is usually, because usually the nurse who is burned out will not recognize it. It is someone else who points it out and then that nurse has to come to terms with it and either choose to get out of the job for a while or revamp her life in order to make sure that they're fending it off a bit better like upset the balance a little bit so that they can get back on course again. But I have found that it is usually what I've seen is usually an event that will get the nurse out and so Medical Services has designed this wonderful critical incident stress program which is going to fix the event but it does nothing for the ongoing day to day burn out involving the job and it is because it is such a pervasive thing and they're given this cynical (inaudible) nurses, whenever the government offers to try and do anything to help it will be turned down. Because I don't think the nurses know what they want. But I think that Medical Services' approach could be, like all they have to do is pull out any article and say what do you need to stay healthy, do you need to exercise, well, then why don't we put some exercise equipment in all the nursing stations? You need to have a social life, well, why don't you make sure they

have common areas for all the nursing stations. Yet you look at place like xyz where you know that the plans are now that they're going to take away the common area. So we've lost our common area because the powers that be at region, the people who are there because we are here working, are going to take away the only source of satisfaction that the nurses have for their off hours and I don't need that common area in my off hours because I have a life outside the clinic, but I can see it being for the nurses here because they need to know that they have somewhere else to go other than their suite and if they're not comfortable going out in the community, they have that alternate location. And yet Medical Services is doing the very thing that is going to contribute to more burn out. So Medical Services ability to provide for nurses with burn out is it's non existent. They don't do anything. All they do is add to it and until they stop this wheel from rolling they're just not going to be able to hang on to their nurses. There aren't nurses (inaudible) their rations. The nurses aren't allowed to buy junk food, diet pop, pop at all. Nurses drink pop. Nurses eat popcorn, they eat granola bars. These are all things that they've now been told they're not allowed to buy them. And it doesn't affect me, again, I'm not on rations but I sure could see the need, and yet Medical Services says, well, no, you can't buy those things anymore. It's like it's this great big thumb of that the government is on top of you and it will always tip the balance. You've got your work with the community, your satisfaction with the work and then you've got the Federal Government. And the things that will always tip the balance is some sort of personal event or some sort of problem with the community if the community starts to do some political gesturing which has happened (inaudible) and as soon as they start to bring politics into the nursing station, (inaudible) the nurses really feel like they aren't doing anything when the politics starts. I recognize the politics for what it is, gesturing.

Me: Yes. Positioning, gesturing, flexing your muscles, whatever you want to call it.

#1: Yes. Yes.

Me: Trying to exercise some role of trying to see what we can do.

#1: Yes.

Me: It's an exercise.

#1: Yes. Yes. Well, and this is a community that has lost it's right to choose. They're stuck with this zzz nurse nursing station with one position that is completely under resourced and nurses think that they haven't got that right to choose and then the nurses get upset when they say well, the community thinks we're not good enough. Well, if they would look at it from the outside, no, we are providing a good service, but is this community getting what it should get in terms of the city standards, no, they're not. They're not getting what they should get and they have a right to choose that, in fact they should be encouraged to do that. Nurses, they will contribute more to nurses' increased self esteem when they see that (inaudible) down the way might say that we've got a nursing station that doesn't do anything, when in fact we do everything. But when you're told that again and again and again that you're no good then you start to believe that. (inaudible) community attitude that will contribute to it. But in this community they don't say that. They certainly don't say it to me but what they will say is that this nursing station is not satisfactory and they're right. They have to say that and the nurses have to allow them to say that and still be able to continue with their work. I feel like I've got a lot of responsibility to the running interference for this community, so it's quite a bit of stress for me because I know this community well, and I know that it's a likeable community and if I see a nurse that doesn't like the community I know that they just aren't seeing a lot of the good, they're only seeing the bad. I'm always trying to help them see that, but right now I'm actually at the point now where (inaudible) nurses do that because I can't take on the responsibility (inaudible). I'll just (inaudible) myself a lot and I shouldn't. All I'm doing now is I tell them where I'm at, this is how I feel about it and I as a manager will do this, and I'm not going to try and take on their feelings ad it's a daily chore to make sure that I don't do that because I think that that can really fry a supervisor when you start to take on the feelings of your employees and making correct decisions, and you'll get nailed for it eventually because it's happened to me. You will get nailed for it eventually. If you try and protect your nurses

too much you aren't doing yourself a service and you aren't doing them a service. You are responsible for yourself and if you take care of yourself and you're happy with yourself, then -- like everybody else might see that or they might not see that but that is up to them it's not up to you. You have to tidy your own backyard. So that's where I'm at (inaudible). The community and taking care of the nurses (inaudible).

Me: Which is attainable but not easily.

#1: No, not easily. I think a lot of nurses leave. I think they just leave. They really haven't got a life up here. If they do come up here with their family, eventually Medical Services is going to get to them. That's what I think. I think eventually it's the employer or the community that will make them move. They'll either see that they're not doing any good or they just cannot put up with this shit of Medical Services' any longer, and I think that's where they throw in the towel, because the government will keep messing and messing and messing around with you until you finally just had enough of what it is that they are doing. The only thing that would make a change for the nurses now is the fact that local control is coming up so it's going to be somebody else (inaudible). You know it's going to be the Federal Government in behind it, but it's going to be controlled by the Band. For me personally I welcome it because it's no longer going to be (inaudible) approach. We're no longer going to be the Federal Government, we're going to be a part of the community, we're going to be the community's nursing station so they can't equate any pressure on their nursing station because they're responsible for it and this is what I've told (inaudible) many, many times that when this station is yours, you're no longer going to be able to say that we're not good enough because you are now responsible for it. The Federal Government is content in it's ability to say (inaudible) and the Band's are taking it on (inaudible). They're going to be able to change it and they're not (inaudible). Then they're going to know why nurses leave. Nurses leave because they just cannot put up with it any longer. If it's not your supervisor it's Medical Services in general. And it's mainly just because you've lost sight. You have to do the day to day jobs and be happy with (inaudible) the only thing that's going to get you through. You

won't get it from Medical Services, not in (inaudible).

Me: So in terms of surviving, it's a very personal thing.

#1: Yes.

Me: In terms of staying healthy, it's a personal thing.

#1: Yes. It's a personal choice. I have to choose it.

Me: And it's a choice on either having a social support system and physically looking after yourself and you also mentioned making certain complete choices.

#1: Yes.

Me: Deciding to stay ahead of burn out.

#1: Yes. Because it's very -- it creeps up on you. I feel it does.

Me: Do you think you can learn? You have gone through the cycle a few times, do you think one learns, then, over time to be more resourceful maybe, or you become more resolute, stronger?

#1: Yes. I think I might have become stronger, you know, or like I said I think I've become very keen in my ability to recognize when I'm getting burned out. Because I look at myself now and I look at myself in say 19--, 19--, when I had a social life, I was finding (inaudible) in the community, I was fending off burn out then just as well as I'm doing it now, but the things that I did then was I would walk, I would write letters, I would listen to music. Of course I had no other people in my life that I was responsible to so the things that I did then were different.

Me: Different goals then.

#1: Yes. So it's because of the way that my life has changed now that the way that I have to deal with the burn out is different. I would still like to see this lost life of writing letters and reading books and listening to music. I'd like to see some of that return, but as it stands right now, I have to find the time to do that as well. So I think that my ability to deal with burn out is I don't think it's changed all that much but I can recognize it more and I can put more of an effort into trying to stay ahead of it, rather than letting it get to me. I think you can go through burn out once and you might learn from it. You might learn from it and you might not and you'll likely go through it again. I think it's the second time that gets you. That's what I think. I think it's like getting stung by a bee. The first bee sting is going to give you (inaudible) shock (inaudible) second you know you get built up with a few antibodies from the first one, but boy it's that second one that's going to get you because you knew that it was coming. You knew in your mind that you were supposed to do something about it and you didn't do anything about it and you still let it happen.

Me: And then after?

#1: And then after, well, and now I'm going to be looking at well, when's the third one going to be? It's like this preparation day where --

Me: But you will be much more (inaudible).

#1: Yes. Or at least I'll tell people. I think in this situation I'll tell them, if you see I'm not coping with the job then you better tell me. Don't hide it from me and make sure that within two to three years I have made a significant life change that's going to get me out of the position for a while because I do not think that anybody can do this job long term, particularly nurse in charge but even community health nurse. I'm convinced of it after going through it and seeing other nurses go through it.

Me: No. That's fairly common (inaudible) that other nurses say the same.

#1: Yes.

Me: Thank you so much.

#1: You're welcome.

Identification of Significant Statements: Respondent # 1

I find it tremendously satisfying
 I feel like I'm doing something
 I feel like I'm doing more than I would be had I remained in the city
 I'm doing what I was meant to do
 I feel like I'm doing what I'm good at
 I think that the satisfaction that I get is probably what's keeping me here

I'm less restricted
 I'm more independent in my ability to do things
 I can deal with people on a one to one without having restrictions placed on me
 I can pretty well practice in the way that I want to practice.
 I feel like I have a lot of control over what it is I want to do for the community
 I feel like I have a lot of control over where I see the health care going for the community
 I feel like when I'm making decisions I'm making long term decisions that are going to affect a lot of people
 Any of the changes that I make, even though it seems like slow change, I know that with time a lot of it will work
 I can use a lot of input from people I work with in terms of programs that everybody's going to be happy with.
 I feel like when I'm working with this community I'm working with a lot of people in order to build something.
 I don't feel like I'm doing it by myself
 When I start to feel like I'm doing it by myself, that's when I know I'm getting burned out
 When I feel like I'm the only one who is doing anything
 When I feel like I'm isolated then I know that I'm starting to get fried
 It's time to either make a change
 Make a move in a different direction.
 That's probably why I change so much in what I'm doing at work

That's probably why I change what I'm doing at home too
 I'm trying to avoid static,
 I'm trying to avoid being in one spot
 I feel like if I stay in one spot and keep doing the same thing day after day after day after day after day, I'm going to get burned out, so I try to avoid that at all costs.
 There's a fair amount of negative things going on here
 There's a fair amount of negative things going on here but really there isn't,
 If you really look closely at what you're doing and if you're finding some happiness in what it is that you're practicing,
 If you're happy with what it is that you're doing at that time and you're doing your best for that client,
 When you send them away you really do feel like you've done something.
 A lot of the nurses don't feel like they're doing anything.
 They feel like they're just spitting into the wind
 They feel nothing is happening with regards to their work
 They feel there's always a lot of patients that's going to keep coming every day,
 They feel it is going to keep coming every day because it's a very sick community
 They feel we have to provide a service and that's the position that we're in.
 They feel we're in a service position and we have to do what we have to do
 I recognize that we have to provide a service and that's the position that we're in.
 I run across a lot of nurses who don't recognize that we have to provide a service and that's the position that we're in.
 I wonder if I'm on the same track as those nurses.

I think that a lot of them, particularly the ones that have been here a while or been around a while, do not see any purpose to their being in the north
 if you don't see a purpose to why you're here then you should reconsider why you are here
 I don't think that you should have this view of coming to the north in order to make a lot of money so that you can live your life at a later time.
 I feel that if you're not living it while you're up here, you're never going to get satisfaction from it
 you will never be happy up here unless you are gaining some sort of satisfaction from your daily work
 I'm running into nurses who feel that after all these years, there is just nothing more that they can do.
 I don't know what the difference is between me and the other nurses.
 I didn't have any notions about living in the north, living on a reserve.
 I had absolutely no preconceived ideas as to what I was going to be doing
 It was all a complete surprise to me when I got up here and I liked the work from the start.
 I liked it from the start
 I left because I knew it was time to leave this community.
 I was just tired
 I felt that if I didn't get out of the community I wouldn't be able to stay in the community long term (inaudible) at a later date. I felt that I would never go back into a station
 I got to the point where I was so tired from doing the same thing day after day after day after day,
 I just no longer could see any point to it
 I was really, really constricted by my supervisors

what it was they were telling me I had to do and what I knew that I wanted to do.
 I was really bound by other people's feelings
 I just didn't feel that what we were doing in the clinic at that time was going to achieve any goal.
 I can see how other nurses can end up like that
 they are working in a set of rules and they look at it and what their idea of what they should be doing
 is different from the person that they're working under.
 So I designed this (inaudible) program and I tell the other nurses that I know it works,
 I'm getting satisfaction from it and if they aren't getting satisfaction, well, that's too bad.
 I know that I know in my heart that it will work because I've been around for a while in this
 community
 I'm getting support from the community in what I'm trying to do

they're saving a lot of money, they're working for the money.
 the only positive thing they can see with regards to their work is the pay cheque that they're getting.
 I find it really hard to believe because money has never been that issue with me.
 The pay cheques are fine and I've never had to worry about money because of my job.
 I've always been able to spend and not have too much difficulty, but I don't see it as being the most
 important thing.

The money -- you cannot get paid enough money to do this job as far as I'm concerned
 the work we do deserves probably twice the amount of pay for what we're doing.
 we're in a service industry and service industries, except for physicians, are always very underpaid
 people.
 We have lost control of where we've been and what we're doing and I don't think that we're getting
 paid enough.
 I'm getting paid for what I'm doing and I'm getting rewards on the side for what I'm doing

I know now that I have to get out of the position about every two to three years and take a good
 break from it in order to not fry myself
 I think that I lose sight after a while.
 I just get tired of all the stuff and I look for someone to blame.
 I can't blame myself because I know that I'm working hard so I never look at myself when I'm getting
 burned out,
 I always seem to look outward and try and look for something else, the cause of that.
 if you don't have any other supports or any other outlet, anything just for you, then you lose sight of
 the point to it all
 it starts to build up.
 It's very, very small, it starts to invade you, tiredness at night and not sleeping.
 You're feeling like you don't really want to come into work that day
 I don't want to come into work every day
 When I wake up in the morning I'm either overwhelmed with all that I have to do
 I feel like, well, there wasn't really anything I have to do,
 I know that if I have to look at that because there is always something to do in this job.

If I'm at the point where I feel like I haven't got a list in my mind anymore, then I'm getting tired
I'm losing sight of what it is that I should be doing
usually I'm very goal directed during the day
I try and get a certain number of things done and clear my desk
I can't always do that
I think it happens probably about after three months even from starting
I know that if I don't get out in November or December, I'm going to be very, very tired.
I have to see my family twice a year back home
if I don't see them twice a year I feel that.
I feel like I am homesick
I feel like I want to go home and that will probably happen to me for as long as I remain in Lost Lake,
I have to have time for myself on top of that.
It's hard to do. You can't leave all the time, you can't be gone all the time.
I've got two kids in school, now, so I can't just pick up and go like I used to.
I know that I have to plan to get out of this clinic at least every three or four months for a minor time
period,
I have become very, very cynical about the Federal Government and it's ability to provide for the
nurses.
We've got this bureaucratic system above us that is working because we are out there.
The only reason that they have jobs is because we are working here
yet the attitude that we get from the upper echelons is that they are the ones who are supposed to
create the rules,
they are the ones who have the complete power over what's going on in the field when it's supposed
to be the other way around
I used to feel that they were working for us, but I don't anymore.
I think that most of those people have not seen a nursing station, they don't know what it is we're
doing here
when they start questioning what it is we're doing here and saying that they know better, then they
shouldn't be doing it anymore.
A lot of what we should be doing is being held back by the bureaucracy
I think that that in itself is contributing to burn out, that nurses are getting the feeling that they just
don't matter to anyone after a while.

To me burnout is part of the job
if you think that you are going to come to the north and not get tired of the job after a specific period
of time, then you're kidding yourself
as soon as they come in I tell them to make sure they're planning a break in about four months time
because they will get tired.
I don't know what it is that's causing it.
I think that there's a lot of pressures on the nurses to do a lot of things that they just don't feel are
working after a while,
they're just too tired,
they're just too tired because of the demands of the job

they can't get what they need.

If they got out every second weekend

if they had some kind of support system in the community,

a friend in the community

someone that they can talk to and someone that they can just let loose with every once in a while

they're contained in the nursing station and they stay in the nursing station,

they work in the nursing station and the only time they really get out is to go to the store and come back.

if I see a nurse doing that day after day after day, I know that they're going to burn out

I know that if you haven't got any support systems outside this Federal Government building, you cannot make it

you can't live a life just for a job.

I think that people are supposed to do a job, they're supposed to be happy with their job, but some people aren't.

Some people, they work eight thirty to five and they have a life outside their job

Either way if you're happy with your job or your not happy with your job, you still have to have a life

when I see nurses who will work every day and not have a life outside of their job, I know that they

just can't possibly be coping

if you don't have anything going on outside your work, you're not living

I don't think you can come particularly into the north and work day after day after day after day, and

live your life every four months on the vacations. I don't think that you can do that.

you have to find some sort of a happiness on a daily basis up here, something outside of your work.

I think tiredness contributes to the burn out.

I think it's something that always has a potential for being there

all you need is the right environment for it to flourish.

I think it's like depression.

I think that everybody has a propensity to be depressed and you choose not to be depressed,

you choose to be happy,

you choose to find something that is going to prevent you from becoming depressed.

you can choose to have a healthy, mental attitude, and that comes with work.

You choose to always be fending off burn out

I don't think that you can get out of here and not be burned out.

there is just too much going on with the job. There is too much.

they are providing absolutely no support.

They're supposed to be giving all these things to these nursing stations and they're not,

they don't give you what you feel you need to practice as a nurse.

You're not getting all the staff that you need to practice as a nurse,

if nurses were to look at what it is they're doing in their practice and their own practical nursing

training, they'd realize that they're not practicing correctly

it's because of the constraints of the Federal Government that they're not doing it.

So you've got the Federal Government contributing to your burn out in your practice

you've got a community who, for the most part, knows that you're here for money,

they know that you're here because it's a job and you're getting paid well to do the job
 they put expectations on you to perform
 you get one bad apple who will colour your view of the community for everyone else,
 even someone who is nice to you, you can't see it because all you've seen is people who are bitter and
 angry that you happen to be there.
 it's particularly if you're white and it becomes even a greater issue.
 It happens to the Native nurses as well but particularly if you're white.
 Your reason for being there will always be questioned
 when you stay, your reason for staying will be questioned.
 Why are you staying here? Do you really like us, or are you just going to leave in ten years?"

I've got a support system outside the community with his family
 I know that if something were to ever happen to me at this nursing station, I would still have a life
 here, I would still live here. that's why I know that I need to get out of this position every two years
 so I don't lose sight of why it is I'm here.
 I'm here because I feel that I've been doing a good job
 when I'm not doing a good job then I need to step out of the position for a while, put it back into
 perspective and then start again after that.
 I take it very personally
 I try not to because that can affect me long term.
 I'm here to do a job, but I know that if I didn't have that personalized attitude towards the work, I
 don't think I'd be able to cope.
 I stay goal directed in my daily tasks.

The reason that I'm happy with this job is because I get satisfaction from it
 I see these people and I know them
 I know either them, personally, or I know their families or I know something that has happened to
 them in the past that connects me up with them.
 I see them and I see them for their ailment and I send them away satisfied.
 if I get a complaint that's directed right at me, I take it very personally because I feel like I have not
 done what it is I wanted to do
 It adds up with me because I'm living here in the community too
 if I start not satisfying a lot of people then people aren't going to like me in the community either
 that will stretch out into my home life, and I don't want that.
 I try and separate myself from that but I can't really do it.
 I've basically been told by the community that they know that I'm here and they know that I do a good
 job at the nursing station.
 When I'm not there they ask when I'm going to go back, but I'll always be seen as a nurse.
 I won't be able to separate myself from that role that I can do that with my own family,
 In my own family life, you know, I'm a person, I'm a mother, I'm a wife and I can do that with my
 own life.
 I have to try and find something that's satisfaction that is outside of this work and if I don't do that
 then I just can't cope with the job significantly at the time.

It usually takes about two years and what always happens is there has to be an event that will cause it.

I feel that burn out is a very pervasive thing,

Burnout creeps up on you and you're not aware of it

you will become tired

you will be aware that you are tired but you'll think that you're functioning quite well on the job

this will go on for a period of between one and two years

Your heart won't be in it after a while.

You'll be able to get all your tasks done during the day but your satisfaction will decrease and decrease

then there will be an event that will shake you.

It will be an assault, it will be something in your personal life.

With me, when my father died, that was the event.

There is always an event that will make you look and realize that you just were not coping with the job

you have to get out and re-evaluate.

you're not just re-evaluating your job, you're also re-evaluating your personal life.

I do not feel that any nurse can come in here and not get burned out.

I don't think that they're being at all realistic about their lives at all if they come up here and they don't have a life outside of their work on a daily basis.

What I see here is nurses who don't have a life.

how do you stay healthy, how do you cope? Well, I don't. Well, I obviously don't because I get burned out every two years

"I don't believe that anybody working here will not burn out."

I don't stay healthy,

I just know when it's time to get the hell out.

I've got a life outside work, but I've got two kids to take care of, I've got a husband who I live with and have to maintain a relationship with and it's work, it's work to maintain this family life outside my work

I will look at that and I go well, where is the time for myself?

Because there isn't any.

the actual only time that I get to myself is between twelve and one when I go home for lunch and there's no one there.

I take my time for myself when there's no one else around

I have to find little things to do

most of it is work, it's work around the house or something like that.

But what I know that I need to do is I need to exercise

I need to get outdoors

I need to have a project that's going to provide me with something at the end like a craft,

I haven't got the time to exercise

I haven't found a time of day when I feel like I can do that so I have to do that

my problem is more rooted in the fact that I get tired from work
 I'll go home and I'll sit instead of keeping myself mobilized
 I think that half the battle to staying healthy is keeping yourself mobilized
 keeping yourself moving and doing something,
 I feel like I must be constantly running ahead of burn out.
 I don't know if it works for me because I -- right now, I'm not exercising, I haven't got any crafts to do.

Right now I've got a project I'm taking an ECLS course
 It's certainly going to increase my self esteem if I pass the course, so it's good.
 I have to do a lot of things that I don't necessarily feel like I want to do in order to stay healthy.
 I have to do a lot of things that I don't necessarily think are useful.

I have to force myself to go outside when I don't feel like I want to go outside
 but I feel better for having done it
 That is actually the biggest battle is trying to get on the cycle of the things that make you feel good
 the things you have to make yourself do until your body wants them, until your body gets into this routine,
 if you don't get into that routine of doing things that are going to make you healthy, then you'll just sit and you won't
 it'll creep up with you in your own life.

Nurses are doing that, they're doing that with their work and they're doing that with their own life
 this is what I do, I get tired and I choose not to exercise.
 But I'm not sitting during those times when I'm not exercising,
 I mean I'm cleaning the house and taking care of kids.
 I have to find satisfaction in parts of my life that aren't necessarily right there
 You know, like bath time with the kids, I love that
 I'll take them for a walk up the road and down Saturday mornings and those are the things that are really important

I think that you can lose sight of your family life too
 I need to know that I've got a family there and I can get support from that as well and I have a responsibility to these children. I brought them into the world.
 My husband has a responsibility to the family. I'm responsible. We're all this unit and we're responsible to keep each other together and doing things as a family.
 it's difficult to find the time to do that.

You have to work to find the time to make a family life,
 I've got goals outside of work that have absolutely nothing to do with my nursing.
 I leave here and I'm thinking on the way home, what am I going to make for supper tonight.
 I'm finding enjoyment in those things that are right in front of me.
 I shouldn't have to look very far. That's what they say about having kids, you don't have look very far. It's right there.

I practice that with work and I practice that at home.
 I know that with regards to me personally and taking care of myself, that is where I'm worst.
 I don't exercise

I don't find the time for myself

I don't sit down and read a good book like I used to.

I don't write letters like I used to.

Things that used to make me very, very happy, I don't do them anymore
it's because of my lack of time or my lack of ability to find the time.

I find the time for all the other things but I can't find the time for myself.

that's probably why I am in this two to three year cycle of burn out

I'm not taking that little bit of extra time to take care of me.

I think regardless for me personally I'd still think I'd have to get out of this job every two to three years.

I wasn't satisfied with the work anymore,

I sat on a couch for seven months. I got up in the morning, I turned on T.V. at eight o'clock in the morning, I watched T.V. until five o'clock at night everyday. It was like my work schedule. That is exactly what I did.

I should have been happy. I should have been happy to be in the city but I was so fried that I did nothing.

All I did was get up and I watched soaps and talk shows all day long and I waited for Eric to come home and I had no money.

But I ended up leaving there because my family life was suffering.

I think you're always on the balancing act between your family life and your work life

the only thing that pushes you over the If they don't support their nurses

they don't let them know that they are doing something, you are doing something of value here
it helps to be told from the outside. It helps.

if they don't see that they're doing anything then the balance gets tipped

you end up being fried as a nurse

it goes right into your personal life because you can't separate the two.

You're one person, you can't separate.

So I feel like it's always the balancing act for the nurses.

I always try and tell them when they are doing well because I think that people need that, I think they need to know that

I'll tell nurses, "boy, that patient really likes you. It's obvious you've got a good rapport with them,"

I'll try and connect patients up with nurses that they have a rapport with because they'll get more satisfaction from that.

You get more from that than you will from anything else

because you sure as hell won't get support from Medical Services. You will not get it.

You know what Medical Services, now, they've designed a critical incident stress program that pulls nurses out of the community and sends them on talks to someone and they'll pay for the first five sessions which is very gallant, but five sessions doesn't cut it,

they put this band aid on an entire problem that isn't going to be solved.

They aren't talking to the nurses

they aren't saying what can we do for them on a daily basis that's going to help them?

maybe we should make sure they have adequate numbers of staff every day so they don't get tired at work.

Maybe we should provide them some positive feedback for what they're doing and you do not get that

the nurse who is burned out will not recognize it.

It is someone else who points it out and then that nurse has to come to terms with it either choose to get out of the job for a while or revamp her life in order to make sure that they're fending it off a bit better like upset the balance a little bit so that they can get back on course again.

what I've seen is usually an event that will get the nurse out and

this wonderful critical incident stress program which is going to fix the event but it does nothing for the ongoing day to day burn out involving the job

it is because it is such a pervasive thing

I don't think the nurses know what they want.

what do you need to stay healthy, do you need to exercise, well, then why don't we put some exercise equipment in all the nursing stations?

You need to have a social life, well, why don't you make sure they have common areas for all the nursing stations.

we've lost our common area because the powers that be at region, the people who are there because we are here working, are going to take away the only source of satisfaction that the nurses have for their off hours

they need to know that they have somewhere else to go other than their suite

if they're not comfortable going out in the community, they have that alternate location.

yet Medical Services is doing the very thing that is going to contribute to more burn out.

So Medical Services' ability to provide for nurses with burn out is it's non existent. They don't do anything.

All they do is add to it

until they stop this wheel from rolling they're just not going to be able to hang on to their nurses.

There aren't nurses (inaudible) their rations. The nurses aren't allowed to buy junk food, diet pop, pop at all. Nurses drink pop. Nurses eat popcorn, they eat granola bars.

These are all things that they've now been told they're not allowed to buy them.

It's like it's this great big thumb of that the government is on top of you and it will always tip the balance.

the things that will always tip the balance is some sort of personal event or some sort of problem with the community if the community starts to do some political gesturing which has happened (inaudible) as soon as they start to bring politics into the nursing station, the nurses really feel like they aren't doing anything when the politics starts

the community thinks we're not good enough.

Well, if they would look at it from the outside, no, we are providing a good service,

but is this community getting what it should get in terms of the city standards, no, they're not.

They're not getting what they should get and they have a right to choose that, in fact they should be encouraged to do that. when you're told that again and again and again that you're no good then you start to believe that.

they will say is that this nursing station is not satisfactory and they're right.
the nurses have to allow them to say that and still be able to continue with their work.
I feel like I've got a lot of responsibility to the running interference for this community, so it's quite a bit of stress for me
if I see a nurse that doesn't like the community I know that they just aren't seeing a lot of the good, they're only seeing the bad.
I'm always trying to help them see that, but right now I'm actually at the point now where (inaudible) nurses do that because I can't take on the responsibility (inaudible). I'll just (inaudible) myself a lot and I shouldn't.
All I'm doing now is I tell them where I'm at, this is how I feel about it and I as a manager will do this I'm not going to try and take on their feelings
it's a daily chore to make sure that I don't do that because I think that that can really fry a supervisor when you start to take on the feelings of your employees
If you try and protect your nurses too much you aren't doing yourself a service and you aren't doing them a service.
You are responsible for yourself
I think a lot of nurses leave. I think they just leave.
They really haven't got a life up here.
If they do come up here with their family, eventually Medical Services is going to get to them.
I think eventually it's the employer or the community that will make them move.
They'll either see that they're not doing any good
they just cannot put up with this shit of Medical Services' any longer,
I think that's where they throw in the towel,
because the government will keep messing and messing and messing around with you until you finally just had enough of what it is that they are doing.
Nurses leave because they just cannot put up with it any longer.
If it's not your supervisor it's Medical Services in general.
It's mainly just because you've lost sight.
You have to do the day to day jobs and be happy with (inaudible) the only thing that's going to get you through.
Do you think you can learn? I think I might have become stronger,
I think I've become very keen in my ability to recognize when I'm getting burned out.
Because I look at myself now and I look at myself in say 1986, 1985, when I had a social life,
I was fending off burn out then just as well as I'm doing it now,
but the things that I did then was I would walk, I would write letters, I would listen to music.
Of course I had no other people in my life that I was responsible to so the things that I did then were different.
it's because of the way that my life has changed now that the way that I have to deal with the burn out is different
I would still like to see this lost life of writing letters and reading books and listening to music.
I think that my ability to deal with burn out is I don't think it's changed all that much
I can recognize it more
I can put more of an effort into trying to stay ahead of it, rather than letting it get to me.

I think you can go through burn out once and you might learn from it.

You might learn from it and you might not

you'll likely go through it again.

I think it's the second time that gets you.

I think it's like getting stung by a bee.

You knew in your mind that you were supposed to do something about it and you didn't do anything about it and you still let it happen.

At least I'll tell people. I think in this situation I'll tell them, if you see I'm not coping with the job then you better tell me.

Don't hide it from me and make sure that within two to three years I have made a significant life change that's going to get me out of the position

I do not think that anybody can do this job long term, particularly nurse in charge but even community health nurse.

APPENDIX B**RESPONDENT #2**

Me: I would like you to tell me about the experience of working as a nurse in the north, tell me how it's affecting you, and how it makes you feel. I would like to know whether you find it stressful and whether you feel burned out sometimes. I would also like to know how you cope with this, or to put it differently, how do you stay healthy. You can take your time.

#2: Boy, that's a big question.

Me: You can start whenever you like.

#2: Okay. Well, how do I feel about being a nurse in the north? Well, when I first came up here, way back when six years ago almost, I didn't have a clue what I was getting into and I think most people don't. I was very stressed out then because I didn't have an idea why, like how am I supposed to do this? I don't know. I was just sort of thrown up here without any guidance and no orientation, pretty much, they just told me --

Me: Six years ago?

#2: Yes. They did the paperwork and that was it, sent me up there. And after awhile I got used to it and I really enjoy it. I enjoy having, like, well, as compared to hospital nursing, I hate doing bed baths. I just hate that, I don't want to do that anymore. It's more of a -- in a hospital you're doing kind of aid work and here you're doing a bit more, which is nice, and you sometimes have the time to do it. It can be busy and stressful at time, like when you've got someone coming in who is overdosing and you don't know what pills they've taken, and of course, the person who found them

is gone, you know, and you don't have an idea of the history or the story and it's very frustrating trying to figure out, piece together what's happened and what you're supposed to treat. History is something you don't normally get a lot out of anyway, but it's a good job and also if only it wouldn't be so political as well. I find that really stressful. If someone phones me and says, "my kid's got a fever," I tell them how to handle the fever and then I get a call from the Chief, or just people who are saying, "well, so and so is sick." And where did they get that from, what kind of assessment, here, like that's all they can tell me and "they need to sent out." And then sometimes you feel like let me do my job. That's stressful. What I wish I could actually --

Me: "Let me do my job?"

#2: Yes. Okay. I assess somebody and I assume that this is what the assessment is, this is my assessment, they can be sent home. They get sent home and then I get a call from Chief and Council. It's not been here but in other places I've had six counsellors show up at the door demanding to see the nurse in charge, saying that so and so is really sick, and they're not. They're just -- there's a lot of attention seeking with that. Some people like it, that sick role. I've had to defend myself against Chief and Council before. This is not here, it's in different places where they sat me down with the chart and said, "Now, why did you do this? Why did you send them home? Why did you do this treatment? Why did you give them this?" and all sorts of stuff. And usually it was because the person who complained about me didn't have the facts, you know what I mean, they misunderstood me or, I don't know, they just plain lied. Because one girl said I put her in the corner to die and I was in there every hour taking her vital signs and monitoring her. She had the call bell and I kept offering her stuff for pain, she was having pain, but she didn't want any. And she told Chief and Council I sat her in the corner to die and I had to prove myself. The Chief had to sit there with the doctor and all the other nurses, sitting there with the health committee from the community, Chief and Council, and they just kept sitting there saying, "now, why did you do this, why did you do that?" And I said I didn't leave her in the corner to die because I was in there every

hour. And it was written, "refusing pain medication," that kind of thing, the vital signs were there and stuff like that, and I don't know where she got that from. That's what I mean, let me do my job. If you want a second opinion, get a second opinion, but don't tell me I don't know what I'm doing. Well, Diane told me Sidney was saying that he wants all of the nurses qualifications before they come here or when they come here, he wants to know what your experience is, what your qualifications are to work here. All I've got to say to that is if I have to prove my qualifications to him, he better give me his qualifications as Chief to ask that. And that's what I mean by the political thing. If they don't like the way you did something or they don't like the way you told them something, or you put the responsibility where it belongs on the person, "well, this is your responsibility, you're supposed to be taking your medication," or whatever, and then they run to the Chief and say, "well, I don't like this person," and you do whatever they wanted, you know what I mean? Or, "I had an ingrown toenail and they wouldn't see it at two o'clock in the morning," that kind of thing. Little things.

Me: So there's a lot of stressful little things?

#2: Yes. Generally, the job is really good when you work in the clinic and stuff like that, and I don't mind seeing real emergencies after hours, I don't mind it at all. People come and they're really sick, I'm just like "oh, let's do something," and that's fine, but the ones -- I mean sometimes it's like general clinic at eleven o'clock at night and that shouldn't be happening. I mean, look at this community, it's what, 5,000 people, and Winnipeg has how many, three quarters of a million and even they have dead times and that type of thing. They're not constantly going like we are here. And there's a lot of dependents and I don't know where that comes from. Or I don't know if it's all attention seeking or what, but it's really, really big here. I worked in Emerg in Health Sciences Centre and that's like the biggest place in Winnipeg and it's not like this all the time. I'm just trying to figure out why.

Me: Hmm-hmm. Hmm-hmm.

#2: And yet we try and educate. Dick tried to put together this package, well, Bumstead says they're not ready to learn about their own health care and how they can do things for themselves, like basic first aid things. I've seen people come in here with cuts and they're bleeding and nobody thought to put something on it, even their hand. They're just draining blood, just falling all over the place. I mean just basic first aid that could help, you know, nobody knows what to do. They just sort of walk in here (inaudible) "come on." Like don't you think that pressure on bleeding, I thought everyone knew that. You get that from movies. You do.

Me: Yes.

#2: You're looking at me like, "sure, sure."

Me: No. You do. You're right.

#2: You know, it's actually the little things, I guess. I'm kind of picky I guess. I pay attention to detail. But how I cope with it, I find that I need to get out every so often. I have to physically remove myself from here because if you end up having a day off here, say a night off or an evening off, or even a day off, you're still called sometimes if it's really an emergency. And so, really, technically, you're working on your so called night off, and you never get that back. So I go home and I like the fact that I don't have to answer the phone, that nobody needs me, like nobody has to call me to do something whether I want to or not.

Me: You mean home away from here?

#2: Yes, in Winnipeg. So I know when I need to get out because I keep saying to myself, "I've got to

get out of here." I keep saying that sort of like it's a litany in my head. "Hang on till the end of the week, you're going to get out of here." But also, I wish I could have more time, I'm doing my exercise, I'm trying to lift weights and keep fit that way. I'm eating low fat diet and really proud of it. You haven't noticed, I've lost weight and stuff? And I've got muscles now, you can see it, like a bit of a definition and tone, and I'm really happy with that. Because I'd look at myself in the mirror and flip. I'm going, "wow, look at that, I've never had that before." I'm trying to do that for myself and plus I'm bringing up all my little hobbies and stuff because I'm actually staying in a place for a change as opposed to moving around, like I don't know where I'm going next week. So I bought a sewing machine, I learned how to sew, I sewed my first dress, I do my knitting and I knitted my first cap and I'm doing my exercising and stuff. Sometimes I feel I don't have enough time for that because after hours you're on call when we get short staffed. It's like a struggle to find to make the time, that one hour to do that and I really get frustrated. I want to do it at least three times a week, sometimes I do it twice a week, sometimes I don't even have a chance to do it because I come home from work, and I work until seven, I'm just going "no way, not tonight. I'll do it tomorrow."

Me: That's "not tonight" for hobby, "not tonight" for what I want to do?

#2: Yes. Well, mainly my exercises. That's what I really, really want to do, like I'm saying to myself I want to do it this many times and then I can't do it because I'm really tired, so I'm almost always thinking that I have to work, it's just something I do. And then I say, okay, I won't do it tonight, I'll just sit and veg and then I go to sleep and then the next day comes and so and so is sick, or something's happened, or you get called out or there's a medivac or something like that, and then you don't get to do it again, and then you're going "oh," and then the next night you're too tired to do it again for some reason and it's almost like there's all these excuses going on and I really am hard pressed sometimes, some weeks, to actually do my thing for myself. And I wrote a letter way back in '91 to the Canadian Nurse, they had this thing nurses and burn out and it was about Northwest Territories, which I thought was a terrible article, saying that you know a nurse is feeling better

when she gets (inaudible). They'd wait till she was almost going, bll-bll (phonetic), like that, and send her out for a couple of weeks. And then they knew she was getting better because she'd be making these huge purchases and buying herself a ring or a car or something like that, which I think is a poor coping mechanism if you're trying to buy something to make yourself feel better and that will work for a little while but it's not actually solving the problem. Anyway, I -- you know what I mean?

Me: I know exactly what you mean, you mean now you sit with a debt.

#2: Yes. Well, hopefully you can pay it, but it's not going to -- "I have to go back to work now to pay for the thing I bought to make myself feel better." It only works for a little while. Anyway I said that there's a couple of things that Medical Services should be doing to retain staff. First of all, don't just throw them into the nursing station with absolutely no idea of what they're getting into. Before they go up they should be trained in, this is how you do blood work, this is what you're going to assess, basically. Even just like to look at what a normal ear looks like. I had no idea when I came up here. I had no idea how to use any of the equipment like that. So that would relieve a lot of the stress. At least you've seen and looked in someone's ear, you know what normal looks like and you have an idea what you're going to be seeing, colds and flus, well, this is tonsillitis, this a (inaudible), just the basic stuff, even if you just come up with that, and how to process lab work, what you need for what and they could write it down or whatever but at least it won't be such a shock. And physically removing this person from the community after so long. Not, you have to leave but you must take time off after so long especially in busy places and I said two months. Right now, I think it's more like six weeks. In Alberta they do that, like in six weeks it's one week off on comp time and people are trying to get into Alberta. I went to Edmonton for my NCP. I tried to get into Alberta, they don't need anybody. Everybody goes there and loves it there and they stay there. The woman that pushed really hard for this, (inaudible), she said she fought tooth and nail for that and they didn't want to do it and they didn't want to do it, and she says and since they've done it, they've

retained people, like years, because of that. When you look at Manitoba, and everyone went to NCP who either worked in Manitoba or knew someone who worked in Manitoba said, Manitoba nurses are always in the state of crisis. They don't get enough staff, they -- I don't know. There's something about Manitoba. I don't know if it's because this is the place with the most reserves.

Me: You're specifically referring to northern communities?

#2: Northern Manitoba, reserve Man., like that kind of (inaudible) reserve work, like what everyone else says, working for federal government. And they've heard nothing but horror stories. Ontario is bad too like from what everyone's talking. Half the people said come to B.C., come to Alberta, don't stay in Manitoba. And even when I went to NCP, the woman that was there --

Me: Sorry. What is NCP?

#2: National Clinical Program.

Me: Okay.

#2: That three month course.

Me: Hmm-hmm.

#2: The woman who was my, what do you call that, Regional Education Officer, she said to me, "I was worried about you." And I said, "why?" "Well, because you're from Manitoba and those nurses are very, very stressed out." And this was in my posting for my practical and she's heard this stuff and I guess she thought I was just going to flip out about everything. Well, I mean I don't know, Manitoba, just in general, has a bad reputation.

Me: Where is that coming from?

#2: From where I heard this is people across Canada. Some of them have lived in Manitoba and are working in different places, and most people will say, "I've never heard anything good about Manitoba, working in Manitoba." The nicest thing I hear is that they still have (inaudible). That's it. Like where Ontario doesn't and Saskatchewan doesn't, B.C. doesn't but that's it.

Me: So do you think this is from company's point of view, or no, from your point of view, concerning the company, getting a raw deal? I mean this is just -- I'm not going to quote you on this, I'm just sort of --

#2: With just --

Me: It sounds as if Manitoba has sort of a bad reputation.

#2: It does.

M: Where is this coming from?

#2: Just from people who used to work here, staff. I mean, look at this place. We have three nurses on the long weekend, more or less on Sunday. Three nurses in a community this size that they know is this busy. How many times have we been running short staffed and the reason I gave up the prenatals is because I never got any admin time to do it. I'm trying to track 60 women and find out when they're supposed to be coming in, making sure all their lab work, all their ultrasounds, all their information is there in their chart, and trying to organize 60 people with no time and I have to do it on my own because there's no staff to give me the time for admin, because they're running on five or four and that's half. Oh, on paper it's seven, I guess, like people take time off they never

replace. Dick and I went on a vacation in May. Pam had said she'd talk to Penelope (phonetic), who said, "tell them not to leave." This was booked time off, given three months advance notice. What were they doing for the last three months? And they told people, "we don't need people for the summer." They sent Cathy (phonetic) home and now they're going, "oh, gee, we're a little short. We might have to call you back." They don't know what they're doing with staffing. I don't have a very high opinion of that anyway, but telling you, you can't take your time off period. You should stay because we can't send you anybody, and yet they were turning people away earlier. And they had the board there in his own office and it's saying where people are going and stuff, they do that ahead of time. They knew. When Al left for a wedding in Edmonton, Dick and I were leaving for a week's vacation and they replaced all three of us with one nurse who got her house broken into and couldn't come. Why are you replacing three people with one in a place like this?

M: I cannot answer that.

#2: No. You can't. It's bad. That's probably why everyone says in NCP that Manitoba is always working in a state of crisis because there's never enough staff. And when you have enough staff, they pull. Like they pulled Tandy (phonetic) when we were understaffed. And she sat there all weekend, coughing because this guy was burning sweet grass in the suite, and (inaudible). She couldn't live in there (inaudible), and she phoned, she was just so bored and she was so upset at having to go there, she wasn't even on call. She said, "heck, I could stay here, at least I'd be useful." I can't understand how this is run. I know it's government, I know it's bureaucratic and stuff like that. And it takes forever to get paid, it takes forever to get anything in writing, and the paperwork is always slow because it's that caught in the wheel thing, but knowing ahead of time, staffing, that you're not going to have staff and then not given any and then what is everybody else left to do? It was Cathy, Wendy and Pam on one weekend. There was three of them on the long -- they were just like all three of them were working one eight hour shift and that meant if they had to call somebody back, that person would be hired for their shift. If there's a medivac and Latty couldn't

go, it was two nurse medivac with a prenatal, then they're down to two unless you get another air company in. It's not fair. I mean life isn't fair, but that's really not fair. That's asking for your nurses to get stressed and burnt out. (inaudible) and he either, well, Penelope, she laughs, it was very inappropriate, or else they say, "gee, I feel for you but I'm not going to do anything for a solution. I can't give you any staff. That's too bad. I sympathize with you." Yes, but you go home at five o'clock and you can have a beer at home, or you can go out and see a movie. You're not sitting here. I'm getting (inaudible), I think.

M: Is that how you cope with it or is this just --

#2: This is just complaining, actually.

me: Just complaining.

#2: Yes. I'm trying to put this into some kind of perspective sometimes when it starts happening.

M: Does this mean that you would quit, does this mean that you would not do this for a long time?

#2: I have done it for a long time. I'm seriously --

Me: So how do you cope with this, I mean, you've learned this now for six years and it sounds from what you're saying that you know it pretty well, the system.

#2: It's like you do the best you can with what you got.

Me: So can I ask you why you do it?

#2: Why I do this job? I like punishment, I guess. It is a punishing job sometimes. Actually when these things happen, they just happen, you know, it's sort of like what can you do? People leave and then you're understaffed. I mean, what can you do about the weather on Monday?

Me: You mean when it was weathered out?

#2: Yes. When it was weathered out, I kept thinking, I hope we don't give a medivac because Dick went on the last medivac and flew tree line all the way back, like just above the tree tops. I was hoping, well, I hope we don't have to send somebody out, because God forbid, we're not going to be able to (inaudible) them. But I mean that's part of the job. I mean, shit happens. It does. Wendy phoned me, I went for a break and Wendy phoned me and she said, "the doctor's the only one that's come here. Everybody else is coming on the last flight." And I went, "you're kidding." She said, "no, they won't be here till four o'clock." And I went "all right." I mean we'd been going all day already, we were so tired. I would go up to Wendy and I would say, "Wendy, blah, blah, blah, I got this person with (inaudible), I don't know what to do. Tell me, what kind of medication can I give him?"

Me: Does that scare you, does that stress you?

#2: Well, Wendy was doing the same thing to me, we were checking each other because we knew we were so tired that we were unsafe. I had this elder come in from the nursing home, and I said, "okay, when she comes in I'll let one of the fresh girls do her because I really think she needs a very good assessment, she needs to have an x-ray done, she needs this, that and the other thing. I'm going to get the doctor to check her too, but I want somebody to do a real thorough assessment on her, before we go to the doctor." And, of course, nobody stepped off the plane except Greta and that was it. And I was just like, gee, I've got to do it now myself. Well, I'll do it the best I can and I'll do it really slow because that's the only way I know I'm going to do it properly. Like she wasn't

urgent, in danger of anything, but she really needed to be assessed well, and she was. But I just had to take some time to do it because I was thinking slower.

Me: Hmm-hmm.

#2: I screwed up the first x-ray too, I didn't use enough juice, but. That happened to us in the hospitals too. Two people would call in sick and they'd send you a Medox nurse and LPN and you had five stages of chemotherapy running and a couple of central lines, what do you do? The best you can. That's it.

Me: Is that easy for you to deal with?

#2: You sort of go, "well, okay, let's do it." It has to be done and it gets done whenever it gets done.

Me: You don't find it overwhelming?

#2: If I sat there getting overwhelmed by it, it wouldn't get done. I'd be freaking.

Me: Have you ever freaked?

#2: Like "bl-bll (phonetic). Oh, I don't know what to do." I have to think. Once. And boy, did I catch shit for it. It was my first time up north, I did not know what to do. Our housekeeper was opening boxes and opened a box and sliced her leg open, and she called me and I was seeing someone, "Well, I'm seeing a patient, can I get to you in a sec?" She goes, "No, Barb." I think you ought to come here right now." And she's giggling and laughing and all I could see was her head outside the door. I walked into the room, and honest to God I turned around, there was blood everywhere. She had cut a vein and it was just running down her leg. I was just "take your pants off and get on

the stretcher now." I tried to put a pressure dressing on it and then I didn't know what to do. I kept thinking, "be calm, be calm, be calm." And I went to another nurse, who was the nurse in charge, and I said, "she cut her leg. There's blood everywhere. I put the pressure dressing on. I don't know what to do." So we go over there and she had passed out and everybody was sort of walking around in this blood and I was just standing there, I didn't know what to do and so I was looking at everyone, they were going back and forth between the supplies and to her, but they were more busy looking at the floor and trying to avoid stepping in the blood than they were in getting the damn thing and just getting it and doing whatever they had to do with it. So I grabbed the mop and a bucket and I started cleaning the blood up and then after that I had the reputation that during an emergency, all I can do is clean the floor. That's what this nurse told me, the nurse in charge, and she gave me supreme shit because I didn't have the side rails up. Well, she was conscience when I left her and I didn't leave her with anybody and I should have, because I just panicked you see because it was someone I knew as well, I knew her, and I've never seen anything like that. But I -- okay it's you, you deal with it, you know what I mean? So that's why I ran and got help because I thought that's all I could do, that's all I could think of, I couldn't think of anything more, went and got help and, yes, I did forget to put the side rails up, she could have fallen off and really hurt herself, like broken something, but I thought I was still helping and I was told to get the hell out of the room unceremoniously. I left and I felt this big. I cried about it for a week. I thought she could have died and it was all my fault and the nurse in charge was just going up one side of me and down the other. It was just experience after that. The more exposure you get to stuff like that, the less it scares you. Cuts don't bother me so much anymore. That was the worst because it was her.

Me: So do you think that it's just experience that caused you to deal with things better?

#2: Inside you sort of go "ah, shit" that kind of thing. I had a pregnant woman and that's my worst, absolute worst, pregnant women in labour. I would rather not have anything to do with the women in labour. I would like to stand there and watch, the more I watch, the more I'll feel comfortable

with it, but to stand there and watch, the more I watch, the more I'll feel comfortable with it, but to stand there and to deliver that damn thing with nobody else, or next to no help, or just a little bit of help or someone who says, "I don't know anything about delivering babies" and you know a little and that's all that's going to get you both through. Because it's happened. I remember this woman, a South Indian came in pregnant, wasn't even from South Indian, had to phone and get her other information, had no idea what was going on and then the other nurse was on the phone, "I'm public health. I don't know anything about it. You do it." I was just running around and under my breath, "okay, let's start her I.V. Okay. That's a good place to start, let's take some vitals. That's an even better place to start." It was "now, what do I do? Okay. I've done this, now what do I do?" You know, like what's next? And it came but while I was running to get stuff, under my breath I was going "fuck, fuck, fuck, fuck, fuck." I mean the patient didn't see that or hear that, but it was just like this panic. I'm going in there, I start an I.V. "Okay. Now, this is what you do, blah, blah, blah, blah, blah. We're going to do this we're going to do that." I said, "okay, I'm going to go get this." And I leave the room and I'm going "fuck, fuck, fuck," down the aisle. And this nurse is just on the phone, she didn't want to go in there. I said, "You get in there." We did this medivac, we come back, there's another prenatal and she says, "I'm delivering." I thought, "oh, great. Again." We just went through this and we've got to go through it again. We did a p.v. exam and there's a foot hanging out there. She was only 6 weeks, though, we were really early but the baby won't survive if it had been delivered, but there was a foot hanging out, and I'm feeling this. I'm going "I feel toes. What do I do? I don't know. Get her out of here." That's the only thin I could think of. Let's get her, let's just take her out. I hope she doesn't deliver this in the plane because I don't know how I'm going to tell her that this is a 16 week fetus because it's really not -- and this other nurse, she -- and I said, "go and check that, okay?" She said, "well, that's the cord." I said, "no, that's not. Feel it some more. Can you feel toes?" I said this very quietly. She goes, "oh, yes. It's a foot." And what does this woman start doing, freaking out. I just turned to her, "you be quiet. You breathe oxygen to that baby. I don't know if we can save it, but we're sure as hell going to try, so you do as I say." She just calmed right down and that was it and I didn't have a clue, honestly. I really

didn't have a clue if she was going to lose it or not. I thought, just don't deliver it. That's all I kept praying for. She didn't she lose it, but it was in the hospital already. I sort of delivered that and my end of the responsibility ended. But after that, I felt a hell of a lot more confident in myself, because I thought I didn't know what the hell I was doing and no one died because I didn't know what I was doing, you know what I mean? I got them there safe, I did everything that I should have done because I went with the obstetrics nurses and I said, "is there anything I missed, is there something you think I should have done better, because if I forgot something, tell me." They said, "no, that's what we would have done." So it worked out that I did exactly what I should have but I don't know if I did or not. It's just to try and be logical about it. And Joyce even said, "Barb, you look so calm." I'm, "I'm not calm at all. My mind's going a mile a minute. Okay, I do this, do that, do that, do that." I get it done and I think, "what next, what next, what next." Did I talk to much?

Me: No. Do these things build up or is it sort of one thing that is done and then it's gone?

#2: About those two deliveries, like those two pregnant women, I was quite happy about that because I had done the right thing by just sheer common sense and I was really proud about it and I carried that with me for a while. What do you mean, like these experiences way back, they build up? No. They don't for me. It's sort of like when something's funny you say this is only a five minute funny, this is only a 30 second funny, this is a chuckle funny, like a moment funny and then once you've fulfilled that funny, it's not funny anymore, like you don't have anything left, do you know what I mean?

Me: Do you equate funniness with stress now?

#2: No. No. No. I'm just saying any emotion for me, it's like you can only feel it for so long and then once you've exhausted that feeling, you can't bring it back. It's like pain.

Me: Okay. And then (inaudible) where does it go?

#2: I don't know. Out into outer space in that big pink ball that I hoof out there. I do that imagery thing when things really bug me. If I feel guilty about something, like I should have done more or I'm really angry about something, but I do let it out verbally, I'm quite verbal and emotional about things, the way I react to things, not necessarily at that time but maybe in private. But bad feelings I try and dump as soon as I can.

Me: How?

#2: In my pink bubble. It's huge and sometimes I fill and sometimes I only half fill it and sometimes I'll barely like start filling it, but once I exhaust the feeling, I hoof it and it's gone. It makes me feel better to know that I was getting rid of it, that I actually felt it and then it's gone. I can't feel angry about this anymore so I'm going to get rid of it now. Because I've felt as angry as I'm going to be. I was only angry about five minutes about this, you know what I mean?

Me: Imagery, is that competent control, is that an emotional thing? It's competent.

#2: Okay. I'm sitting somewhere or I'm lying somewhere and it's right in front of me. It's big.

Me: But it's something that you imagine?

#2: Yes. I imagine, I'm feeling it and as I'm feeling it, it's coming out of me and I see it filling in the ball. There's whatever, guilt, there's anger, there's, I don't know, sadness. It's all in the ball because as I'm feeling it, it's going and towards the end I'm sort of going "(inaudible) mad about this.

Me: And that's how you stay healthy?

#2: Well, that's what I do. It's probably the weirdest way of handling things that you've ever heard.

Me: No. Well, it sounds as if it's working for you.

#2: Also, when I work out I get a lot of that out too, doing something physical or I'll tear around the house, "it's time to do laundry and it's time to wash the walls or it's time to wax the floor." I try and do something constructive with it. It makes you feel better because then afterwards you've got this sense of accomplishment that okay, yes, I was kind of pissed off but at least I waxed the floor, I did something good with it. You got to look on the bright side, life's too short to sit there and stew anyways like things that you really can't control. I'm just learning now that you just can't control them and that there's nothing really you could do. I used to get really emotional about it, but it's not worth it sometimes, you sort of just have to sit there. Something like yesterday I was just going like, huuuh (phonetic), like what can I do? I'm not angry, Wendy said, "you're going to be furious." No. I'm not furious because the weather is (inaudible) what am I going to do, wave a magic wand and make the weather go better? I mean I can't do it. I've got to live with what's happened. So, oh, well. And usually when I'm not too happy with somebody I'll try and let them know as soon as possible. I don't pull any punches.

Me: In terms of confronting?

#2: Yes.

Me: Or dealing with an issue?

#2: Yes. I have dealt with Alice for neglect of charting. And I mean I do it, everybody does it once in a while, but Alice seemed to do it a little more than usual and I told her, "I could technically write you up on this but I don't want to." But you know, because then, "I'll write you up, you write so

and so up, so and so writes so and so." We'll all be back stabbing each other writing papers and having this major paper war about how you forgot to chart on something. I said, "just take a minute or two to chart. I know sometimes you forget, we all forget but that message has to be conveyed to the next person who sees this person." Because I was seeing somebody who had come in from the night before that she had seen and all she'd written down was a temperature, and I have no idea what she's done, what the person was like and they were coming in for a reassessment and I just panicked on that one. How am I supposed to know if I don't even know what originally happened, so I called her back and I said, "you get in here and you chart and you're not claiming a call back for that either because you've already been paid for that charting and you haven't done it so you do it now because that person's coming in in 15 minutes and I need to know what happened." So she did, she did it in good humour. I spoke to her very nicely about it. A month later I said, "come here, I want to talk to you." I took her aside and I said, "it's about your charting." And she looked like ahhh (phonetic) and I said, "you did a great job. I haven't found a single chart." And I gave her a great big hug. I said, "thank you for doing that, for taking that time because I haven't been stressed by it at all ever since I talked to you." And I mentioned it to Diane that I had said these things to her and she said that Alice had never mentioned it to her so she said you didn't offend her. I tried to say to Alice it's because I give a shit about you, I give a shit about the person who's coming in to be reassessed. I tried to put it in the respect that yes, I was pissed off with you Alice, I'm really sorry I was now because you weren't intentionally trying to do this so that no one would know what happened. It was just you forgot. You forget a lot.

Me: I'm interested in something here, you more or less answered all the things there but how did you get into nursing?

#2: I applied to be an electronic technician or a nurse because I thought I'd like to be either one and whichever one responded first, is what I would be.

Me: Why?

#2: Fate. I just threw it to fate. Why did I want to be a nurse because I have this idea that a nurse helps people and I wanted to be useful, I wanted to help people help themselves. (inaudible) I went into and that's what (inaudible) I do now.

Me: You had a calling?

#2: I don't know if you could call it a calling because I sort of just said, well, it's either that or electronic technician because I had an interest in both, like I like sciences, and I liked electronics in high school. I took all my sciences, I took advance physics all the way down to grade 10 physics, I took biology all the way up, I took chemistry all the way up and I liked it. I also took electronics and I like that too.

Me: And how did you end up in the north?

#2: I was working in Health Sciences Centre, I had worked in medicine for 14 months and I started floating and I loved floating because every day I was seeing excitement, adventure an really wild things, I didn't know where I was going to go, I never knew what was going to happen and I never knew who I was going to work with or where I was going to work. They sent me to psyche, they sent me to emerg, they sent me to ICU, then sent me everywhere, I worked everywhere in the Health Sciences Centre and it sort of got to the point where it just seemed routine, and I thought I need a change, I need to do something different, I need a different system, I need a different something, I got a little restless. I thought I'd go down to the states and I applied and I was all ready to go down and then I gave them all my information for my visa in August and in October when I was supposed to leave they still hadn't put it in. I said, "well, sorry then, I've got to do something." You know, go up north. I heard some nurses talking about it, they said it was

different, I though, okay, I need different, this is what I want. I'll take a six month (inaudible), I don't want to go back to work, they wanted me back, but I sort of felt like it was crawling back to them. Here I go through all this hassle (inaudible) away and then I won't even take it. So I thought I've got to do something with myself, so I thought, okay, let's go up north. I applied, two weeks later, bang, I was up north. And I didn't have a clue.

Me: So are you going to stick around?

#2: I have to do my year but Richard's saying already, "enough of this." It's getting really, really political with this self government. I mean they turned that sasquatch bingo into a political statement about how they can do anything they want on a a reserve, that Phil Fontaine, there. They say he supports it and Sidney was saying about how they had security people surrounding the building, that the R.C.M.P. raided the bingo, they had an alternative place to call the numbers and broadcast from and they were making it like this was chalk one up to the native people of Canada because you did this, you had a monstrous sasquatch bingo on the reserve. I don't know if that's illegal. I couldn't figure it out. I thought you could do --

Me: No. Apparently it was illegal I just heard that, to answer your question.

#2: I thought how (inaudible) people because they don't like the way they look or the way they said something, so they could do what they want, do all the bingo they can. The sell illegal cigarettes at Rosseau River the R.C.M.P. can't do nothing about it really. And there's bootleggers here, I mean they do what they want, people do what they want here. It's just getting to the point already when I was here before in May, things were okay, like just generally, I never felt any tension between the community and the nurses and then I leave, I come back and the nursing staff has changed and I have to say, we are a good crew. We really, really try to work together, you know, when someone's got a bad day the other one tries to make them feel better, it's sort of like, "oh,

what's wrong, you having a bad day, want to vent at me?" And it happens. I've listened to other people vent and I've vented at other people and they're good about it. "I understand you're having a bad -- I'm really sorry to be dumping this on you." "That's okay. We're having a bad day." Wendy has been really great with that because I like to vent at her, I seem to like that and she doesn't mind, she's really good about it. But I've noticed that there's this really, I don't know, I can't put a finger on it, but it's just you really got to watch your step now because if somebody complains about you, you're really going to be up shit's creek without a paddle. And I said to Denise I'm having a real hard time with just dealing with some of the stuff here, like the stress, like at the time I was doing the prenatals, like I said, it's really hard to do that, we're really under staffed and this is the way things are going and stuff like that. I'm having a hard time with it and I just feel really overwhelmed. I'm sitting there, I'm trying to keep up with it and I'm crying, I'm crying over it already. I'm sitting there, tears are pouring down my face and I am crying because I can't seem to keep up. I feel confused that I just can't keep up with these women. And you know what she says, "well, I don't know where you can transfer to." That's not what I wanted. I said "I want to stay, I'll stay six months, thank you very much, maybe things will change. It's not going to change right away, but that's not the answer, transfer me." And I told Diane that. She just about hit the roof. Oh, that's the support she gives you, oh, well, then you might as well leave, just give up. That's not what I want to do. I just want to let her know I'm upset about it. Instead of saying why don't you transfer, how about we send you an extra nurse, somebody to take the heat off in the clinic so you can do the other stuff that needs to be done, the paperwork and stuff. Of course, that's just like ideal.

Me: You really sound frustrated (inaudible).

#2: Staffing? Yes. I am but there's nothing I can do about it.

Me: Yes. But you don't feel you get enough support from them?

#2: From zone? I don't feel Diane gets enough support from zone and this meeting she had with Sidney, I have to shake my head about that. He wanted you to explain blah, blah blah. As soon as you go to open your mouth, he's say, "you're not allowed to talk, you're here to listen to how you can best serve our people." Well, I'm sorry. I told Diane if I'd been at that meeting and he said that to me, I would have said excuse me, when you're willing to have a conversation that goes both ways, call me. I've got things to do. I'm not here to listen to you. I'm here to discuss with you, not at you or listening to you discuss at me. There has to be a two way street and if you're not willing to meet me half way, then there's no use. And she sat in that meeting, getting more and more frustrated, getting more and more upset, probably blood pressure climbing and climbing. I wouldn't have bothered. I had that once. I had a kid with chicken pox and the mom wanted to bring the kid in during prenatal clinic and I said, no, you can't bring that child in. But she hadn't done nothing for it either, like tylenol, sponge bath, I said do that and then we can see this child, but you just can't walk into a clinic with a kid that's contagious with chicken pox in a room full of pregnant women and sit there with the, God knows how long, until you'll be seen because we'll see all the pregnant women first and that means that kid's going to sit there exposing these women the whole time. And the next day four counsellors walk into the office and started to scream at me constantly, "why did you refuse to see that child?" I finally said, "listen, when you're willing to hear what I have to say, give me a cali. I've got people to see in the clinic. Bye." They got up and left. I thought, oh, shit. I'm (inaudible). I bet you anything, I'm (inaudible). They got up, they left, they never said a word. Every time I opened my mouth to try and explain what she said, what was happening, we'll give them a little bit of an idea of what chicken pox is, they would just scream at me. I let that go on for maybe about 15 minutes before I said, I don't need this shit, and left.

Me: So it's a stressful job.

#2: Yes. I mean it's not always that bad. I'm just going over highlights here. There's been some times that I've done some real good. I've delivered a baby. It didn't get named after me, though. I've

caught an ectopic by myself, diagnosed some diabetics that had gone unnoticed for I don't know how long, stuff like that. I've caught things that people didn't even think of just because they think on a different plane I guess. You know think in a tangent and right away, you say let's see what's her blood sugar, just let's check that. And low and behold that's the problem. Things like that make you stay. I don't have the power to do that in the city. I don't have brains in the city. I've got to go to the doctor if I want to give over the counter aspirin to somebody or tylenol. I can't even do that myself. Here I'm prescribing medications and examining people and starting I.V.'s and I'm doing things. I consult the doctor as a colleague but I don't ask him for every little thing either. I like the autonomy. I've got a brain and I can use it here. I'll waste it in the city.

Me: But that's the challenge of being here?

#2: That's the best part about being up here. I couldn't go back to doing bed baths and begging the doctor for glycerin suppositories, no way. I couldn't do it anymore. I'm spoiled.

Me: So what, then, going down to the states?

#2: Emerg. As close as I can get to what I'm doing here or ICU or something. Something different because I'll have to get training to do ICU but I like the fact that in the states they let you go to school. They really are into that, they'll make time for you to go. Maybe get my BN, maybe learn how to read EKG's, do something like my masters. I don't know. I don't think I'd want to go further than my degree. I think after that, like I would always like to keep my nursing license sort of like -- but I'd like to get into something else too. I'm sort of kicking that around, but God, what if I miss it because I like what I do sometimes, I really like it. I don't know I used to say it would be so nice to --

Me: Like it's an (inaudible) like, like this is making life worthwhile?

#2: Yes. I mean I made a difference sometimes. I made a difference. One thing that I like to do that I really try to do is listen to the person, what's on your agenda. You're coming to me and you're saying blah, blah, I got this pee infection again. Okay tell me more about it, blah, blah, blah, blah, and I've had people say to me, "thanks for listening. You really care. Everyone else just hands me sepra." Yes, it takes a little bit of extra time, but that 20 minutes you spent talking to them, that might save them three trips a year, you know what I mean?

Me: Hmm-hmm.

#2: And also you're listening to the person, is this really a problem or is there a gain you're getting from it, or have we tried this, have tried that, has this been done? I can't order any of those tests but it's nice to sort of delve into it and stuff like that and really find out what's been going on with this person because they have a story. In the hospital you don't got that. You don't have the time.

Me: So it's worth it?

#2: This? Right now, for what I want, yes. It wasn't what I expected, it was a lot more than I ever bargained for but I think that I've become a better person because of it at times. It's kind of rounded me out a bit seeing these things because I've never seen certain things and --

Me: So if you had the choice of making the same decision again, this is six years ago?

#2: If I knew then what I knew now, I would definitely come up, but I would insist on more training and I would insist on some other stuff. I would insist on it before I came up.

Me: That system changed subsequently, has it?

#2: Yes, because actually the NCP's started in '89 and I started in '88 and I was always on the back burner for it you see, which is another pet peeve of mine. They really don't value the education, they feel that seeing as your body's been up there for 'x' amount of years that you can wait till doomsday to get that. I have to say that I wasn't too impressed with the NCP, they didn't really spoon feed me anything that I didn't know already and even the teacher said you've got a broad knowledge base. That was from five years working experience, that wasn't because I knew this stuff. Oh, yes, like I didn't know what the whole crowning process was but I delivered a baby that was blue and this is what I did with it and would this medication -- was there something else I could have done? I'd given them these case histories and they'd say, "well, it's hard to say because it's hard to know, blah, blah, blah." Well, apgar was this and mom's vitals were this and this and that and the other thing, and I remember it because this is something I want to learn from. I remember that this happened and this was going on here and that and the vital signs were roughly around there and I was doing that in NCP and the doctors would be looking at me and other people would just be looking at me, like who the hell are you? You remember this, you making this up? Especially this one guy, he just thought he was the bee's knees and he didn't like anybody, but I wanted to know, would this have made a difference? What would you have done? You know, you're a doctor, you're here in the city, you've got all this equipment at your disposal, is there something else I could have done with this bush stuff that would have made a difference, or did I do exactly what I should have done, and yes, you did. Or you could have done this. Why? What would that have done if I had checked this? Oh, because of blah, blah, blah, blah, blah. Really? Oh, thank you. That was it. I learned something. That's what I wanted to do but it was more like I had to go looking for it, they didn't really hand me anything.

Me: Yes. You mentioned that earlier at one time when you talked about this.

#2: It was a waste of time.

Me: Yes, you said that you felt a lot of the things were sort of -- you had to go look for it. That's very interesting. Thank you. Thanks for your time.

Identification of Significant Statements: Respondent # 2

PRIVATE

Well, when I first came up here, way back when six years ago almost, I didn't have a clue what I was getting into and I think most people don't.

I was very stressed out then because I didn't have an idea why, like how am I supposed to do this?

I was just sort of thrown up here without any guidance and no orientation, pretty much,

They did the paperwork and that was it, sent me up there.

And after awhile I got used to it and I really enjoy it.

I enjoy having, like, well, here you're doing a bit more, which is nice, and you sometimes have the time to do it.

as compared to hospital nursing, I hate doing bed baths,

in a hospital you're doing kind of aid work.

It can be busy and stressful at time,

like when you've got someone coming in who is overdosing and you don't know what pills they've taken, and of course, the person who found them is gone,

you don't have an idea of the history or the story and it's very frustrating trying to figure out, piece together what's happened and what you're supposed to treat.

History is something you don't normally get a lot of anyway,

but it's a good job

if only it wouldn't be so political as well. I find that really stressful.

If someone phones me and says, "my kid's got a fever, " I tell them how to handle the fever and then I get a call from the Chief, or just people who are saying, "well, so and so is sick." And where did they get that from, what kind of assessment, here, like that's all they can tell me and "they need to sent out." And then sometimes you feel like let me do my job. That's stressful.

I assess somebody and I assume that this is what the assessment is, this is my assessment, they can be sent home.

They get sent home and then I get a call from Chief and Council.

in places I've had six counsellors show up at the door demanding to see the nurse in charge, saying that so and so is really sick, and so and so is not.

there's a lot of attention seeking with that.

Some people like it, that sick role.

I've had to defend myself against Chief and Council before where they sat me down with the chart and said,

"Now, why did you do this? Why did you send them home? Why did you do this treatment? Why did you give them this?" and all sorts of stuff.

usually it was because the person who complained about me didn't have the facts, you know what I mean, they misunderstood me or, I don't know, they just plain lied.

one girl said I put her in the corner to die and I was in there every hour taking her vital signs and monitoring her. She had the call bell and I kept offering her stuff for pain, she was having pain, but she didn't want any. she told Chief and Council I sat her in the corner to die and I had to prove myself.

The Chief had to sit there with the doctor and all the other nurses, sitting there with the health committee from the community, Chief and Council, and they just kept sitting there saying, "now, why did you do this, why did you do that?" And I said I didn't leave her in the corner to die because I was in there every hour. And it was written, "refusing pain medication," that kind of thing, the vital signs were there and stuff like that, and I don't know where she got that from.

If you want a second opinion, get a second opinion, but don't tell me I don't know what I'm doing.

The chief said he wants all of the nurses qualifications before they come here or when they come here, he wants to know what your experience is, what your qualifications are to work here.

All I've got to say to that is if I have to prove my qualifications to him, he better give me his qualifications as Chief to ask that.

And that's what I mean by the political thing.

If they don't like the way you did something or they don't like the way you told them something, or you put the responsibility where it belongs on the person, "well, this is your responsibility, you're supposed to be taking your medication," or whatever, and then they run to the Chief and say, "well, I don't like this person

Generally, the job is really good when you work in the clinic and stuff like that

I don't mind seeing real emergencies after hours, I don't mind it at all.

People come and they're really sick, I'm just like "oh, let's do something," and that's fine,

sometimes it's like general clinic at eleven o'clock at night and that shouldn't be happening

I don't know if it's all attention seeking or what, but it's really, really big here.

I've seen people come in here with cuts and they're bleeding and nobody thought to put something on it, even their hand.

how I cope with it, I find that I need to get out every so often.

I have to physically remove myself from here

if you end up having a day off here, say a night off or an evening off, or even a day off, you're still called sometimes if it's really an emergency.

"I keep saying that sort of like it's a litany in my head. Hang on till the end of the week, you're going to get out of here."

I wish I could have more time, I'm doing my exercise, I'm trying to lift weights and keep fit that way. I'm

eating low fat diet and really proud of it.

I'm trying to do that for myself and plus I'm bringing up all my little hobbies and stuff
I bought a sewing machine, I learned how to sew, I sewed my first dress, I do my knitting and I knitted my first cap and I'm doing my exercising and stuff.

I said that there's a couple of things that Medical Services should be doing to retain staff.
don't just throw them into the nursing station with absolutely no idea of what they're getting into.
Before they go up they should be trained in, this is how you do blood work,
Even just like to look at what a normal ear looks like. I had no idea when I came up here.
I had no idea how to use any of the equipment like that.
you must take time off after so long especially in busy places and I said two months.

"Well, because you're from Manitoba and those nurses are very, very stressed out."
I guess she thought I was just going to flip out about everything

Three nurses in a community this size that they know is this busy.
How many times have we been running short staffed
the reason I gave up the prenats is because I never got any admin time to do it.
I have to do it on my own time because there's no staff to give me the time for admin
on paper we have seven on staff, but that is not how it works out.
I guess, like people take time off they never replace.
They don't know what they're doing with staffing.
I don't have a very high opinion of that anyway,
but telling you, you can't take your time off period.
You should stay because we can't send you anybody, and yet they were turning people away earlier. And
they had the board there in his own office and it's saying where people are going and stuff, they do that
ahead of time. They knew.
they replaced all three of us with one nurse who couldn't come.
Why are you replacing three people with one in a place like this?

I can't understand how this is run. I know it's government, I know it's bureaucratic and stuff like that.
it takes forever to get paid,
it takes forever to get anything in writing,
the paperwork is always slow because it's that caught in the wheel thing,
but knowing ahead of time that you're not going to have staff and then not be given any
then what is everybody else left to do?
It's not fair. I mean life isn't fair, but that's really not fair.
That's asking for your nurses to get stressed and burnt out.
The ZNO (Zone Nursing Officer) laughs, it was very inappropriate, "gee, I feel for you but I'm not going

to do anything for a solution. I can't give you any staff. That's too bad. I sympathize with you." they go home at five o'clock, she is not sitting here.

This is just complaining, actually.

I'm trying to put this into some kind of perspective sometimes when it starts happening.

It's like you do the best you can with what you got.

that's part of the job.

I mean, shit happens. It does.

she phoned me and she said, "the doctor's the only one that's come here. Everybody else is coming on the last flight." And I went, "you're kidding." She said, "no, they won't be here till four o'clock." And I went "all right." I mean we'd been going all day already, we were so tired

we were checking each other because we knew we were so tired that we were unsafe.

of course, nobody stepped off the plane and that was it.

Well, I'll do it the best I can and I'll do it really slow because that's the only way I know I'm going to do it properly.

But I just had to take some time to do it because I was thinking slower.

If I sat there getting overwhelmed by it, it wouldn't get done. I'd be freaking.

"Have you ever freaked? Oh, I don't know what to do.?" I have to think. Once. And boy, did I catch shit for it. I cried about it for a week.

I thought she could have died and it was all my fault

and the nurse in charge was just going up one side of me and down the other.

It was just experience after that. The more exposure you get to stuff like that, the less it scares you. Cuts don't bother me so much anymore

I was quite happy about that because I had done the right thing by just sheer common sense and I was really proud about it and I carried that with me for a while.

it's like you can only feel it for so long and then once you've exhausted that feeling, you can't bring it back.

It's like pain.

where does it go? Out into outer space in that big pink ball that I hoof out there.

I do that imagery thing when things really bug me.

If I feel guilty about something, like I should have done more or I'm really angry about something,

I do let it out verbally, I'm quite verbal and emotional about things,

the way I react to things, not necessarily at that time but maybe in private.

But bad feelings I try and dump as soon as I can. In my pink bubble.

It's huge and sometimes I fill and sometimes I only half fill it and sometimes I'll barely like start filling it, but once I exhaust the feeling, I hoof it and it's gone.

It makes me feel better to know that I was getting rid of it, that I actually felt it and then it's gone.

I can't feel angry about this anymore so I'm going to get rid of it now.
 Because I've felt as angry as I'm going to be. I was only angry about five minutes about this,
 I imagine, I'm feeling it and as I'm feeling it, it's coming out of me and I see it filling in the ball.
 There's whatever, guilt, there's anger, there's, I don't know, sadness.

It's all in the ball because as I'm feeling it, it's going and towards the end I'm sort of going "(inaudible) mad about this.

Well, that's what I do. It's probably the weirdest way of handling things that you've ever heard.

when I work out I get a lot of that out too, doing something physical
 or I'll tear around the house, "it's time to do laundry and it's time to wash the walls
 I try and do something constructive with it.
 It makes you feel better because then afterwards you've got this sense of accomplishment
 I was kind of pissed off but at least I waxed the floor, I did something good with it.
 You got to look on the bright side, life's too short to sit there and stew
 anyways like things that you really can't control.
 I'm just learning now that you just can't control them
 I used to get really emotional about it, but it's not worth it
 sometimes, you sort of just have to sit there.

No. I'm not furious because the weather is (inaudible)
 what am I going to do, wave a magic wand and make the weather go better?
 I mean I can't do it. I've got to live with what's happened.
 usually when I'm not too happy with somebody I'll try and let them know as soon as possible. I don't pull
 any punches.

Why did I want to be a nurse because I have this idea that a nurse helps people and I wanted to be useful,
 I wanted to help people help themselves.

But I've noticed that there's this really, I don't know, I can't put a finger on it, but it's just you really got to
 watch your step now because if somebody complains about you, you're really going to be up shit's creek
 without a paddle.

you don't feel you get enough support from them? From zone?
 But that's the challenge of being here. I couldn't go back to doing bed baths and begging the doctor for
 glycerin suppositories, no way.

It wasn't what I expected, it was a lot more than I ever bargained for but I think that I've become a better
 person because of it at times.

It's kind of rounded me out a bit seeing these things because I've never seen certain things
 I would insist on more training and I would insist on some other stuff. I would insist on it before I came
 up.

APPENDIX C**RESPONDENT #7**

Me: I would like you to tell me about the experience of working as a nurse in the north, tell me how it is affecting you and how it makes you feel. I would like to know whether you find it stressful and whether you feel burned out sometimes. I would also like to know how you cope with this, or to put it differently, how you stay healthy. Take your time, you can start whenever you like and if you want me to repeat any of the questions.

#7: It'll be okay. Very challenging, especially going from a hospital setting into the northern communities. As far as to back to the hospitals, I'm in a big debate now, I don't know if I can because it's such different nursing and it's a continual challenge. It's a reward, I guess, all in it's own as far as being able to do the things that you can't do elsewhere, except in the northern communities. The expanded role is really good. Coping. Just challenge --

Me: Sorry. Can I just --

#7: Yes.

Me: Just give me a little bit of your background in terms of, so you come from a hospital setting?

#7: Yes.

Me: Okay.

#7: And from there, I went into management of northern communities, whatever. But about six years ago I did a stint in Shamatawa and I never forgot it. I loved every minute of it, and that

was just after the nursing station got blown up, or shot at, or whatever, and I still liked it just because of the big difference going from, I guess, hospitals to the north.

Me: In terms of challenge -- you mentioned that word.

#7: Yes. Challenge and it allows you to do more than what you can do. That's my biggest thing, being able to do a lot more. And in a hospital setting, you follow the doctors around. It sounds bad, but it's the nurse/doctor stigma, you follow behind. You do as you're told, what you're told and you do it when you're told, whereas, here, you're in complete control of yourself. And coping, well, it's a lot easier to do it when your family is not around. If find it, anyways.

Me: Okay. So your family is staying with you here at the nursing station?

#7: Yes. I'm relating it more to the beginning. Six years ago in Shamatawa I did it by myself and then at the beginning, up to November, I was by myself. And it's a lot easier. It's stressful not being away from your family, but it's a lot -- it's more stressful having your family here because you have to bounce back and forth.

Me: Okay. I must just say that you have two children, small children, and I'm just saying for the benefit so that I can -- so it is, it's more as if you're now split between family and work?

#7: Very hard.

Me: Yes.

#7: Yes. I find it a lot harder. You can't sit down on your break and have a break. You now have to quick, go be a mom instantly and it's very hard and I know the kids find it hard, but

I find it hard. It's difficult. But to be up here and to be without family or to be single, I think it would be different.

Me: In terms of easier?

#7: Yes. Yes.

Me: Why would you say that?

#7: Because I guess you have your time by yourself, you have your own time to unwind, do whatever, but I don't have that. I have a little bit, but not like (inaudible).

Me: It's interesting. So you don't really find your family supportive in that, it's more like it's just work.

#7: No. I do, in one respect, but --

Me: It's a different role.

#7: Now, you're catching me.

Me: No. I don't want to catch you, I'm just trying to sort of get the feel of what you're saying to me. It is just an added burden, that you think it --

#7: Hmm.

Me: No?

#7: It depends on the mood I'm in. I would say, yes, sometimes. It sounds mean, but sometimes. But other times -- for myself, I guess, as an individual, sometimes that's hard to go -- I can't explain myself. To go -- like I don't want to say that it's a burden, because it's not a burden, but you don't get the time to unwind and to do the things just for yourself, because you bounce back into spending as much time as you can with your kids and your husband, because of the on call and stuff, you try and make every little time and, yes, I guess that can be a burden because you put expectations onto yourself. I do anyways. More expectations to please everybody else, and I'm kind of left out and sometimes that's hard.

Me: So in terms of the work of being up here, how does that make you feel?

#7: I like it. Like I said at the beginning, it's rewarding and that part of it, I guess, makes me feel good.

Me: Because you find the work stimulating?

#7: Yes. Yes. Being in control. Like I think that's a big thing with me because I'm almost finished here, three more weeks and I'm in the big debate, do I do it again or do I go back to the hospital. I don't know if I can go back to the hospital or back to doing this.

Me: What's the option? Thompson?

#7: Thompson, yes. I'd come back here if I could come back here but as it stands now, they can't guarantee me coming back here and I don't want to take the family and the kids (inaudible). It's too hard.

Me: Can you, in the terms of the word control is a word that you used, can you just sort of tell me more about that, your experience, your perception of that term? It's not a trick question, it's

just really something that I'm interested in, in that feeling that you experience. Let me help you out in terms of this. I sense that you say this being in control, doing your thing, being in charge, sort of helps you or is it one of the big stimulants for you being here, right?

#7 Yes. That would be it.

Me: So in other words, that would be one of the things that keep you healthy?

#7: Is enjoying that part, I guess.

Me: Yes.

#7: Yes. I would say so. You go to work with a smile and they'll never know that you like it. When I was in the hospital tour, I used to like being in charge. I used to like that a lot as far as charge nurse or whatever, so that's what it is then. But then if I have to go back to hospital, I give up all of this stuff. I now go back to not really having any, you have a little bit of say in stuff, but not really having any -- you're just basically following very, very strict guidelines or whatever with no ability to expand. You just do your job and that's it.

Me: You find the work stressful?

#7: Yes. I did what I liked here. I would thrive on that. I guess that's part of the thing.

Me: What about the feeling very tired sometimes?

#7: Yes. Yes. Go home, go to bed when the kids go to bed to sleep. But that just seems to be a part of it. I don't think I've gotten burnt out from it or not, but I think it's just a part of it.

Me: So how long have you been doing this?

#7: A year.

Me: A year. Do you think there are other things that keep you healthy?

#7: Yes. My kids, my family. Well, contradicting what I said before, but (inaudible) my kids and just enjoying this part of it and I guess I make plans to try and get something going, like go camping and that makes me feel good, I guess.

Me: Do you do that?

#7: Yes. Yes. We're going camping for the whole month of August (inaudible).

Me: Where are you going?

#7: To Vancouver and we'll be camping with my sister and her four little boys, so it will be interesting.

Me: I just wonder if you're aware that your time is almost up in terms of the big decision like that?

#7: Yes. (inaudible).

Me: Tell me a bit more about -- I think, yes, you have said, but try to tell me a bit more about why would it be so difficult to return to the old setting?

#7: The old setting? Because you give up all of the things that you can do here, you can't do there.

Me: Like what?

#7: Just the whole expanded role. You can't do that back in a hospital. Like I mean something as simple as starting an I.V. Most of the hospitals have an I.V. team so what do you do is you phone up the I.V. team to do it and then you know that you can do it, it kind of, I don't know (inaudible) it's frustrating to go back to that. You can't make a lot of medical decisions (inaudible).

Me: Do you think that in essence what you're saying is that you are thriving on this?

#7: Oh, yes.

Me: Okay. And that's no my words, that's sort of that's what you say, yes?

#7: Yes. Yes.

Me: Yes. So do you think that in time this might be too much for somebody? That's a more general question.

#7: For anybody or just --

Me: Well, maybe we should stick with you, I don't know, do you think this would become tiring for you too, to the point where you --

#7: I don't think I could do it forever and ever.

Me: Why?

#7: Because it's hard on your life (inaudible).

Me: Okay.

#7: You can't do a lot of the things that you can do -- you can't do certain things in a remote community that you can do elsewhere.

Me: Just because of the isolation?

#7: Yes, the isolation. And for me I can't do it forever with the kids and that, it would be too hard. Like this is the only school I'll let the kids go to. The other communities are too -- they're really behind in it.

Me: They're going to school?

#7: Yes. Yes. They (inaudible). Kids call them little pork chops, but (inaudible).

Me: Why is that?

#7: I guess it's white meat or something, I don't know. They say they call them that on the bus. (Inaudible). But, yes, you can do it for awhile and I guess the money is a lot better too, so that pushes you a little bit too. You get a lot more money than you have where you go back to the hospital and your wage is cut in half. Another drawback.

Me: Or another incentive to stay?

#7: Yes.

Me: Right? Just look at it the other way around.

#7: Yes.

Me: Going back is a drawback because that would mean less money, you earn the money (inaudible)?

#7: Yes. Yes.

Me: I am not asking, I am not saying.

#7: Yes, but that's right now, I think, the money does right now but only for a certain amount of time, I guess. It depends when I get paid off, I want to get paid off and get what I want to get and then after that, it's still nice to have the money but you wouldn't be able to get anything like that at the hospital.

Me: I think something that we just touched on, not it detail enough or what I would like to hear more about you, is the stressful part of this, do you find it stressful, you mentioned --

#7: The most stressful part for me is splitting myself.

Me: It's the splitting?

#7: Yes.

Me: So it's not really work related, it's both. It's work related, it's family. It's all split up between it?

#7: Yes. I find that the hardest.

Me: That's very interesting.

#7: Yes. I do, I find that the hardest.

Me: Being a nurse and being a mother almost simultaneously?

#7: But only in the northern community.

Me: Yes. Only -- yes.

#7: Yes. Because of all the uncommon stuff.

Me: Yes, and I realize, I mean you're a minute away from home, here, and the one moment you're in the nursing station, you're a nurse, and the next minute you're out and you're a mom and there's no --

#7: And just when you're trying to be a mom, you get called back to be a nurse and that's hard.

Me: And is there anything else?

#7: Well, the hours and that can be very stressful, working that amount of time, like doing how many your, you do 70 hours a week sometime and I guess that can be tiring except I'm trying to think, the first time I was in Shamatawa I'd been there without the kids and I didn't find it as stressful because I got to go back and do the things that I kind of like to do, like even to sit down and knitting or whatever, that kind of stuff, whereas with them, I go back. I --

Me: You mean go back, go home?

#7: Yes. I go back and I can no longer go put my feet up or whatever, I have to go and attend to the needs of the kids and the husband, but I'm left out, you know --

Me: The second time you've said that phrase.

#7: I know because it's true.

Me: Okay.

#7: Okay. Yes. So then you put yourself aside and you go back to work and you're fine and then you go back to being that, but then every now and then it pops in, "I never get anytime to do this," or whatever. But that's the most stressful part for me, it really is.

Me: How do you deal with that?

#7: I don't know.

Me: I mean what you say to me is something like, "well, I don't really have time for myself and I feel it, I realize it." So?

#7: I don't know. I don't think I do anything for it. Sometimes I stick it away and, "oh, well, tomorrow," whatever. Or sometimes I try to sneak in a nice long hot bath or whatever and read a bit, and that's my extent of my time (inaudible). And coming to work is almost my time, too, because I like it. But I don't know, (inaudible).

Me: No. I don't think it does.

#7: It does. It sounds like I'm going, "God, I go home and my family is a big burden to me so if I go back to work, I'm happy again."

Me: But I think somebody can be a big burden. I think that is part of the reality that life is stressful.

#7: Yes.

Me: I always remember that movie where Steve Martin, in Parenthood, where he said something, I can't remember the exact words but he said, "I've never had the luxury to do this and that and relax. I had to be a parent. I had to do this and this." And it's very true. Maybe once you become a parent you do.

#7: Yes. It's different. But I still -- everybody here knows that it is really hard for me to go back and forth like that, it's not something that's not obvious or whatever.

Me: And what you also say is that you don't spend enough time with yourself --

#7: No. I don't.

Me: -- for yourself. So what you in effect then say, sorry, but that you don't take proper care of yourself or you don't know?

#7: My time is so limited with two little kids and a husband, how -- like I don't know how I'm supposed to, like they say, make time for yourself, but how do you do that? Like how am I supposed to do that? What can I do, you know? Like, really, when you're on call and you're supposed to be available, even when you're not on call because if something goes on you have to come back here, so how do you do that? You just have to do the most important things, I guess I'm leaving myself out as being important or something. My priorities are everything

else except little old me. But that's not true either because I'm enjoying both of those things, so that's good for me. (inaudible).

Me: No. It just sounds to me as if (inaudible). On the one hand you say, "yes, well if I say this, if I look at it from this perspective, yes, it is good, it is good for me. But on the other hand if I look from a different perspective, then I feel a bit done in."

#7: Well, just talking about it like this is sort of making me, I don't know, think about it differently.

Me: And the fact is, is that you don't talk about this often, you don't think about it really because that's the way we are.

#7: You just go on. Yes. You're grinning. Don't grin.

Me: I'm just trying to see whether we have covered this, that I've asked you. You do find it stressful, but you --

#7: The stress of work is alleviated by enjoying the work.

Me: Does it sometimes happen that it's too much?

#7: The stress is too much or -- I guess, yes, you have days like that but you get past it. It doesn't stick around either.

Me: Why did you become a nurse?

#7: I have wanted to be a nurse since I can ever remember. When I was six, seven years old I was

in school getting medical books. I don't know. And my mom was a nurse, and I just sort of--
I don't know.

Me: Do you think you have a great calling to help other people?

#7: No. I don't ever feel like that. I feel like I'm, I guess, good at my job, I feel that, but I don't feel like I'm above anything. I mean as in work, I like it. Because I think (inaudible).

Me: Would you then describe your life as fairly stressful at present?

#7: Right at this moment I would say yes, just because of this decision I have to make. That is it's a very big decision and I would say, yes, I find it stressful.

Me: But that's something that's going to come and go?

#7: Well, it could come and go, but if it's the wrong decision and I hate it, it's going to stick around for a while too.

Me: Okay.

#7: I don't want to do it and regret it.

Me: That's very interesting. Thank you. Was there anything you wanted to add, anything that you think that you have not covered?

#7: No.

Me: Maybe just to summarize, how do you stay healthy then?

#7: A born natural, I don't know. I don't know. I eat okay, I eat good and I exercise running after the kids and I like the job. (inaudible).

Identification of Significant Statements: Respondent # 7

It is very challenging, especially going from a hospital setting into the northern communities. As far as to back to the hospitals I don't know if I can because it's such different nursing and it's a continual challenge.

It's a reward, I guess, all in it's own as far as being able to do the things that you can't do elsewhere, except in the northern communities.

The expanded role is really good. Coping.

about six years ago I did a stint in Shamatawa and I never forgot it.

I loved every minute of it, and that was just after the nursing station got blown up, or shot at, or whatever, and I still liked it just because of the big difference going from, I guess, hospitals to the north.

Challenge and it allows you to do more than what you can do.

That's my biggest thing, being able to do a lot more.

in a hospital setting, you follow the doctors around. It sounds bad, but it's the nurse/doctor stigma, you follow behind. You do as you're told, what you're told and you do it when you're told, here, you're in complete control of yourself.

And coping, well, it's a lot easier to do it when your family is not around. If find it, anyways.

Six years ago in Shamatawa I did it by myself and then at the beginning, up to November, I was by myself. And it's a lot easier.

It's stressful not being away from your family, but it's a lot -- it's not a stressful having your family here because you have to bounce back and forth.

So it is, it's more as if you're now split between family and work?

You can't sit down on your break and have a break.

You now have to quick, go be a mom instantly and it's very hard and I know the kids find it hard, but I find it hard. It's difficult.

But to be up here and to be without family or to be single, I think it would be different. In terms of easier? Yes.

You have your time by yourself, you have your own time to unwind, do whatever, but I don't have that you don't get the time to unwind and to do the things just for yourself, because you bounce

back into spending as much time as you can with your kids and your husband, because of the on call and stuff, you try and make every little time and, yes, I guess that can be a burden because you put expectations onto yourself. I do anyways. More expectations to please everybody else, and I'm kind of left out and sometimes that's hard.

in terms of the work of being up here I like it. Like I said at the beginning, it's rewarding and that part of it, I guess, makes me feel good.

Being in control. Like I think that's a big thing with me because I'm almost finished here,

You go to work with a smile and they'll never know that you like it.

When I was in the hospital tour, I used to like being in charge.

I used to like that a lot as far as charge nurse or whatever, so that's what it is then. But then if I have to go back to hospital, I give up all of this stuff. I now go back to not really having any, you have a little bit of say in stuff, but not really having any -- you're just basically following very, very strict guidelines or whatever with no ability to expand. You just do your job and that's it.

You find the work stressful? Yes. I did what I liked here. I would thrive on that. I guess that's part of the thing.

What about the feeling very tired sometimes? Yes. Go home, go to bed when the kids go to bed to sleep. But that just seems to be a part of it. I don't think I've gotten burnt out from it or not, but I think it's just a part of it.

Do you think there are other things that keep you healthy? Yes. My kids, my family. Well, contradicting what I said before, but (inaudible) my kids and just enjoying this part of it and I guess I make plans to try and get something going, like go camping and that makes me feel good, I guess.

So do you think that in time this might be too much for somebody? I don't think I could do it forever and ever. Because it's hard on your life (inaudible).

You can't do a lot of the things that you can do -- you can't do certain things in a remote community that you can do elsewhere.

The isolation. And for me I can't do it forever with the kids and that, it would be too hard. Like this is the only school I'll let the kids go to. The other communities are too -- they're really behind in it. Kids call them little pork chops, I guess it's white meat or something, I don't know.

You can do it for awhile and I guess the money is a lot better too, so that pushes you a little bit too.

You get a lot more money than you have where you go back to the hospital and your wage is cut

in half. another incentive to stay? Yes.

The most stressful part for me is splitting myself. So it's not really work related, it's both. It's work related, it's family. It's all split up between it?

I mean you're a minute away from home, here, and the one moment you're in the nursing station, you're a nurse, and the next minute you're out and you're a mom and there's no --And just when you're trying to be a mom, you get called back to be a nurse and that's hard.

Well, the hours and that can be very stressful, working that amount of time you do 70 hours a week sometime and I guess that can be tiring I go back and I can no longer go put my feet up or whatever, I have to go and attend to the needs of the kids and the husband, but I'm left out, you know --

So then you put yourself aside and you go back to work and you're fine and then you go back to being that, but then every now and then it pops in, "I never get anytime to do this," or whatever. But that's the most stressful part for me, it really is.

How do you deal with that? I don't think I do anything for it. Sometimes I stick it away and, "oh, well, tomorrow," whatever. Or sometimes I try to sneak in a nice long hot bath or whatever and read a bit, and that's my extent of my time (inaudible). And coming to work is almost my time, too, because I like it. But I don't know, (inaudible).

It sounds like I'm going, "God, I go home and my family is a big burden to me so if I go back to work, I'm happy again."

everybody here knows that it is really hard for me to go back and forth like that, it's not something that's not obvious or whatever.

And what you also say is that you don't spend enough time with yourself --no. I don't.

My time is so limited with two little kids and a husband, how -- like I don't know how I'm supposed to, like they say, make time for yourself, but how do you do that?

Like how am I supposed to do that? What can I do, you know?

Like, really, when you're on call and you're supposed to be available, even when you're not on call because if something goes on you have to come back here, so how do you do that?

You just have to do the most important things,

I guess I'm leaving myself out as being important or something.

My priorities are everything else except little old me.

But that's not true either because I'm enjoying both of those things, so that's good for me.

(inaudible).

You just go on. Yes.

The stress of work is alleviated by enjoying the work.

The stress is too much or -- I guess, yes, you have days like that but you get past it.
It doesn't stick around either.

Do you think you have a great calling to help other people? No. I don't ever feel like that. I feel like I'm, I guess, good at my job, I feel that, but I don't feel like I'm above anything. I mean as in work, I like it. Right at this moment I would say yes, just because of this decision I have to make. That is it's a very big decision and I would say, yes, I find it stressful.

How do you stay healthy then? A born natural, I don't know.
I eat okay, I eat good
I exercise running after the kids
I like the job.

APPENDIX D**RESPONDENT # 8**

Me: I would like you to tell me about your experience of working as a nurse in the north, tell me how it's affecting you and how it makes you feel. I would like to know whether you find it stressful and whether you feel burned out sometimes. I would also like to know how you cope with this, or to put it differently, how you stay healthy. And you can start wherever you like.

#8: That's quite a big chunk. I'm not sure where to begin.

Me: That's the whole question so you can just take it.

#8: Okay. How do I feel about working in the north? I've enjoyed it for the most part. It's basically been what I thought it would be.

Me: And what is that?

#8: Well, you know, the usual words, challenging, it's been very interesting work. I found it interesting learning about the different cultural group which I really knew nothing about before. I've learned tons, made my money. That wasn't the main reason why I went up, but it helps because I would like to get into community health someday, I think, so I've come from a critical care area to there. Critical care, I did that full time for two years. That was enough. I've had my fill, so I'm just sort of moving on to a different area so it's like a stepping stone, I guess. What else was I supposed to answer there?

Me: Experience of working as a nurse in the north, a bit more about that, maybe? Tell me about

the experience of a different culture that you've mentioned.

#8: Oh. Well, I knew nothing about the Indians. When I worked in Churchill most of our patients there were Inuit which is totally different and my only contact with Indians was like Main Street Indians, you know, the types in Winnipeg you see and that's not a very good representation. That certainly doesn't give you a very good image of these people. He's laughing to himself because he's thinking I worked in Gibson, what is it? No.

Me: (inaudible)

#8: But I don't know, maybe it's all the same but you see them different. I don't know how to -- because it's in their own -- what is it?

Me: Backyard.

#8: Their own backyard. Exactly. And I think I'd only seen them like I said lying around drunk on Main Street before and certainly I had my share of that in Gibson, but you certainly see them sober. They rarely come into clinic during the day drunk. For the most part, sober. I found after awhile they sort of begin to know you and trust you and talk more and you laugh along with them, and -- how do I put this in words?

Me: No. That's great. So there is more to the experience then? What do you experience, then, another people, another culture?

#8: Hmm-hmm. Oh, yes. That's part of it. I suppose the whole experience of living on a reserve, isolated in the north, that that's a whole thing in itself too.

Me: Would you like to tell me a bit more about that?

#8: What can I tell you about that?

Me: Your experience, your feelings about that.

#8: Well, I've been up north before because I've been in Churchill but it was sort of totally different because Churchill's a town and it has access by rail, there's no road, but it's not a reserve. I guess it's an eye opening experience. It's sort of what I expected because you see pictures on T.V. of a reserve, the conditions that people live in, you know, no running water and doing wash for 15 kids by hand and spending all day chopping down wood so you can heat your house. You know you go into some of the houses in the winter time and they're freezing. You wonder how -- I couldn't live like that, so. It's eye opening and then how the Band runs things. That's another thing. I mean I could go on and on. The mismanagement.

Me: That's you're feeling, your experience up at the --

#8: Well, just recently Karla and I just found out the Memorial Centre has an annual monies allotted to it of one hundred and ninety-seven thousand, and what is the Memorial Centre, it's a shack. There's nothing there. With that much money you think they could have done wonderful things, they had a wonderful Recreation Director and bought all kinds of wonderful equipment and pool tables, whatever, for the kids to play on, and there's nothing there. It's a shack. There's a canteen in it. So where did the money go? The Band's broke right now. You know this is all very interesting and I almost feel like, oh, my God, if the Canadian taxpayer knew, just had any idea how much money is sunk into these places, to what? I'm sure there's just so much corruption going on. So I suppose we're like anywhere else in that way I suppose it's just maybe they're not as clever at covering it up.

Me: So how does this make you feel, that experience of the -- it sounds like a bottomless pit.

#8: I don't know. You just shake your head. Yes. I don't know. You just shake your head, like, where's it going to end? There's not an infinite amount of money. You're negative zone here. I was going to say something else but I forgot what it was. I can't remember. Maybe it will come to me later. It was another thing about the people. Oh, yes. And the caring for the environment. That's what I was going to say. Yes, right. It just makes me laugh. Sometimes now you hear these Native leaders on television or whatever talking about, "oh, yes. Indian people are in tune with Mother Earth," and da, da, da, da (phonetic). Yeah, right. Who throws the Pampers all over the place, you know, it's just a mess out there. They don't give a, you know, (inaudible) about it. I don't know.

Me: So what you're saying to me all in all is this is a fairly negative experience.

#8: I guess so.

Me: I don't want to put words in your mouth, but are there any -- what are the positives, then?

#8: I know it's sounding negative. It's all part of the eye opening part I think, you know, I've seen these things. What's good? Well, they're basically a fun loving people, but kind of screwed up. I think I would say it's been more of a positive experience even though it doesn't sound like it. I guess it because I'm trying to take everything all in together, you know, like learning about the culture, the experience of living in the nursing station and doing that kind of work, operating the nurse practitioner role. I think now I've seen that I think that's the area I want to go into. I would like to go down that path now.

Me: Say a bit more to me about the experiences as a nurse practitioner in terms of how that --

#8: Well, I guess my choice in the jobs I've had over the years have gradually been more positions with more and more independence. Okay, my first job was in Churchill. Brand new grad, you

know, basically pretty dependent on direction from the more senior nurse's positions, whatever, and then I went into critical care where you're very independent actually and given wide open doctor's orders, like you know, tight trait dopamine (phonetic) to maintain (inaudible) blood pressure reading. Well, that means you can play around all you want with this (inaudible) and you don't need a doctor's order, well, it is kind of there, but you do a lot of stuff on your own. This is gone even more, you know, you're it. A lot of people say to me isn't that scary, but I've never found it that way. I don't know why because I know I can always pick up a phone and I can phone a physician somewhere and get some advice on something and you don't have that (inaudible). The equipment, well, you know it's part of living in an isolated community and I'm sure the people that live there must -- I mean if that's not okay with them, then they're going to have to go move somewhere else, that just sort of goes with it. So I guess the gradual gaining of independence, making your own decisions not relying on other people so much.

Me: And that's a positive thought?

#8: Hmm-hmm. Yes. I've had lots of experiences and you feel good when you've diagnosed something correctly and actually over the years it gets easier, you know, you've seen things you can rely on past experiences more and gut feelings. Well, I mean it is something totally new where you're able to do someone comes in with a complaint, you have to take a history and do a physical assessment and basically come up with a diagnosis. Well, it's not something you're taught in nursing school. That's the physician's role.

Me: Okay.

#8: Is this making any sense?

Me: Sure it is. So how is this all affecting you, then, this whole picture you've been trying to paint?

Yes. You've painted a very broad picture of negative feelings and also of positive feelings, feelings of independence.

#8: Hmm-hmm. Well, I guess it must affect your self esteem. I mean I don't think I was ever really lacking in it, but it certainly hasn't -- I mean it's definitely helped a bit more. Oh, I guess so. I shouldn't say I wasn't lacking in it, but, you know, once in a while you'll have little things, "oh, can't do that, couldn't possibly do that." I don't say that so much anymore.

Me: Okay. So what about -- and how does that make you feel?

#8: Well, I think it's a positive thing. I think it's good to be independent. I'm not saying you shouldn't rely on other people for anything, but when it comes down to it, you know, you have to help yourself. No one else is going to.

Me: Is that pretty much your philosophy of life?

#8: Hmm-hmm. Well, to a degree. If you want to do something you have to do it yourself. No one else is going to. Is that what you're getting at?

Me: No. It's not what I'm getting at. I'm just trying to clarify what you're saying.

#8: Yes.

Me: So that is a pretty strong belief that you have.

#8: I guess so.

Me: Okay. So when did you find any of -- or do find any of this stressful?

#8: Anything, like this is very broad. Anything very stressful --

Me: Well, within this picture that you've painted so far.

#8: Well, I'm someone -- I don't think I let things really get to me. I don't. There's some things, but for the most part I think I tend to let things roll off of me. I don't know, I'm a type B personality, I'm quite laid back.

Me: Have you have filled out a questionnaire like that or something that you know a type B, or?

#8: No. I just think I am.

Me: Oh. Okay. No. I'm just asking.

#8: From what other people have said, you know, "nothing every ruffles your feathers." My mom always says to me, "yes, well, Wendy showed some excitement. Oh. Oh." I've had that on past jobs, my performance appraisals. I remember my charge nurse in Churchill said Wendy has a calming affect on people she works with. If something happens, I don't go off in a flap. I don't know why I'm like that, it's just that's me.

Me: So you are pretty laid back so you don't really find it stressful because you're pretty laid back. You did say maybe some things.

#8: Well, the first thing that comes to mind is the Rina thing and if we can use that. You know what I'm talking about. It always seem to be things that aren't really inherent in the work but it always seems to be something else, like something maybe in my personal life but not the work specifically I don't think.

Me: But was Rina not part of work I mean that's an interpersonal issue you know, just to make it clear for transcription, that was an interpersonal thing.

#8: Yes. Hmm-hmm.

Me: But also in terms of a nurse that you worked with that stopped performing or gradually became more or less dysfunctional?

#8: Hmm-hmm. Hmm-hmm.

Me: And how did that affect you? Sorry. I'm just trying to get to the --

#8: Yes. Yes. I know I don't elaborate a lot. I mean I've known Rina since about ten years so I consider her a fairly good friend. You know you have an attachment to that person and when you see something like that start happening, you know I guess I seen it happening but I -- here I am, I'm going to eat my own words. I said I didn't feel I could do anything about it. Like I really felt it was over my head. I just didn't know -- did a lot of (inaudible) which I see now I shouldn't have. I've learned from this experience.

Me: Okay. So if you bite your tongue what emotions are there?

#8: A lot of it was just telling her how I felt about things that she was doing.

Me: Not telling her.

#8: Yes. Yes.

Me: But a lot of that frustration you didn't share.

#8: Oh, well, I'd flap off to somebody, you know, Karla was there to listen, "blah, blah, blah, blah, blah," (phonetic) you know and then Karla finds the same thing I do and so we were just a great -- you know. Or I'll phone up a friend in Winnipeg, "oh my God," you know. They just probably sit there and listen to me spout off and not have a clue what I was really going on about, but. I don't know I guess it's because she was in -- it's a strange position because your friend is your boss and you have the work part that you have to separate from the social part. And that worked up until recently and then it really got to be a problem in resolving the issue I think or for letting it go on for so long.

Me: Hmm-hmm. So you did find it stressful, but you dealt with it by --

#8: Yes. I mean I'm not going to say that there wasn't any stress, but a mild stress, like I wouldn't feel like I ever felt really overwhelmed by it or anything but just sort of nagging on your mind, you know, I would talk to somebody. If I feel stressed out I'll talk to someone about it. I tend to intellectualize things a lot, I'll sit and think about it, what's going on. Another thing, I can go for a walk.

Me: Do you believe that there's something like burn out?

#8: Oh, sure. Yes. I'm looking at this, now. I made up my mind I am leaving the end of March. I don't think I'm burned out, I just feel that I've had enough, you know, three years of Gibson, three years of you know, the no road, not being able to get out for a weekend off or not enough staffing, but being confined to this one little community. Sometimes (inaudible) going for a walk sometimes. Well, after dark I wouldn't say I never have but I'll always take someone with me usually. I guess the whole lifestyle of being so closely tied to your work, I don't think that that's healthy.

Me: Do you think that if you say burn out (inaudible) do you think that's something that is inherent

to the job, to that job?

#8: Okay. I think that depends on the individual.

Me: Hmm-hmm.

#8: I think some people are obviously a lot more prone to that than others. I think maybe inherent -- yes. Maybe if somebody stays at it like 20 years, oh, yes. Maybe someone else maybe would have been feeling burned out after two years, but you take a different person who has a different make up, well, it may take them ten years but I think maybe eventually, like in that type of situation, where you never get away from work.

Me: It sounds to me it's not specific things, it's more the gradual erosion that you're talking about of liberty, of isolation.

#8: Yes.

Me: Yes.

#8: Yes. I think eventually, like at first these things are easy to cope with but then after awhile, like you said, an erosion.

Me: So as far as you are concerned it hasn't really eroded so much yet but --

#8: If I stay it will. I think.

Me: Okay.

#8: I think. It's hard to say, but I just feel I'm ready for a change. So I'm taking a six month (inaudible) the end of March. But nobody knows. I haven't told Jan that, but.

Me: No. I won't say anything, but does that mean you're taking a six month break?

#8: (No audible response.)

Me: Okay. And then (inaudible).

#8: Well, what I'm going to do is I'm going to travel. I'm going to sort of live out of my car for awhile, head out to B.C., the Yukon. I'd like to work (inaudible). I might just drive out there and make it like a job hunting, like a holiday combined job hunting thing, just to see what else is out there because I know it's just pitiful right now for jobs. That's why I'm not going to quit. I mean if I don't find anything else, well, I'll go back to Medical Services, but I'm not going back to somewhere like Gibson. I might even try another province.

Me: So would you try, and I know this is difficult, would you try to just put it in words what this is about, what this feeling of this might get to you over time, for you personally?

#8: I guess just being so unconnected from the rest of the world almost, like you're in some northern bubble. Like I have often felt those people in Gibson they haven't got a hot clue what it's like. I just figure off the reserve there's no way they'd survive, like they haven't got a clue what (inaudible) the real world is like. You know if something bugs you, oh, you go run and tell Chief and Council and they'll fix it for you, but they can't do anything for themselves there. Like they're so dependent and I know that's part of the whole slue of things, all this history and whatever. I think I'm getting off topic here.

Me: You decide. Okay. So this is the experience of the isolation and how did you stay healthy,

how do you stay healthy by just being (inaudible) inclined (inaudible)?

#8: I think that's maybe a large part and trying to stay connected with the outside, you know phone calls to friends and family, watching the news, getting out frequently, like we've said this how many times, like even a weekend out in Thompson. You sort of connect again.

Me: Sorry. I just want to change this. - (Side A ends) - No. I didn't really think that you were difficult. Not more than I know you. So we were just talking about our staying healthy. Oh, and something that I -- you also exercise, I know that you do exercise.

#8: Hmm-hmm. Hmm-hmm. Well, I try to eat right. That's kind of hard sometimes, lack of fresh fruit and vegetables sometimes. I guess trying to do a variety of things, having interests. Like I enjoy reading, I'm doing some crafts, I love listening to music, I like getting outside on the Hondas and the snowmobiles wherever the (inaudible). Of course there's a lot of socializing that goes on here.

Me: Do you think that the fact that you don't have a family makes it easier?

#8: That's interesting. Well, it certainly makes it easier. I couldn't see being in a position like, okay, look at Anne Watt (phonetic). She goes in like four weeks at a time and her husband's in Thompson. I think he finds it a bit harder than she does, but that kind of situation, that would be difficult. If you could bring the person up with you like Karla and Johan. I think that must help things. Yes and no. Like Karla says she's getting adjusted to marriage that's probably a very difficult last year for her, like where she says I can't just decide I don't want to do something one day because it's not just me anymore so I've got to think of this other person, oh, well, I've got to make supper. I can't just have a bowl of cereal. You know that's (inaudible). But then it must help I think sometimes because you've got somebody there all the time you can, you know, but I (inaudible) because there's a lot of other people there too,

like I know I'm friends now with -- there's Rene next door and they're wonderful to have there, and Gina and Christine and Renfrew, so there's a lot of other people who are sort of in the same boat obviously.

Me: But I get this distinct feeling that it stays very artificial or very different than any other experience you will have.

#8: The friendships that are made up there or what?

Me: Even the friendships, yes. Because you all stay within the same reality of isolation, I mean it's not necessarily what they would have liked to do right now.

#8: I've thought of this a lot of times that people you befriend up there you wouldn't probably normally have if you were in -- is this true? I mean you need that human contact. You need to be able to have an intelligent conversation with somebody else. I don't mean to bat down the people in Gibson, but most of them I can't exactly talk about the latest John Irving books I just read.

Me: Yes. I understand what you mean.

#8: Answers part of that question there.

Me: Oh, I think you have more or less covered everything. You've told me how you cope with this, or how you stay healthy. Can you just tell me more about do you think the break that you're taking, the six months that you're taking, sort of a recuperation, (inaudible)?

#8: Oh, yes. It's like Karla would say, regrouping, "let's regroup." Yes. I think it will probably be a time to re-evaluate and try and see what other sort of options are available. It's like

everything else like I felt like critical care sort of fulfilled something. You know it was a challenge. I took the eight month intensive care course and it was something new and exciting to do for a while and then after a while it was like (inaudible) been there, done that. And then you know up north was another experience and like I said it was maybe a bit of a stepping stone and probably opened up some doors for me. I see where I might want to go next, like into the nurse practitioner area. I'll never say I ever resented going up north. Never.

Me: Just to return to something that we've talked about before about doing this for years and years, would you ever see yourself doing that?

#8: Years and years, make it a career up north? Well, I would hope not. I don't tend to think too, too far down the road because you never know what's going to happen. A lot of times I go with the flow, but I think if there was nothing else, I would --- no. I don't want to stay up north on an Indian reserve for the rest of my life. I would like to get into different areas. I think I'd like to get into community health. I think being up north has shown me that I'm not so sure if I want to live in the city, I think I might always want to live in a smaller place but not way up there in the boonies anymore. I mean I like being out in the country, but I like to have some access to things I enjoy, like going to restaurants, maybe going to a play. Gibson's kind of culturally barren.

Me: I think I can appreciate that.

#8: Relate.

Me: Relate to what you're saying. Yes.

#8: Making a career of it? No. I would hope not. I think it would have to be a case of not being able to find anything else and I don't think things would get that hard. The way employment

goes, it goes in dips and we're in a terrible dip right now, I think. I mean health care is moving in a different direction and it is definitely moving into the community. I think that's where the jobs will be and that's why I'm interested in, I think that's where I'll try to start (inaudible). Usually if I make up my mind to do something, I usually do it.

Me: I'm trying to fathom why not by the things that you're not saying in terms of why not make a career of it, but to me it's what I understand you saying to me is that I don't have to in the first place, and the second place, there's other things I would like to do.

#8: Well, yes.

Me: And as a last resort I will think of it but that I don't have to right now --

#8: Right.

Me: -- so there are other things that I would like to move on to.

#8: Right. I think that sums it up.

Me: Great. Thank you so much.

Identification of Significant Statements: Respondent # 8.

PRIVATE

I've enjoyed it for the most part.
It's basically been what I thought it would be.
challenging, it's been very interesting work.

I found it interesting learning about the different cultural group which I really knew nothing about before

I've learned tons, made my money.

That wasn't the main reason why I went up, but it helps because I would like to get into community health someday,

I've come from a critical care area to there.

critical care, I did that full time for two years. That was enough. I've had my fill,

I knew nothing about the Indians.

I think I'd only seen them like I said lying around drunk on Main Street before certainly I had my share of that in Gibson,

but you certainly see them sober.

They rarely come into clinic during the day drunk. For the most part, sober.

they sort of begin to know you and trust you and talk more and you laugh along with them,

the whole experience of living on a reserve, isolated in the north, that that's a whole thing in itself too.

the conditions that people live in,

no running water

doing wash for 15 kids by hand

spending all day chopping down wood so you can heat your house.

you go into some of the houses in the winter time and they're freezing.

It's eye opening and then how the Band runs things. That's another thing.

The mismanagement.

The Band's broke right now.

You just shake your head, like, where's it going to end?

the not caring for the environment.

this is a fairly negative experience. I guess so.

It's all part of the eye opening part I think, you know, I've seen these things.

What's good? Well, they're basically a fun loving people, but kind of screwed up.

I would say it's been more of a positive experience even though it doesn't sound like it.

I guess it because I'm trying to take everything all in together,

like learning about the culture, the experience of living in the nursing station doing that kind of work, operating the nurse practitioner role.

I think now I've seen that I think that's the area I want to go into.

I would like to go down that path now.

my choice in the jobs I've had over the years have gradually been more positions with more and more independence. then I went into critical care where you're very independent actually and given wide open doctor's orders,

it is kind of there, but you do a lot of stuff on your own.

This is gone even more, you know, you're it. A lot of people say to me isn't that scary, but I've never found it that way. I don't know why because I know I can always pick up a phone and I can phone a physician somewhere and get some advice on something and you don't have that (inaudible).

I guess the gradual gaining of independence, making your own decisions not relying on other people so much.

I've had lots of experiences and you feel good when you've diagnosed something correctly and actually over the years it gets easier, you've seen things you can rely on past experiences more and gut feelings. someone comes in with a complaint, you have to take a history and do a physical assessment and basically come up with a diagnosis. it is not something you're taught in nursing school. That's the physician's role.

I guess it must affect your self esteem.

I don't think I was ever really lacking in it, but it certainly hasn't -- I mean it's definitely helped a bit more.

I shouldn't say I wasn't lacking in it, but, you know, once in a while you'll have little things, "oh, can't do that, couldn't possibly do that." I don't say that so much anymore.

I think it's a positive thing.

I think it's good to be independent.

I'm not saying you shouldn't rely on other people for anything, but when it comes down to it, you know, you have to help yourself. No one else is going to.

If you want to do something you have to do it yourself. No one else is going to.

I don't think I let things really get to me.

I don't. There's some things, but for the most part I think I tend to let things roll off of me.

I'm a type B personality, I'm quite laid back.

I've had that on past jobs, my performance appraisals. I have a calming affect on people

If something happens, I don't go off in a flap. I don't know why I'm like that, it's just that's me.

the first thing that comes to mind is the Rina thing and if we can use that. You know what I'm talking about. It always seem to be things that aren't really inherent in the work but it always seems to be something else, like something maybe in my personal life but not the work specifically I don't think that's an interpersonal issue you know, just to make it clear for transcription, that was an interpersonal thing.

I've known Rina since about ten years so I consider her a fairly good friend. You know you have an attachment to that person and when you see something like that start happening, you know I guess I seen it happening but I -- here I am, I'm going to eat my own words. I said I didn't feel I could do anything about it. Like I really felt it was over my head. I just didn't know -- did a lot of (inaudible) which I see now I shouldn't have. I've learned from this experience.

A lot of it was just telling her how I felt about things that she was doing. Not telling her.

I'd flap off to somebody, you know, Karla was there to listen,

Or I'll phone up a friend in Winnipeg, "oh my God," you know. They just probably sit there and listen to me spout off and not have a clue what I was really going on about, but.

it's a strange position because your friend is your boss and you have the work part that you have to separate from the social part.

And that worked up until recently and then it really got to be a problem in resolving the issue I think or for letting it go on for so long.

I never felt really overwhelmed by it or anything but just sort of nagging on your mind,

I would talk to somebody. If I feel stressed out I'll talk to someone about it.
 I tend to intellectualize things a lot, I'll sit and think about it, what's going on.
 Another thing, I can go for a walk.
 I made up my mind I am leaving the end of March.
 I don't think I'm burned out, I just feel that I've had enough, you know, three years of Gibson,
 three years of no road,
 not being able to get out for a weekend off
 not enough staffing,
 being confined to this one little community.
 I guess the whole lifestyle of being so closely tied to your work, I don't think that that's healthy.
 I think burnout depends on the individual.
 some people are obviously a lot more prone to that than others.
 at first these things are easy to cope with but then after awhile, like you said, an erosion.
 I have not really eroded so much yet but if I stay it will. I think.
 I just feel I'm ready for a change.
 So I'm taking a six month (inaudible) the end of March.

I'm going to do is I'm going to travel. I'm going to sort of live out of my car for awhile, head out to
 B.C., the Yukon. I'd like to work (inaudible). I might just drive out there and make it like a job
 hunting, like a holiday combined job hunting thing, just to see what else is out there because I know
 it's just pitiful right now for jobs.

I'm not going to quit. I mean if I don't find anything else, well, I'll go back to Medical Services, but
 I'm not going back to somewhere like Gibson. I might even try another province.

I guess just being so unconnected from the rest of the world
 almost, like you're in some northern bubble.
 Like I have often felt those people in Gibson they haven't got a hot clue what it's like.
 I just figure off the reserve there's no way they'd survive, like they haven't got a clue what the real
 world is like.
 they're so dependent
 I know that's part of the whole slue of things, all this history and whatever.

I stay healthy by trying to stay connected with the outside,
 phone calls to friends and family, watching the news, getting out frequently, like we've said this how
 many times, like even a weekend out in Thompson. You sort of connect again.
 So we were just talking about our staying healthy. Oh, and something that I -- you also exercise, I
 know that you do exercise.
 I try to eat right.
 That's kind of hard sometimes, lack of fresh fruit and vegetables sometimes.
 I guess trying to do a variety of things, having interests.
 Like I enjoy reading, I'm doing some crafts, I love listening to music,
 I like getting outside on the Hondas and the snowmobiles wherever the season.

Of course there's a lot of socializing that goes on here.

Do you think that the fact that you don't have a family makes it easier? Yes and no.

people you befriend up there you wouldn't probably normally have. I mean you need that human contact. You need to be able to have an intelligent conversation with somebody else. I don't mean to bat down the people in Gibson, but most of them I can't exactly talk about the latest John Irving books I just read.

It's like Karla would say, regrouping, "let's regroup." Yes.

I think it will probably be a time to re-evaluate and try and see what other sort of options are available. it was a challenge.

I took the eight month intensive care course and it was something new and exciting to do for a while and then after a while it was like (inaudible) been there, done that.

up north was another experience

like I said it was maybe a bit of a stepping stone and probably opened up some doors for me.

I'll never say I ever resented going up north. Never.

A lot of times I go with the flow, I think I'd like to get into community health.

I think being up north has shown me that I'm not so sure if I want to live in the city, I think I might always want to live in a smaller place but not way up there in the boonies anymore.

I like being out in the country, but I like to have some access to things I enjoy, like going to restaurants, maybe going to a play.

APPENDIX E**RESPONDENT #9**

Me: I would like you to tell me about the experience of working as a nurse in the north, tell me how it's affecting you and how it makes you feel. I would like to know whether you find it stressful and whether you feel burned out sometimes. I would also like to know how you cope with this, or to put it differently, how you stay healthy. Take your time and you can start whenever you like.

#9: Can I just sort of read that and answer (inaudible). It's been a long day. We're renovating. Working as a nurse in the north. I prefer it to working than rather working in the city. I mean we have more autonomy and you're allowed to think. I think it's made me a better and a stronger nurse and how does it make me feel? I really enjoy it. Stressful. At times it can be very stressful but lots of times, well, especially in the last few months, the most stressful part was dealing with the nurses I was working with and with some of the zone officers. That I find usually more stressful than the actual work.

Me: Why would you say that?

#9: Okay. Well, with those nurses, personality clash, you know, just sometimes I felt like I was dealing with youngsters instead of mature women that are supposed to be professionals. You know their attitude, the way they were working. Mostly after hours as opposed to in clinic, they tended to be a bit more careful in clinic with their attitude. But the zone officers, other than one that I really enjoy working with, I don't find that they support the nurses very well. If a nurse is complaining of something either personal or whatever, because as a union steward I was hearing a lot of this and I have experienced myself, the first thing they'll say is you're burned out when that's actually not the case. It's just that they're going through a stressful

time and it's almost like the want to maybe name, just put that -- most people think of it as a stigma, but they just don't seem to listen.

Me: What is a stigma?

#9: What is a stigma? It's sort of like a -- what is a stigma? It's like a --

Me: No. No. I mean what do you mean, is the stigma --

#9: Well, burn out is not a stigma to a lot of people but the way they say it, you know you tend to take it as such. And a lot of nurses -- and they -- I think this (inaudible) in stress started, the briefing teams, they're a little bit more supportive but I know before they weren't. But there's still a lot of work to go on their part for supporting the nurses in the field. (inaudible). Burned out sometimes? Stressed out is more like it. Very tired (inaudible). I know when I left Lutz in June I was really glad to leave. That wasn't so much as (inaudible) as the nurse who I was working with, though. I just couldn't handle them anymore. How do I stay healthy, or how do I cope? I'm lucky. I have a lot of friends that I can phone at anytime of the day or night and they'll sit and listen, and I can talk to them about mention person's names and situations I've been through or I'm going through. I find, too, that if I can get out frequently, like every four to six weeks. I find that really helps. Even if it's just for a weekend or a day, even. The odd time I used to go out just for the day (inaudible) and that was a nice break. I'm not afraid to say when I'm tired. I don't know of that's a plus or whatever, like I'll tell Jan I'm tired, can I come out for a while or something (inaudible). Talking about it, I guess is about the best thing that I can think of that I do is talking about what I'm going through.

Me: So what do you think burn out is?

#9: Burn out is to me -- I don't know, maybe I'm wrong, but to me burn out is when you don't enjoy your work anymore, you don't function well. I can't say you don't meet deadlines, but there's sometimes things happening and you just don't meet your deadlines. I don't know just that you don't enjoy your work, like you just don't want to be there anymore. For me it was -- if you want to consider it burn out, for me it was I didn't want to be around those nurses anymore. I just didn't want to be around them.

Me: Because of the feeling you mentioned, the maturity?

#9: Yes. You know, whispering behind the back, the purposeful isolating, the talking in angry tones when a simple question was asked. Just little things like that. It just built up and built up and it was like before it was once in a while and then it was like almost every day and then it was several times a day and then it was just like, phhhh (phonetic), I don't want to deal with this anymore. If I asked them how things were, they'd say things were right and fine and then I find out later it wasn't or they wouldn't even answer at all. Like they wouldn't want to discuss anything. I mean how do you deal with that? I don't know how to deal with stuff like that. That's probably something I should learn, but how do you deal with people who don't want to talk and tell you what their issues are and you know you're supposed to be supporting each other in the type of work that we do. But having the long break that I've had from them, well, to me was a bonus. I'm feeling much better and stronger. Whether I want to work with one of them in particular, that's debatable. The other one, yes, I'm willing to try again.

Me: So the experience of working in the north --

#9: Generally, is a good one.

Me: Tell me a bit more about your experience of the community.

#9: The one I was working in most recently, like Lutz? The first couple of years it was hard because there was only two of us and there should have been three. We dealt with a lot of trauma, really bad trauma, a lot of deaths and to me there was a couple of deaths I found really difficult to handle. One was a munchkin, when a munchkin died and the nurse there was quite cynical and when I was sitting there and I had tears in my eyes, she just turned and looked at me and said, "I don't know what you're crying for because you're born and you die and that's all there is to it." It was just like nothing else that this (inaudible) and I found that really hard to take. There was just no support and stuff. Another one was a traumatic death that we all went through and it was just that he was such a nice person and I'd seen him lots in the clinic and that took me a long time to get over but I'm over it now. I think I am, anyway. I don't feel bad about it, like I know we did everything we could.

Me: How long had you been there?

#9: Over three years. October '90 till June '94, I guess. It would have been (inaudible) whatever. I find, like as much as I enjoyed Tatawa where I was there for a year and I was in Nelson for six months, I found I enjoy it far more than I did the six months in Nelson. In Lutz the clients are more receptive to you. The majority of them appreciate when you do something nice for them or if you help them. I even had patients phone back or see me on the road there and apologize if they swore at me the night before. I mean I never saw that in Nelson, I mean they just liked to swear at you and that's all there was to it. But in general I enjoyed working there. Like I said, the thing that was hardest to deal with was the (inaudible) because most of them feel a nurse shouldn't be there more than a year and they would do everything they could to get you out like saying you're burned out, it's time you left, it's too stressful for somebody to be there that long and always having to hear that.

Me: So the way that they deal -- to your feeling is that the way that they deal with that, is not support but just taking the nurse away --

#9: Yes. Right.

Me: -- to somewhere else, or wherever?

#9: Yes. That's the way they deal with things and they don't really listen. We've had several conversations where I've said you can work anywhere no matter what the conditions are if you work with someone that you enjoy or that you get along and work well, or if you get out frequently and if you get our frequently. And I said it's not just Lutz, it's everywhere. And I still believe that. But they just don't listen. They're just not listening as far as I'm concerned, just by some of the comments they have to make.

Me: Give me an example.

#9: It doesn't matter -- oh, how did that one put it? It doesn't matter how often you get out but when you're dealing with as much as you deal with in Lutz, you shouldn't be there more than a year. And yet as far as that goes, when I was in Nelson, we saw trauma far more than we saw it in Lutz. We just see more deaths in Lutz but the trauma was just as bad if not worse. When I was there, we were averaging three, four hours sleep a night if we were lucky, where in Lutz you can sleep the whole night through sometimes, well, not just sometimes, frequently. And yet they never say anything about Nelson.

Me: Is it a bigger nursing station?

#9: We were three nurses when I was there, it was a three nurse station. I think it's up now. I think it's four.

Me: I can't remember. I might have been there before.

#9: I think it's four now. I can't remember. (inaudible).

Me: Okay. So you feel there's a lack of support, a misunderstanding, maybe, about burn out or do you think that people just accept that you will burn out after a year in the field?

#9: Yes. Yes.

Me: Okay. Come what may.

#9: And I sometimes wonder -- yes. Come what may. And I sometimes wonder if that is because of what used to happen before when they take nurses straight out of training who had no --

Me: Experience.

#9: -- experience or anything and apparently from what I understand and from what I've heard, that happened quite frequently, but now the majority of nurses that are coming out into the field I should say, have several years experience and they basically know what they're getting into. Before you didn't.

Me: But they still deal with it in the same way, that's what you're saying, they still think that after a year -- or is that just Lutz?

#9: I never heard that about Nelson or any of the other stations, it's always Lutz. I've never heard them say -- because when I've asked them about them, well, what about Nelson, that was more violent when I was there than Lutz is, I mean Lutz goes in spurts whereas Nelson was continuous, and they said, well, you can get out easier. Well, no, you can't when there's only two or three of you and you're so tired you don't want to get out. You just want to go into your apartment and sleep because you're so tired because you've only had a few hours sleep.

To me that doesn't make sense. I think they should get nurses out frequently, more frequently in all the stations and not just one that they think (inaudible).

Me: What more about working in the north? You also like the autonomy, you like the fact that--

#9: Oh, yes, that they let you think and I'm glad they have the limitations that they do, there's certain things we're not allowed to do, well, we're not doctors and there is guidelines and I'm glad there's the guidelines there. It just makes things a little bit more safer for the patient. I think that's what I want to say, otherwise you just might have people just thinking, well, this is the best thing to do when it really isn't. But it gets scary, though, when you have a -- because I know a few times we've had cardiac cases and the phone lines were out and you just sort of fly by the seat of your pants and you pray that all things are going to mesh. A couple of times that's happened when I've thought, "what am I doing here, like this is nuts." But that stuff doesn't last very long it's just sort of (inaudible) but I'm always glad when the phone lines come back on. You really have a sense of isolation though because you kind of wonder if they know out there if your phones are out. One thing about Medical Services that they've changed just now, is when they know the lines are out that they -- last time the phones were out when I was in Lutz and I was out in Thompson, they sent one plane to the triangle, that's Brochet (inaudible) and (inaudible). I can't remember where the plane sat, I think it was in Brochet and they have radio phone that works, it actually works and then a Medi Vac plane sat there in case they needed it in any of those three stations, and then they sent one to Lutz to sit there just in case, and it was good because we did need it. Then the phone lines came back and the planes didn't have to sit there. That was nice. That was the first time they ever did that and it was very well received. (inaudible).

Me: So in terms of staying healthy?

#9: The only bad thing for my health is the fact that I smoke. I eat well, I have the usual binges,

sometimes I'll have a junk food night and stuff. Physically, healthy that way. I think I eat well and I try and maintain my weight so it's not too high or too low. Staying healthy, sometimes just talking about --

Me: Yes. You've mentioned the talking and discussing things particular (inaudible). So these things just make you feel stressed out from time to time when there's a lot of things going on in the station?

#9: I think the most I've ever felt stressed out was when they left me in there by myself for a week. I was really stressed, I was really exhausted too. I was really tired, physically and mentally. I'll never let them do that to me again. Before I just didn't -- you know, I thought it was okay but I found out it wasn't. So I know better now, I've learned from that. With the union's help we've sort of made it mandated that nurses are not left alone like that ever again. At the max it's three hours if they have to go on a Medic Vac, but they have to return right away type of thing, but not for a day or certainly not for a week like I was. When I left in June, I was really tired. I just collapsed. I was just tired.

Me: What is this being tired, can you be more explicit?

#9: I think it had a lot to do with being really sad because of one of the nurses, like someone I thought was a friend and seemed to have turned and taken -- like I've never had a friend do that before and I guess sad hurt. Hurt is the only word to use. And I was just tired, like I just wanted to sleep and I did sleep for about three days but then after that I just started getting my energy back and you know, I've got to start making some decisions here, and then you go back and do this or be in that situation, am I going to stay away, and I decided to stay away and I was glad. I think I needed that time away from them. In Lutz, I don't know, there's something about Lutz that I really like and I don't know what it is. I don't know if it's the people or if it's the challenge. I think a lot of it has to do with the challenge of working there.

I really like working there as opposed to the other stations I've been in and it's not to say anything bad about Tatawa because it was a good experience there too, it's just Nelson. Nelson was a blur because I just worked and slept for six months. It was horrible. You see during that last few months with the girls, even though I was sleeping, it wasn't a restful sleep. I'd wake up tired even though I'd go to bed early sometimes, not even go to bed early every night, but sometimes, you know -- and I think it was just knowing I had to deal with them again the next day, it just tired me out.

Me: It wasn't holding up all the time, then, and it got worse as time went on?

#9: Yes. Yes. Because it seemed as time went on, the less and less they talked and admitted things and would deal with things and it just got to the point that -- because I can remember talking to you and to Jan about it and just nothing worked. Nothing worked. So maybe we all needed a break from each other, I don't know, but I was told I had to leave. I know I mentioned to you about that was the first time I ever left the station crying in all the time I've worked up there. I always felt strong when I left, well, basically strong, maybe tired but strong. That was the first time. When I'm leaving having them yell at me and stuff and not to acknowledge when I left, that really, I guess it hurt. It hurt a lot. I don't know, just no support, nothing.

Me: How do you think one recuperates from that?

#9: From that type of situation I was in? Well, for me, I don't know how for everybody, I guess it's different for everybody, but for me, going away to Montana for a week did wonders because my family, when I got home, they couldn't believe, they said that was the worse they've ever seen me coming out of the north. And it just hurt so much I couldn't even tell them what I'd just been through with the girls. And I didn't. I said, "I can't talk about it right now. You have to give me some time here." And I'm thinking, when did I get out, Thursday,

Friday? Friday I guess I left. Anyways, on the Sunday I went to Montana for a week and it was at a sun dance. And just for me praying and just being by myself, I mean there's people around me, but just being able to calmly think about things and being so far away from it, I just felt so much better and lighter when I go back, like I just felt good. But it was something I knew I had to keep working at and I just took my time with it, like I didn't rush it. I just thought about it and it just made me think about what I'd been through. I don't know. That's a hard one to answer other than the fact that I do know going to Montana for that week really helped. It was incredible. I couldn't believe the difference. I just felt so much better and it's really hard to explain. It may be the fact that for those four or five days I was there, we'd get there about seven in the morning and leave about nine at night and you know because we'd have lunch and stuff, we'd bring that all with us, and just praying and just listening to the music and just sort of getting into myself again as opposed to having to deal with everybody else's problems and stuff. I don't know. I can't answer that one. That's so hard to answer. All I know is it worked for me. It's starting to work for me. It's started the healing process. If I hadn't gone there I don't know, I just don't know. I think it would have taken longer.

Me: It's an introspective thing that you're talking about, beginning to think about what happened, beginning to strengthen yourself.

#9: Yes. Because basically it's a lot of that, that's a lot of what I did.

Me: You've started there, you've continued there.

#9: Continued. Yes. Even my family noticed a difference and they said you look so calm, you look so -- you look like you again. And I felt like me again.

Me: Sorry. I just want to turn this over. - (Side A ends) - So after that, you have slowly used time off.

#9: Hmm-hmm. And this last time with me coming out was sort of forced on me by one of the (inaudible), actually the one that I had most of my problems with and she gave me three choices and one of them was to come out for critical incident stress debriefing and because I knew her and had dealt with her in the past and sort of run into brick walls, like she was just so closed, she just does not listen, I thought I'll take that one because I don't want to deal with this woman anymore. And actually it was the best things I could have done, because it's giving more time at home and I've started working on my house which is something I've always wanted to do since I got it. It gives me more time with my friends, not that I've never lost touch with my friends because I cannot see them for weeks on end and come in and pick up like I just saw them a few days ago. It's been a nice break but I'm ready to go back to work, but as long as I don't have to work under that (inaudible) and that will be one of the things I'll insist on. But I know that at times I'm going to have to work with her but as long as she's not my -- what is the word? Oh, shoot. It was given to me a couple of weeks ago, I can't think, but where she's my main boss. Like I prefer Jan as my boss. Jan is more reasonable, she thinks and she cares about her nurses. She listens.

Me: So do you think that something like burn out exists?

#9: Oh, yes. Yes. I can't say that -- like I don't know. Was I burned out when I left Lutz from dealing with those girls? It's not that I didn't want to do my job anymore, I just didn't want to work with them. I was burned out with them.

Me: And you felt tired.

#9: And I was tired.

Me: And you felt --

#9: And I think a lot of that tiredness had to do with the stress of having to deal with them everyday and sort of waiting, now, what's next that are they going to pull? What stunt are they going to pull next? And I found that very stressful. I don't know. I think most people would find it a bit stressful. But I still liked my work. I resented having to leave. Because I couldn't get them to really be honest about what was going on, I knew somebody had to step out for a while and I knew they wouldn't, and I really resented that it had to be me, but I knew that was the only choice I had. I really resented that and I still do a little bit, not as much as I did, but. (inaudible). But, yes, it exists I think. Can you be burned out from people?

Me: Yes, you can.

#9: Well, I think I was then, in fact I'm sure I was with those two. And it was like we were all sort of struggling some how with something. But I want to go back to Lutz, I like my work there. I feel like I've left something undone and I don't know what it is, but I have to go back and see. It's never been my intention to stay there forever and retire from there type thing because it's just that I just have this feeling that I've left something undone. I don't know what it is. When I was ready to leave -- I knew when I was ready to leave Tatawa, I knew when I was ready to leave the ICU and I knew when I was ready to leave Churchill, and I certainly knew when I was ready to leave Nelson, but I haven't hit that point yet with Lutz.

Me: Were you involved a lot in seeing patients or was it more administrative?

#9: When I first got there?

Me: No, now at the end.

#9: At the end? It tended to be more administrative and only in the fact that it was all the suicides that we were dealing with. I found as much as I tried not to get pulled in and I know I refused

to go a lot of the meetings, I found that Chief and Council were dragging me into a lot of meetings, so for me, that's administrative. And it just seemed every time I turned around they had another meeting because they were so concerned about all the suicides and yet they also wanted us to make sure that we didn't forget about the other issues like the other projects that we had started there and whatnot, and it just seemed they were (inaudible) me away and I do prefer patient care as opposed to admin. When I initially started there I found I was doing a lot of my admin work after hours, like I was going to bed after midnight doing admin work because I just didn't have time, but I found once we had the three nurses it was easier to sort of keep caught up, but then at times like I said, being pulled into all these meetings and it was almost like Bill, well, he did warn me that's why he was joking, he warned me that once he became Chief, I would be pulled into a lot more meetings than I've ever been to before. And I thought he was joking but he was serious, but I know I managed to get out of a few and I'd send Wendy to a few because I didn't think it was necessary for me to be there, but it just seemed I was getting dragged into that admin stuff.

Me: Okay. No, I think we've covered everything. If there's anything that comes up when I look at the transcription of this, I'll let you know, but, no, for now, this is just fine. You were a bit vague on how you stay healthy you know.

#9: You know because, Charl, so many people have talked to me about that. They have asked me and I don't know how to answer that. I know when I was younger, when I first started nursing and stuff, I was taught the old school, nurses don't cry, nurses don't talk about what they've been through, nurses are strong, nurses are supposed to do this, this and this and be the support for everybody.

Me: Which is of course utter nonsense.

#9: Right. But it took me a long time to learn that and once I've learned it, like I do, like Sharon

and Wendy, I can talk to them about what I'm going through. I have friends that I'm really close to and again, and I'm serious, I can phone them at three, four in the morning and say, "listen, I'm sorry, but I have to talk to somebody." And they'll say, "sure," and I have friends that do that to me the odd time. But I think for me it's just -- I think it's something I just learned along the way. Like I've been nursing for over 20 years, I started nursing when I was 19 and 20 and I'm 44 now, so -- but I have learned the hard way, like holding everything back or inside (inaudible). So I don't know. To me, I don't know.

Me: Do you still follow that old school sometimes?

#9: With certain people, yes, and there's some people I won't tell a thing too, but there's others I'll just spill my guts to. (inaudible). Like this business with Wendy and Karla and Drew (inaudible) like I didn't see her when I first came out, you know, from Lutz, I saw her after I got back from Montana and stuff, and she came out for coffee with me and I'm not sure we sat and talked about five hours and it was just --

Me: But do things get resolved when you talk, do you feel better afterwards?

#9: Yes. Oh, yes. Well, yes. Sometimes it takes longer (inaudible).

Me: No, I mean you must understand one thing, you're not burned out today and not burned out tomorrow.

#9: No, I know, but --

Me: Burn out is different --

#9: It accumulates.

Me: -- or the stress. Yes.

#9: No. I understand that.

Me: But it starts the process for you of dealing with it on a complete level, that's what it sounds like to me when you talk to your friends or to other people, somebody that you trust, it sounds to me as if, well, at least you get it off your chest and that's how you begin to deal with it.

#9: Hmm-hmm.

Me: It's not necessarily finished, but --

#9: It's starting. Yes.

Me: Yes.

#9: And I don't know, like, so many people, no, not so many people, a few people have asked me that saw me when I came back from Lutz and then saw me when I got back from Montana, and that was the hardest part to explain because I don't know what happened other than the fact that I had that time to sit and I didn't have anything else around me, I didn't have anybody else other than Tanya (phonetic) because we went to support Gerrard, but he was dancing (inaudible), so I didn't even have him to talk to. I don't know. I'm not being vague on purpose, I just don't know. It's just never something I've thought about. To me it's just normal to talk about feeling bad about something. To me it's normal. But I pick and choose who I do it to. I don't see anything wrong with that.

Me: No. It's -- that's just one way of doing it. Other people -- it's a form of social support. You have selected social support people that you feel comfortable with, you'll talk to and that's a

form of social support and it's an acknowledged way of dealing with stress and with burn out.

#9: And even with Wendy, not Wendy (inaudible) that is, with her being so stubborn and the fact that as much as I was angry at her because she just didn't give me any choice but leave, I thank her now because I've had time to do my own thing and not have to worry about anything other than the renovations that we're doing (inaudible), but it's fun like you know, I'm enjoying it and a couple of my nephews are really into this kind of stuff and they offered and they're helping --

Me: So you don't think that you were -- you're not sure about being burned out when you left, you were burned out for that specific situation, but not --

#9: Yes. See I don't know because that was so prominent with me --

Me: Yes.

#9: -- that I don't know. That was the thing that I found I had to deal with the most. I know I didn't have any problems with the community that I know of I don't know if any people stopped kept coming to me and stuff. I don't know. Am I supposed to know if I was burned out in the community when, for me, all I could think of was getting away from those two? I don't know.

Me: I can't tell you either, I mean, it's irrelevant for the purpose of this discussion. The point is it's interesting that how you dealt with it, that's what I want to know is that if you were burned out in a specific segment of your life in terms of your interpersonal relationship with those two, with your two coworkers, and how you recuperated from that, that's what I'm getting at.

#9: See, and I've sort of dealt with it because I had the mediation with Wendy and that went well, I mean there's still a lot of work for us both to do, but I still have no desire to have the same thing with Karla as far as I'm concerned. Not that woman. I don't know. I mean this it. I have nothing for her whereas I know it's never going to be the same with Wendy but at least we (inaudible). And I don't even feel bad about not wanting to have to (inaudible). (inaudible) because I've never felt that way before, but for some reason there's just nothing there for me. Is that bad?

Me: No. No, it's a choice that you make.

#9: I don't know if I want to go back and deal with her again. I still can't answer that. Sandra I would more than -- yes. I'd go back and work with her and see how it works, but I can't answer for Jennifer, like I don't know.

Me: Well, thank you so much for this. Like I say, if I need to talk to you again, I will.

#9: Yes. Let me know how I did on that thing.

Identification of Significant Statements: Respondent # 9

PRIVATE

I prefer it to working in the city.

we have more autonomy and you're allowed to think.

it's made me a better and a stronger nurse

I really enjoy it.

At times it can be very stressful

The most stressful part was dealing with the nurses I was working with and with some of the zone officers.

Dealing with co-workers and management I find usually more stressful than the actual work.

with those nurses, personality clashes

I felt like I was dealing with youngsters instead of mature women that are supposed to be professionals.

Mostly after hours as opposed to in clinic,
they tended to be a bit more careful in clinic with their attitude.

the zone officers, other than one that I really enjoy working with, I don't find that they support the nurses very well.

If a nurse is complaining of something the first thing they'll say is you're burned out when that's actually not the case. they just don't seem to listen.

burnout is not a stigma to a lot of people but the way they say it, you know you tend to take it as such.

they're a little bit more supportive but I know before they weren't.

there's still a lot of work to go on their part for supporting the nurses in the field.

Burned out sometimes? Stressed out is more like it.

Very tired (inaudible).

when I left Gibson in June I was really glad to leave.

That wasn't so much the work as the nurses who I was working with,

I just couldn't handle them anymore.

How do I stay healthy, or how do I cope? I'm lucky.

I have a lot of friends that I can phone at anytime of the day or night and they'll sit and listen,
I can talk to them about mention person's names and situations I've been through or I'm going through.

I find, too, that if I can get out frequently, like every four to six weeks, it really helps.

Even if it's just for a weekend or a day, even.

I'm not afraid to say when I'm tired.

talking about what I'm going through.

Burn out is to me when you don't enjoy your work anymore,
you don't function well.

sometimes things happening and you just don't meet your deadlines.

you don't enjoy your work,

you just don't want to be there anymore.

I didn't want to be around those nurses anymore.

whispering behind the back,

the purposeful isolating,

the talking in angry tones when a simple question was asked.

Just little things like that.

It just built up and built up

it was once in a while and then it was like almost every day and then it was several times a day

I don't want to deal with this anymore.

If I asked them how things were, they'd say things were right and fine and then I find out later it wasn't or they wouldn't even answer at all.

Like they wouldn't want to discuss anything

I don't know how to deal with stuff like that.

That's probably something I should learn, but how do you deal with people who don't want to talk and tell you what their issues are and you know you're supposed to be supporting each other in the type of work that we do.

But having the long break that I've had from them, well, to me was a bonus.

I'm feeling much better and stronger.

Whether I want to work with one of them in particular, that's debatable.

it was hard because there was only two of us and there should have been three.

We dealt with a lot of trauma, really bad trauma,

a lot of deaths and to me there was a couple of deaths I found really difficult to handle.

One was a munchkin, when a munchkin died and the nurse there was quite cynical and when I was sitting there and I had tears in my eyes, she just turned and looked at me and said, "I don't know what you're crying for because you're born and you die and that's all there is to it."

I found that really hard to take.

There was just no support and stuff.

Another one was a traumatic death that we all went through and it was just that he was such a nice person and I'd seen him lots in the clinic and that took me a long time to get over

I know we did everything we could.

the clients are more receptive to you.

The majority of them appreciate when you do something nice for them or if you help them.

I even had patients phone back or see me on the road there and apologize if they swore at me the night before.

But in general I enjoyed working there.

the thing that was hardest to deal with was the zone office

Most of them feel a nurse shouldn't be there more than a year

they would do everything they could to get you out like saying you're burned out, it's time you left, it's too stressful for somebody to be there that long and always having to hear that.

they don't really listen.

I know you can work anywhere no matter what the conditions are if you work with someone that you enjoy

I know you can work anywhere no matter what the conditions are if you get along and work well together,

I know you can work anywhere no matter what the conditions are if you get out frequently

I still believe that.

They're just not listening as far as I'm concerned, just by some of the comments they have to make.

The preconception is that it doesn't matter how often you get out but when you're dealing with as much as you deal with in Gibson, you shouldn't be there more than a year.

As far as that goes, when I was in Nelson, we saw trauma far more than we saw it in Gibson.

people just accept that you will burn out after a year in the field.

I sometimes wonder if that is because of what used to happen before when they take nurses straight out of training who had no experience or anything that happened quite frequently, but now the majority of nurses that are coming out into the field I should say, have several years experience and they basically know what they're getting into. Before you didn't.

you can't get out when there's only two or three of you and you're so tired you don't want to get out. You just want to go into your apartment and sleep because you're so tired because you've only had a few hours sleep.

I think they should get nurses out more frequently in all the stations and not just one that they think is high risk

they let you think

I'm glad they have the limitations that they do,

there's certain things we're not allowed to do,

we're not doctors and there is guidelines and I'm glad there's the guidelines there.

It just makes things a little bit more safer for the patient.

it gets scary, though, when you just sort of fly by the seat of your pants

I know a few times we've had cardiac cases and the phone lines were out

you pray that all things are going to mesh.

A couple of times that's happened when I've thought, "what am I doing here, like this is nuts."

But that stuff doesn't last very long

sense of isolation though because you kind of wonder if they know out there if your phones are out.

The only bad thing for my health is the fact that I smoke.

I eat well,

I have the usual binges, sometimes I'll have a junk food night and stuff.

I try and maintain my weight so it's not too high or too low.

The most I ever felt stressed out was when they left me in there by myself for a week

I was really stressed, I was really exhausted too.

I was really tired, physically and mentally.

I'll never let them do that to me again.

I thought it was okay but I found out it wasn't.

So I know better now, I've learned from that.

being really sad because of one of the nurses, like someone I thought was a friend and seemed to have turned and taken -- like I've never had a friend do that before and I guess sad hurt.

Hurt is the only word to use. And I was just tired,
I just wanted to sleep and I did sleep for about three days
after that I just started getting my energy back
I've got to start making some decisions here,
I think I needed that time away from them.

there's something about Gibson that I really like and I don't know what it is.

I don't know if it's the people or if it's the challenge.

I think a lot of it has to do with the challenge of working there

I really like working there as opposed to the other stations I've been in

Nelson was a blur because I just worked and slept for six months.

It was horrible.

that last few months with the girls, even though I was sleeping, it wasn't a restful sleep.

I'd wake up tired even though I'd go to bed early

it was just knowing I had to deal with them again the next day,

it just tired me out.

we all needed a break from each other,

I was told I had to leave.

the first time I ever left the station crying in all the time I've worked up there.

I always felt strong when I left, well, basically strong, maybe tired but strong.

not to acknowledge when I left, that really hurt a lot. I don't know, just no support, nothing.

for me, going away to Montana for a week did wonders

My family couldn't believe, they said that was the worse they've ever seen me coming out of the north.

I couldn't even tell them what I'd just been through with the girls. And I didn't.

I said, "I can't talk about it right now. You have to give me some time here."

I went to Montana for a week and it was at a sun dance.

just for me praying and just being by myself,

being able to calmly think about things and being so far away from it,

I just felt so much better and lighter when I go back, like I just felt good.

it was something I knew I had to keep working at

I just took my time with it, like I didn't rush it.

I just thought about it and it just made me think about what I'd been through.

it worked for me.

It's started the healing process. If I hadn't gone there I don't know, I just don't know. I think it would have taken longer.

Even my family noticed a difference and they said you look so calm, you look like you again.
I felt like me again.

she gave me three choices and one of them was to come out for critical incident stress debriefing
because I knew her and had dealt with her in the past and sort of run into brick walls, like she was just
so closed, she just does not listen,
I'll take that one because I don't want to deal with this woman anymore
it was the best thing I could have done,
It's giving me more time at home and I've started working on my house which is something I've always
wanted to do
It gives me more time with my friends,
It's been a nice break but I'm ready to go back to work,

It's not that I didn't want to do my job anymore, I just didn't want to work with them. I was burned
out with them.
a lot of that tiredness had to do with the stress of having to deal with them everyday a
sort of waiting, now, what's next that are they going to pull? What stunt are they going to pull next?

I found that very stressful.
I think most people would find it a bit stressful.
But I still liked my work.
I resented having to leave.

it was like we were all sort of struggling some how with something.
I want to go back to Gibson,
I like my work there.
I feel like I've left something undone
I don't know what it is, but I have to go back and see.
It's never been my intention to stay there forever and retire from there type thing
I haven't hit that point yet with Gibson.

it was all the suicides that we were dealing with.
I found as much as I tried not to get pulled in, I did get pulled in.
Chief and Council were dragging me into a lot of meetings
I know when I was younger, when I first started nursing and stuff, I was taught the old school, nurses
don't cry, nurses don't talk about what they've been through, nurses are strong, nurses are supposed
to do this, this and this and be the support for everybody.
it took me a long time to learn I can talk to them about what I'm going through.
I think it's something I just learned along the way.
I've been nursing for over 20 years, I started nursing when I was 19 and 20 and I'm 44 now,
I have learned the hard way, like holding everything back or inside (inaudible).

there's some people I won't tell a thing too,
but there's others I'll just spill my guts to.

Burnout is different --It accumulates.

But I pick and choose who I do it to. I don't see anything wrong with that.

I didn't have any problems with the community that I know of

I don't know if any people stopped kept coming to me and stuff.

I've sort of dealt with it because I had the mediation with F and that went well,

There's still a lot of work for us both to do, but I still have no desire to have the same thing with X

I don't know if I want to go back and deal with her again.

APPENDIX F**RESPONDENT # 10**

Me: Okay. I would like you to tell me about the experience of working as a nurse in the north, tell me how it's affecting you and how it makes you feel. I would like to know whether you find it stressful and whether you feel burned out sometimes. I would also like to know how you cope with this, or to put it differently, how you stay healthy. Take your time and you can start wherever you like.

#10: Okay. I started working for Medical Services in 1985. First I stayed in Norway House for a year and then from there I went to Lost Lake and I stayed in Lost Lake. I worked in Lost Lake for seven to eight years and then I left Lost Lake last year and now I'm working in Nelson.

Me: The experience of working in the north?

#10: I feel that nursing experience is far different from what you work as a nurse when you're in a hospital. It's interesting and the nurse is on their own. They make their own decisions and just do things on their own. They don't need doctors' orders and they don't have to have, like in the morning we have to do a bed bath and feed the patient, there's nothing like that in northern nursing, and it's just different. It's interesting when lots of things happen that don't happen in the hospital. Well, they do happen in the hospital but the hospitals, like you have medicine and surgery and OBS (phonetic), they're all separate, but in a station it's everything.

Me: And you have that responsibility (inaudible).

#10: Yes. And that's what makes the work interesting. And the people, they're different, the Indian

people, because most of the stations are on the reserves here in Manitoba, and I think there might be a few in other -- and they're isolated. So the nurses are very isolated some of them that work in the northern nursing stations. Maybe that's why there's such a high burnout of nurses in the north, because I have worked with quite a few nurses since I've been with Medical Services. Some of them stay a few years and some of them just stay a few days. (inaudible) talk about. Burnout. I think there's a high level of burnout in stations because I was burned out when I left Lost Lake. I felt that I was burned out, that's why I had to leave.

Me: What's your symptoms, what is burn out for you?

#10: I felt like I was starting to hate people and if I didn't get out of there I was going to hate everybody, and I had some not sleeping, I wasn't sleeping but my body was tired but I couldn't sleep and I had pain sometime, leg pain, headaches, just physical pain.

Me: Was this sort of triggered by specific incidents or was it just (inaudible) amount of work?

#10: It wasn't just work there was other things that were going on in the station where I was at that I felt caused the burn out that I felt for myself, but I also think now when I look back that I may have been burned out a few times before because --

Me: You were from the community?

#10: Yes. Because I'm from Lost Lake and I worked there and I felt that I had a lot of demand from the people because I was there, from there. They would talk to me all the time, like going even to the store, they'd give me their appointments or they'd start telling me about how they're feeling or their symptoms and what I think it was, and this was in the store. But the problem there, I think, was the language barrier that a lot of the people in the community, they

didn't speak -- mainly the older people, they don't speak any English and maybe I felt too that because I'm from there, they felt freely to talk to me whenever they wanted to talk which I don't see anything wrong with that but sometimes I felt they should go to the Clinic and talk over there when the Clinic is open.

Me: That was very tiring for you?

#10: Yes. I find that very tiring and sometimes I was exhausted. I was just so fed up with what was going on. So I had to leave.

Me: What were the positive aspects of being there?

#10: I find northern nursing very rewarding for me. When I was younger I was an LPN and I worked with Medical Services in a station for about three or four years in 1974 and then I left and after a while Medical Services didn't hire LPN's to go to work in the stations so I went back to school and I did my RN and I thought that was why I wanted to do my RN was to go back and work with the people there, you know, my people, work with them because I find that for me it's very rewarding to work in a nursing station. But I guess any nursing is rewarding if the people sometimes even just say thank you.

Me: What other supports were there for you, how did you cope with feeling tired and feeling burned out?

#10: I lived in a nursing station when I worked at home in Lost Lake and I had to leave because the nurses that worked there they're not from the community so they live and work in the same place and socialize. I don't think that's healthy. I think you have to leave your workplace and sometimes even socialize outside the workplace to stay healthy. I thought that when I was there, that's what I'd do. Maybe that's why I lasted in Lost Lake as long as I did. That's

because I leave right away after work and come home only when I was ready to go to sleep. That's when my family was in there because my husband left Lost Lake with the children, two years ago and I have a lot of support from them. That's my biggest support is with David and when he left we had a lot of times when I needed to talk to somebody it was like a long distance phone call, so I had a big phone bill. I still do. I have a big phone bill because that's my biggest support is David that I can talk to. Sometimes my family, my own parents, sometimes I felt that they didn't understand what was happening in the station, the pressure that we felt, the after hour calls and people that were so (inaudible). People sometimes, well, I guess they don't understand what's happening. When people call you they think that's the first phone call you got is when they're talking to you but in the meantime, you've got lots of phone calls before that.

Me: So at times when you felt burned out, you mentioned that you felt burned out a couple of times or a number of times, why didn't you leave?

#10: Because I didn't want to walk out like that because I felt that I would disappoint too many people, that's how I felt. And for other reasons too, like financial reasons because I had to work and because I like nursing, that part of nursing. Many times I feel I have to get out but I can't work anywhere else other than in a station. I'd like to stay in nursing.

Me: Did you sometimes feel as if you were not coping?

#10: I guess sometimes I didn't feel at that time but when I look back now, that's probably why I couldn't sleep because I wasn't coping well and that's probably why I had sore legs and sore head and sore other things because I wasn't coping, but at the time when I think I was burned out, maybe I didn't cope too well, but.

Me: Maybe you did.

#10: Maybe, I don't know.

Me: Because this is the point, because despite those feelings that you had, despite those physical aches and pains, you also mentioned about incidents.

#10: Yes. Stuff that happened in the nursing station. Lots of things happened, you know, people die and sometimes a violent death, sometimes they'd just have a heart attack, they're so young, but sometimes hangings and self inflicted gun shot wounds, and sometimes accidental, and I think for me anyway, I find that was sometimes very painful for me especially at home because I know the people and it was difficult. Sometimes even when people phoned and said someone got run over by a skidoo or something, the first thing that came into my mind when I was in Lost Lake was my own family, whether it's them, how am I going to cope? When I get a phone call, that's how I used to feel, what am I going to do if that's my mother? And then that was just briefly, you know I'd think of that just briefly and then carry on. But that's caused a lot of stress for me because I was from there and the people had died. Deaths.

Me: That made you feel tired, made you feel burned out?

#10: Yes. Tired like physically tired because you don't sleep very well and you're kept awake and you think. Sometimes when we tried to resuscitate people sometimes you go through what you did and then you think I wonder if I could have done that another way? I do anyway.

Me: So now, this is after an incident or this is at a time when you just feel especially burned out or when you just had to deal with this, how did you do that?

#10: Oh, at the time it happened?

Me: Hmm-hmm.

#10: Usually when we had an MVA (phonetic) or a snowmobile accident and something happened really bad like people died, many times the nurses would just sit together and talk about it. I think that's how we cope with those emergencies that we have. Every emergency that I could think of, the nurses -- you know you just go. After you clean up you just carry on and carry on and then clean up and then go and have some coffee and sit and talk about what had just happened. We've done that most times that I could remember because the nurses would just come together and discuss what we just did. That was our way of coping with emergencies that we had. And then for me is that I would talk to David.

Me: Would you just discuss the incident or would you discuss feelings surrounding it?

#10: The incident with the nurses?

Me: Yes. If you discussed with the nurses and even with David, would you just discuss the code itself or would you discuss the feelings surrounding it?

#10: With the nurses we discussed both. Mostly the incident that happened and sometimes feelings would be discussed with the nurses but with David, just feelings because he didn't know what we did. Just feelings.

Me: And you found that helpful?

#10: Very helpful.

Me: So you mentioned that after seven years in Lost Lake you really felt burned out.

#10: Yes, I really did feel burned out and I was burned out last year. I had to leave. There were things happening. They were personal I guess among staff but it just was not healthy for me

to work there anymore. I had to leave because that's my home and I plan to go back and it was time for me to get out otherwise I wouldn't have been able to go back if I didn't get out when I did. But there was fighting in the nursing station amongst nurses and support staff and I don't like stuff like that and I think that was my biggest burn out, why I burned out. I felt I was at the bottom, I guess, of burn out. It's really bad. And I talked to Solange (phonetic) when I left Lost Lake I talked to Solange but I felt I would be ready to go back last Christmas but I went back for a while, for Christmas holidays and it was still the same there and I came back here and I was supposed to go back again at the end of this Christmas but I'm not going to go back, not for a year. I'm going stay here for another year.

Me: So how do you find working here, you don't have those symptoms here?

#10: No. No.

Me: Not that feeling, "I cannot work here, I'm at the end of my rope."

#10: Oh, no. No. I don't feel like that.

Me: So just the change of place or venue because the work must be the same?

#10: The pace too. The work is the same, we still deal people that have -- there's still a lot of emergencies and the workplace is still the same, in fact it's a little bit different for me here because I have to live here and work here and socialize here, I don't have to but I do, because I don't know too many people out in the community and I feel, for me, I feel that if I get to know too many people and too close to them that maybe they'll start putting pressure on me like the people did to me in Lost Lake.

Me: So you are sort of protecting yourself a little bit?

#10: Yes. I guess. I think so. But I don't feel like I'm burned out and I'm happy to be here because when I think of Lost Lake I still want to go back and work there but I can't work that much. It's too busy. I don't think any nurse can work that long in that -- it's too busy in Lost Lake. It's just too busy.

Me: So what are you saying that inherent in that nursing station, Lost Lake nursing station, the pressure is just too much and that over a period of time people will burn out?

#10: Yes. I think burn out happens in Lost Lake so quickly. I didn't realize that until I could sit here and think of Lost Lake.

Me: Because of the pressure.

#10: Because of the pressure and because of there's just too many people in that community. The facility, I think, is inadequate for the people in the community and the girls are -- it's the nurses that are burning out and you know Medical Services gives us time off when we feel burned out or we can go through this program or something if you need to talk to someone and then you get time off, but that doesn't solve the problem. You go back there and burn out all over again. Something has to be done for Lost Lake. They need something bigger, I think, than that. I don't know perhaps maybe a system where nurses can have some time off because in the station you feel when you live there, you feel that you have no time off at all, not a day off because you're right there, you're at work. Sometimes when I'm here in Nelson even if I feel like I have a flu or something, I just come to work because I'm just here anyway. I might as well be at work because I'm right here. That's how I feel. I think they have to have time off or they leave the workplace -- out, out. Get away, just to get away.

Me: Something that I'm interested in in the dynamics here is that you mentioned having burned out a number of times (inaudible). You've explained to me that you get it from you get

support, you talk, but how do you experience it, do you feel burned out like the one day and then the next day after you've talked to a lot of people you will not feel burned out, or is that always there? I don't know. Explain to me.

#10: No. No. No. I don't feel like I'm always burned out. I think I've been burned out a few times in the years that I have worked for Medical Services. I don't think I'm burned out now. I don't feel burned out. Maybe I am, I don't know, but I know that I was burned out for sure when I was in Lost Lake and when I think of the other years that I was in Lost Lake, I may have burned out a few times and recovered or coped with my burnout, but the last burnout, I think I just couldn't have coped in Lost Lake. I couldn't have.

Me: But still you didn't quit nursing. You just moved venue, places.

#10: Yes. Yes.

Me: Okay. I know this sort of seems to be covering the same ground, we're not, how did you, those times that you recovered, how did you do that?

#10: When I think now how I must have recovered, you know, we'd go out on holidays just to get away from Lost Lake all together, David and the kids, and things kind of settled down in the station. There was more nursing staff staying a little bit longer than what was happening and then there was -- you know they'd have little fights and somebody would leave and everything will be all right and I think that's how I recovered. After this person left or --

Me: Right, because the experience -- the will change (inaudible).

#10: Yes. Yes. And the people felt different. People weren't so negative, then I would feel better myself. Because you work with these people and sometimes some of the nurses that's all they

see is just the people that they work with and when people are feeling kind of upset or something's happened, someone's mad at you or they did something wrong, then you almost have to talk about it to carry on I think in these small little places, because when somebody's not feeling good or you think someone's a little edgy, it's not a good feeling. I don't know about the hospital, I never worked there, but certainly not in a place where you have to live together and work together. I don't think that those kind of stuff, make me feel different. Say somebody left and then it was different. That's how I coped, I think, with the little burn outs that I had but I had a big burn out and I had to get out.

Me: In the past year that you've been here, have you had that incident happen here?

#10: Well, we had a few hangings and drownings. A few drownings, a few hangings. There's a lot of violence in this community, like on the weekends people come in and they're alcohol related violence. But I don't feel the tension that I felt when I was at home in Lost Lake, so it's kind of different. I guess it's because I don't know the people at the personal level and in Lost Lake I kind of knew everybody and I grew up there and everybody's there except my husband and my own children. So that's the difference for me is they're not attached to me personally, I feel that here, but there has been a few things that happen but I don't feel the same about them as I did in Lost Lake. Like I said, somebody's hanging, that could be my own brother or my own sister. In Lost Lake I used to think that, but not here.

Me: So overall, how do you stay healthy? Can I just turn this around? - (Side A ends) -

#10: How do I stay healthy? Gee, I don't know. I just work. I have my own support, my own family and I talk to them and I feel that the job for me is very rewarding. I feel that. I really enjoy this type of nursing.

Me: Yes. It sounds to me like that. If I look at you and I hear that underlying very strongly that

you do enjoy your work and you find it a challenge.

#10: Yes. It is a challenge for me.

Me: And you feel that you're good at it?

#10: I feel that I'm a good nurse because people, there's a few people that have said that to me, like you know patients, total stranger. I know that they do that. They said that to me in Lost Lake too because when I go home, people ask me to come back, you know, "when are you coming back?" I will go back but I'm not ready to go back now. But sometimes Medical Services, they just make me so angry. I think Medical Services have very little support for their nurses out in the field and I think the only time they come in to support their nurses is when something not nice has happened to them and I think Medical Services has to step in and give their nurses a little bit more support before something bad happens to the nurses. That's what makes me angry about Medical Services but I would also not work for anyone right now except Medical Services.

Me: If you talk about support, do you have anything in mind that they don't give in their support, is it financial support, is it physical, what --

#10: No. No. No. The money is good in the nursing station. I think it's more like an emotional support, like a little bit more time off for the nurses, maybe a scheduled time off because when you're full time indeterminate with the nursing station, when you go into a station then you're not guaranteed any weekends off unless you talk to your own little group of nurses that you work with and then you have to schedule yourself to be off at least two or every third or fourth weekend off and get out of the community. But I think a little bit more schedule, for me, anyway where in the hospital the nurses work six days 12 hour shifts and then they get seven, six days off in a row. I think something like that would be nice for the nurses in the

north.

Me: But one of the reasons I suppose it's not done is because of the isolation because it's a real --

#10: I guess. And then sometimes --

Me: And I don't know I'm just --

#10: -- you don't know what's going to happen. People say there's a nurse coming in today and they don't show up and then they send them somewhere else because something has happened where a nurse had to get out of the community, because anything can happen sometimes, weekends, some violence towards the nurses or then they have to take them out and someone else has to go in and I guess that's why that's not happening, the time off.

Me: Do you take this special other do your exercise do you eat healthy, do you pay attention to these things or is that not really --

#10: I don't exercise. Well, I go for walks when I can, but I don't have a regular exercise program and I try to eat healthy food, but sometimes we don't have time for healthy food because we're busy so you just grab whatever is there to eat and I smoke, so that's what I do. Not too much, I smoke a little bit, but sometimes you can't get to sleep, then I smoke more. In Lost Lake I was smoking lots, but now I smoke maybe two or three cigarettes in the evening and I read. I read lots of books. Of course I do a lot of sewing and I do a lot of crafts. I sew, I do cross stitch and beads, stuff like that. That's what I do to keep myself busy when I'm here by myself without my family.

Me: So to an extent, the isolation, that's not bothering you?

#10: No. It doesn't bother me because I'm used to the isolation. I grew up in the north. In fact when I go to Winnipeg, sometimes that bothers me, it's too busy and I can only stay there for a week or so and then I have to come back home because it's too busy for me in Winnipeg.

Me: Okay. I think we've covered everything. Is there anything that you think we've left out, anything that we left out with a mess on the tape at the beginning? I think we covered everything.

#10: I think most of it, we've covered. I think that's it.

Me: Just something that we didn't really cover in the coming back is why you think nurses, some stay, some leave quickly?

#10: Oh, I think sometimes the non native nurses come with their own values and Indian people have their own set of values and this just may be one of the reasons why girls leave. They don't understand the native people, there's very little understanding of the native people and sometimes they bring with them their own values and expect the people to have the same values.

Me: To fit into their own.

#10: Yes. To fit into their values.

Me: It's a bit arrogant, isn't it?

#10: To fit into their own values and I think sometimes that's why they leave. Some stay and some leave. But there's -- I don't know why they -- lots of people stay and (inaudible).

Me: Something that you've mentioned about the time frame, do you think that northern nursing or working in a nursing station is something that you can only do for a limited time?

#10: Not for me. I feel that I couldn't do anything else except northern nursing. That's how I feel. But I'm part of the north so maybe that's why I feel like that because I grew up in the north and I know the people and I know their lifestyle, so I think it's easier for me to stay than a girl coming from Winnipeg.

Me: So you don't think it's personally impossible, you just think that we've talked a little bit about how things are set up, especially in Cross Lake for instance, where you burned out a number of times, you feel that it's because things are set up the way it is. It's not that it's weak people?

#10: Oh, no. It's not weak people, it's just the way that place is set up. I think the facility is inadequate. There's lots of people in Lost Lake and there's only most of the time, I think, there's six nurses working and that's not enough nurses.

Me: Or what happens there, too, is there are six or seven nurses on the books but one's on holiday and one's off --

#10: Yes. Yes.

Me: -- or one is maybe on the Medi Vac and there's four or five.

#10: Yes. Three or four working at one time.

Me: Yes. And it's not -- that is not enough.

#10: No.

Me: You see then you should have ten nurses with seven nurses working all the time.

#10: Yes. Because somebody's always away. Even here with us we have three nurses on staff. One of us is away sometime during the week. One of us will be away. Either somebody's sleeping because they've been up all night or someone's on a Medi Vac or somebody's off doing something on a holiday or upgrading or something. There's always one person off.

Me: Thank you for sharing with me. I really found that this was a very useful session. You told me a lot. If there's anything that comes up I will phone you or I will come and talk to you again if I feel that there's something I missed. Thank you so much.

Identification of Significant Statements: Respondent # 10

PRIVATE

Northern nursing experience is far different from what you work as a nurse when you're in a hospital.

It's interesting and the nurse is on their own.

They make their own decisions

They just do things on their own.

They don't need doctors' orders for everything

they don't have to have, like in the morning we have to do a bed bath and feed the patient, there's nothing like that in northern nursing,

it's just different.

It's interesting when lots of things happen that don't happen in the hospital. Well, they do happen in the hospital but in the hospital they're all separate, but in a station it's everything.

that's what makes the work interesting.

the people, they're different, the Indian people, because most of the stations are on the reserves here in Manitoba,

they're isolated.

the nurses are very isolated some of them that work in the northern nursing stations

that's why there's such a high burn out of nurses in the north

I have worked with quite a few nurses since I've been with Medical Services.

Some of them stay a few years and some of them just stay a few days.

there's a high level of burnout in stations
I was burned out when I left Lost Lake.
I felt that I was burned out, that's why I had to leave.
I was starting to hate people
if I didn't get out of there I was going to hate everybody,
I wasn't sleeping but my body was tired
I couldn't sleep
I had pain sometime, leg pain, headaches, just physical pain.

It wasn't just work there was other things that were going on in the station

I also think now when I look back that I may have been burned out a few times before
I worked there and I felt that I had a lot of demand from the people because I was from there.
They would talk to me all the time, even in the store,
older people, they don't speak any English and maybe I felt too that because I'm from there, they
felt freely to talk to me whenever they wanted to talk which I don't see anything wrong with that
but
sometimes I felt they should go to the Clinic and talk over there when the Clinic is open.

I find that very tiring and sometimes I was exhausted.
I was just so fed up with what was going on.
So I had to leave.

I find northern nursing very rewarding for me.
one reason I became a RN was to go back and work with my
I guess any nursing is rewarding if the people sometimes even just say thank you.

The nurses that worked there they're not from the community so they live and work in the same
place and socialize.
I don't think that's healthy.
I think you have to leave your workplace and sometimes even socialize outside the workplace to
stay healthy.
I thought that when I was there, that's what I'd do.
that's why I lasted in Lost Lake as long as I did.
That's because I leave right away after work and come home only when I was ready to go to sleep.
my husband left Lost Lake with the children, two years ago
I have a lot of support from them. That's my biggest support is with David
it was like a long distance phone call, so I had a big phone bill. I still do.

my family, my own parents, sometimes I felt that they didn't understand what was happening in the
station,
the pressure that we felt,

the after hour calls and people that were so (inaudible).

People sometimes, well, I guess they don't understand what's happening.

When people call you they think that's the first phone call you got is when they're talking to you

financial reasons too because I had to work and because I like that part of nursing.

I didn't want to walk out like that because I felt that I would disappoint too many people,

Many times I feel I have to get out but I can't work anywhere else other than in a station.

I'd like to stay in nursing.

I didn't feel at that time (that I could not cope) but when I look back now, that's probably why I couldn't sleep

I wasn't coping well

I had sore legs and sore head and sore other things because I wasn't coping,

but at the time when I think I was burned out, maybe I didn't cope too well,

Stuff that happened in the nursing station.

Lots of things happened, you know, people die and sometimes a violent death,

sometimes they'd just have a heart attack, they're so young,

sometimes hangings and self inflicted gun shot wounds, and sometimes accidental,

I find that was sometimes very painful for me especially (being) at home

I know the people and it was difficult.

Sometimes even when people phoned and said someone got run over by a skidoo or something,

the first thing that came into my mind was my own family, whether it's them, how am I going to cope?

what am I going to do if that's my mother?

that was just briefly, you know I'd think of that just briefly and then carry on. But that's caused a lot of stress for me because I was from there and the people had died. Deaths.

Tired like physically tired

you don't sleep very well and you're kept awake and you think.

when we tried to resuscitate people sometimes you go through what you did and then you think I wonder if I could have done that another way? I do anyway.

when something happened really bad like people died, many times the nurses would just sit together and talk about it. I think that's how we cope with those emergencies that we have.

you just carry on and carry on and then clean up and then go and have some coffee and sit and talk about what had just happened.

then for me is that I would talk to David.

the incident that happened and sometimes feelings would be discussed with the nurses

but with David, just feelings because he didn't know what we did. Just feelings.

I really did feel burned out and I was burned out last year. I had to leave.

There were things happening.

They were personal I guess among staff but it just was not healthy for me to work there anymore.

I had to leave because that's my home and I plan to go back

it was time for me to get out otherwise I wouldn't have been able to go back if I didn't get out when I did.

there was fighting in the nursing station amongst nurses and support staff

I think that was my biggest burn out, why I burned out.

I felt I was at the bottom, I guess, of burn out. It's really bad.

I felt I would be ready to go back last Christmas but I went back for a while, for Christmas holidays and it was still the same there

I'm not going to go back, not for a year. I'm going stay here for another year.

how do you find working here, you don't have those symptoms here? No.

Not that feeling, "I cannot work here, I'm at the end of my rope."? No, no. No. I don't feel like that.

just the change of place or venue because the work must be the same? The pace too.

there's still a lot of emergencies

the workplace is still the same,

in fact it's a little bit different for me here because I have to live here and work here and socialize here,

I feel that if I get to know too many people and too close to them that maybe they'll start putting pressure on me like the people did before

You are sort of protecting yourself a little bit? Yes. I guess. I think so.

I don't feel like I'm burned out and I'm happy to be here

when I think of Lost Lake I still want to go back and work there but I can't work that much.

It's too busy. I don't think any nurse can work that long in that -- it's too busy in Lost Lake. It's just too busy.

what you are saying is that inherent in that nursing station, the pressure is just too much and that over a period of time people will burn out? Yes.

I think burn out happens there so quickly. I didn't realize that until I could sit here and think of that place.

because of the pressure and because of there's just too many people in that community.

The facility, I think, is inadequate for the people in the community

Its the nurses that are burning out

Medical Services gives us time off when we feel burned out

we can go through this program or something if you need to talk to someone and then you get time off,

that doesn't solve the problem.

You go back there and burn out all over again.

Something has to be done for Lost Lake.

They need something bigger, I think, than that

Maybe a system where nurses can have some time off

In the station you feel when you live there, you feel that you have no time off at all, not a day off because you're right there, you're at work.

even if I feel like I have a flu or something, I just come to work because I'm just here anyway.

I might as well be at work because I'm right here.

I don't feel like I'm always burned out.

I think I've been burned out a few times in the years that I have worked for Medical Services.

I don't think I'm burned out now.

I don't feel burned out.

I know that I was burned out for sure when I was in Lost Lake

when I think of the other years that I was in Lost Lake, I may have burned out a few times and recovered or coped with my burn out, but the last burn out, I think I just couldn't have coped in Lost Lake. I couldn't have.

But still you didn't quit nursing. You just moved venue, places. Yes. Yes.

I must have recovered,

we'd go out on holidays just to get away, and things kind of settled down in the station.

There was more nursing staff staying a little bit longer than what was happening before

Nurses would have little fights and somebody would leave and everything will be all right

I think that's how I recovered. After this person left the people felt different.

People weren't so negative, then I would feel better myself.

you work with these people and sometimes some of the nurses that's all they see is just the people that they work with when people are feeling kind of upset, someone's mad at you then you almost have to talk about it to carry on

when somebody's not feeling good or you think someone's a little edgy, it's not a good feeling. not in a place where you have to live together and work together.

I coped, I think, with the little burn outs that I had

but I had a big burn out and I had to get out.

we had a few hangings and drownings

There's a lot of violence in this community, like on the weekends people come in and they're alcohol related violence. But I don't feel the tension that I felt when I was at home in Lost Lake, so it's kind of different.

I guess it's because I don't know the people at the personal level

the difference for me is they're not attached to me personally,

How do I stay healthy? I just work. I have my own support, my own family and I talk to them and I feel that the job for me is very rewarding. I feel that. I really enjoy this type of nursing.

It is a challenge for me.

I feel that I'm a good nurse because there's a few people that have said that to me,

Medical Services have very little support for their nurses out in the field

I think the only time they come in to support their nurses is when something not nice has happened to them

Medical Services has to step in and give their nurses a little bit more support

That's what makes me angry about Medical Services

but I would also not work for anyone right now except Medical Services.

I think it's more like an emotional support,

like a little bit more time off for the nurses,

maybe a scheduled time off

you don't know what's going to happen.

you are told there's a nurse coming in today and they don't show up

they send them somewhere else

because something has happened where a nurse had to get out of the community,

Anything can happen sometimes, weekends, some violence towards the nurses

then they have to take them out and someone else has to go in and I guess that's why that's not happening, the time off.

I don't exercise. Well, I go for walks when I can, but I don't have a regular exercise program

I try to eat healthy food, but sometimes we don't have time for healthy food because we're busy you just grab whatever is there to eat and I smoke, so that's what I do.

sometimes you can't get to sleep, then I smoke more.

Before I was smoking lots, but now I smoke maybe two or three cigarettes in the evening and I read.

I read lots of books.

I do a lot of sewing and I do a lot of crafts. I sew, I do cross stitch and beads, stuff like that.

That's what I do to keep myself busy when I'm here by myself without my family.

It doesn't bother me because I'm used to the isolation. I grew up in the north.

In fact when I go to Winnipeg, sometimes that bothers me, it's too busy and I can only stay there for a week or so and then I have to come back home because it's too busy for me in Winnipeg.

They don't understand the native people, there's very little understanding of the native people and sometimes they bring with them their own values and expect the people to have the same values to fit into their values and I think sometimes that's why they leave. Some stay and some leave

I feel that I couldn't do anything else except northern nursing.

But I'm part of the north so maybe that's why I feel like that because I grew up in the north

I know the people and I know their lifestyle, so I think it's easier for me to stay than a girl coming from Winnipeg.

It's not weak people, it's just the way that place is set up. I think the facility is inadequate. There's lots of people and there's only six nurses working and that's not enough nurses. somebody's always away. Even here with us we have three nurses on staff. One of us is away sometime during the week. One of us will be away. Either somebody's sleeping because they've been up all night or someone's on a Medi Vac or somebody's off doing something on a holiday or upgrading or something. There's always one person off.

APPENDIX G**RESPONDENT # 15**

Me: I would like you to tell me about the experience of working as a nurse in the north, tell me how it's affecting you and how it makes you feel. I would like to know whether you find it stressful and whether you feel burned out sometimes. I would also like to know how you cope with that, or with this burn out then, or to put it differently, how you stay healthy. You can take your time and you can start wherever you like.

#15: Okay. Can I see the question again? I guess what I'm having a problem with is I've worked with the north from two separate dimensions; the field and management, so when I talk it's sometimes difficult for me to -- it's not difficult for me to separate it, but the two experiences are different, very different. So it's hard for me to determine from what aspect I'm talking.

Me: Tell me in the first place about your experiences working, being a nurse in the north.

#15: They have been very positive right from the beginning. I've enjoyed it a lot and I've learned a lot and I have found it very dynamic. My memories of the field are very positive actually and I don't have a lot of negative memories or feelings about the work or the people. The negative aspect of the work that I did feel, didn't come from the work itself or the job that I was doing or the people, but from management and they caused me an awful lot of stress for about two years of my career. But by and large that's the overall feeling about my experience.

Me: Can you be a bit more specific about the details of what made it so positive?

#15: The people. I found the people very interesting. They were very different from people that I had known and worked with before. They had a wonderful sense of humour and there was

always laughter. I remember laughter in the field, I remember feeling very accepted within the environment in which I was working with the people there that they liked me, they liked me being there and I liked them. Now, I'm not saying there wasn't frustration and there wasn't disappointment and there wasn't sad times involved and there wasn't tragedy, there was all of that. But I just found the thing that made it so positive was the people themselves, their attitude, their tragedies, being able to reach out to people and really feel like you were making a difference. Well, I sort of take that back. You were making -- yes, you do. You were, you were making a difference in a very small way, you weren't changing things in a big way, but there were many a times when people would leave and you felt you had touched them in some way and you had affected them in some way that wasn't necessarily negative all the time. The other thing that was positive about the experience was you were growing all the time. Professionally, you were growing all the time. The environment was dynamic, ever changing and you never knew from one minute to the next what you'd see. It always kept you on the edge which I sort of liked in a way. Like as much as it was difficult to do that, it was still almost invigorating. And when you'd accomplished something and you had done well, which you had an abundance of, it augmented those positive feelings. Near the end of my field work I could tell that things weren't as good as they should have been. I was tired of seeing the same thing. The people, I found that in both the communities I worked in, when I worked in Shamatawa, I just knew it was time to go because I could not affect change anymore and I could see that it was going no where, that the people were going no where except downhill. And I started feeling that in Souter, like I was getting frustrated because things weren't getting better, things were getting worse and people weren't taking responsibility or charge for their lives, they always wanted you to do it for them. And that just became too frustrating after a while, too frustrating. So near the end I was tired, I was very tired and it stopped being fun. It became mundane and, "here we go again," like too much of the same thing and it was getting worse. Person A would come in and you thought you had affected change and then you found you didn't at all, that they were wanting, again, you to do it for them. I just found that frustrating. But I found that looking back, generally, in my career in nursing, that's the

thing that turns me off the most is people that won't take responsibility for their health care, people that expect everything to be given to them. And even if I look at right across the board, that's generally the way I feel about life in general, that you've got to take charge here, you know. Nobody is going to do it for you. I don't mind taking charge for a while but don't ask me to do it forever and don't count on me to do it for you forever, because I won't do it. I just know that that's when my frustration starts to show. And then, of course, you get tired, but I don't remember that, I don't remember the fatigue.

Me: Would you say that you got really stressed out there at times then?

#15: The only time that I really got stressed out was when management was causing me the terrible problems and that was extremely frustrating for me, very, very frustrating. They put a lot of pressure on me and the only thing that helped me survive that were friends that I had in the community plus local people, like they helped me through that but it was a very devastating experience (inaudible) perspective. I was just so frustrated with the organization that I couldn't take it and what I couldn't handle, the thing that was really, really annoying and the thing that if anything is upsetting or if anything is sort of breaking, will break you, and I say, "you," globally, I really think that this is what it comes down to. I don't know if it's an end result of a symptom, but that feeling of being trapped, that feeling that you've got a problem and you can't go anywhere with it, you can't change it, you can't deal with it, it's there and that's it. And you get into that feeling too of being trapped when you feel I can't go anywhere, this is it. Like I'm confined by the boundaries of this community and you just start to stagnate and that's when I started getting really stressed, frustrated, when I feel like I'm no longer growing. But that situation with management was terribly devastating because you just felt that there was absolutely no out, there was no way of reaching past that invisible barrier of zone office to tell people that somebody here is affecting us in a very negative way. You couldn't do that, like all your points of exit were blocked and that was part of the thing, so, because nobody would listen, there was nobody there to talk to and nobody there to listen.

The only person you had was your supervisor who was doing it to you and if you went beyond her, you were defying or breaking the lines of communication and you'd be disciplined. It was a terrible situation to be in. Terrible. There's just nobody to talk to and nobody to share it with.

Me: Would you ascribe your struggle with management as part of being tired and of being there too long?

#15: No. No.

Me: That was a separate thing?

#15: That was a separate thing. They made me tired if anything, but, no, it wasn't that at all. Maybe I'm missing the point, but I don't think it was at all. No, I can honestly say that it wasn't because it happened about two years after I arrived in the community and then I stayed for three or four more years after that and felt okay about being there, so I think had it been a result of being tired, I think I would have just kept going down. I didn't. As soon as that particular supervisor left and after that whole group of (inaudible) left, it was like it was a weight that's gone and I can function again. But then about three or four years after that I started getting tired, I got tired as I said about the not being able to see change and that started to drag me down.

Me: So how did you cope with that, you left?

#15: Yes. Basically, I left. I think if I hadn't have -- I got out. I made plans to (inaudible) into another job for a while and to get away from it. And I haven't been back. (inaudible) a couple of more, but (inaudible). But I knew it was time either to quit or take a leave or, well, those were the two choices, leave or quit. I had to get out. It was just too hard to get out of bed

for those night calls and after a while the money didn't make any difference at all. It just didn't make up for it, for the stress. When I was in it, how did I cope? Well, I don't know. I walked, I did a lot of walking. I don't know how I coped. In the beginning I used to socialize a lot but then that dropped off. I just lost interest in that. I spent a lot more time to myself. (inaudible), I didn't go out as much as I did before, and that's not coping that's succumbing, basically, to it but if I had have coped I would have still been there I suppose. I would have gotten over it, but I could see it going down, I could see myself -- in retrospect, now, at the time I didn't, but in retrospect I could see that I was heading down. It was time to get out. Had I not gotten out I don't know where I would have ended up. I really don't, because I was getting tired.

Me: But you stuck around?

#15: Yes, because I changed. I altered my work environment and I work at it from a different angle now. I like that angle because I feel again like I'm affecting change, that I'm in a position where I can maybe make a difference and affect change. But that's why I'm still around. I'm planning on going back to the field so I don't know how it'll be. I've had a lot of frustrations about it, not frustrations, anxieties about doing that because I can almost feel the way I felt when I left. I'm not sure that it's a good idea, but.

Me: So why are you considering it?

#15: Well, money reasons. I don't want to relocate to Gibson. I mean practical reasons is why I'm doing it. I don't mind the job I'm doing, I like it. It's interesting, but I don't want to live in Gibson, I don't want to relocate to Gibson, so I'm doing it for practical reasons and I've got to eat, I've got to work. And part of it I'm going back because I feel like my skills are fading. I need to go back and when I interview nurses and I go through the initial interview with them, I'm almost envious of them going into the field and I feel as if I'm dated. When I talk to them,

I'm talking from the historical point of view, now. I'm not current anymore and I really want to keep my skills up and I feel like I'm going to lose them if I don't. So it's sort of for a refresher as well, but I don't know how it's going to go, I have no idea but the community has really gone downhill the four years that I've been gone. I'm not just convinced that I can handle it, but we'll see.

Me: So you're going back there?

#15: Hmm-hmm.

Me: Why?

#15: Well, it's community I'm familiar with and I feel connected to the community, and, again, for practical reasons, it's not a reserve and I like that. It's a community, there's not a Chief and Council. I like the way Souther people think, they're a lot more cosmopolitan and they're not tied to that reserve mentality and I like that a lot. I don't want to work in a community where there's a Chief and Council. It's interesting because the more I talk about it the more I realize it, the issue is control. I couldn't handle being in a situation where I wouldn't feel like I had control of the work situation. It would scare me.

Me: So you coped by first living through it and then later you left, came back. Do you feel burned out sometimes now?

#15: Yes. Yes. I do on occasion. I don't know if it's burned out or just frustrated. I don't know if the two are synonymous or not, but I just get so frustrated with the system. I get frustrated with the attitude of the not -- I'm frustrated not with the attitude of management, now, I'm frustrated with the attitude of the native client. Not the client. I'm frustrated with the politics. The grass roots individual, I still see the laughter, I see the sparkle and I see that sad individual

and I can still -- that can sort of, what's the word, keep the spark within me alive, but the political arena just frustrates me to no end. That's when I just feel, I don't need this anymore. And articles in the paper about the health care and the nurses and how bad it is and whatever, that, I just get very frustrated. If that's burned out, then maybe I am, maybe I shouldn't be working anymore in the north, I don't know. But that will just make me pull my hair out and make me walk out and quit all together. But as I said, not the individual one on one client, the one that really needs the care, the grass roots, but it's certainly a political arena here. And the job I'm in now, I find the nursing personnel, I enjoy working with them. I like them and there's a lot of good ideas out there and a lot of very strong people with really strong ideas and I like that. I like creative people and I like people with a vision and I like people that can contribute and have good ideas and I think a lot of the nurses out there are like that, I mean generally speaking. I think there certainly are nurses that are narrow in their thinking or narrow in their perspective and narrow in their outlook but that's a given. But I think by and large, particularly with my nurses in charge that I have I really do like them, I like working with them (inaudible). Management is really trying hard. I think their heart's in the right place now. I don't think it was for a long time but I think it finally is and if it's not in the right place I feel like I can at least say so, that I have a vehicle for expressing that and saying, "look it, you know, you got to look at it from this perspective. You're wrong." And I like that, I like having the power, control, I don't know. I don't look at it as power and control, it's having that ability just to speak out and have your views heard and hopefully heeded, but if that one, that native political element that just drives me crazy because it's counter to what I believe to be very true of the native people. don't see the native political leaders as indicative really of the nature culture at all. They've adopted the white bureaucratic style and you know that's what it is. They're in a situation now where if you want to -- what's that expression, you've got to -- if you want to fight something you become like that, and I know that. I also know that they're going through change, significant change and this is all part of the process, I know that, I can rationalize it, but I don't like it because it's almost like the -- I really have a hard time with people that are in situations for the sake of the power and I find that with the native

political leaders that they've lost sight, in my own mind, they've lost sight of what their purpose and vision is and as I said, counter to what I believe to be true. I think they're like that.

Me: You don't care to define frustration as reclusive? For you, not text book.

#15: Frustration for me is feeling tired, unproductive.

Me: Almost trapped it sounds like.

#15: Yes. Yes.

Me: In that specific domain.

#15: Hmm-hmm. Yes, trapped but not trapped like I felt when I was in the field when I was knowing that it was time for me to go.

Me: Resign?

#15: No. No, it's not a resignation. When I'm frustrated, there's certainly anger, there's a quiet anger, it's not an expressed anger. Well, yes, it is. I become quite vocal about it but how it affects me is fatigue, yes, mainly fatigue I think is the big one, and lack of interest and unproductivity, shuffling papers from one side of the table to the other desk, not getting the report done that you're supposed to do, focusing on the things that aren't important and you sort of think (inaudible). That's how it manifests, and not wanting to go to work. That's not all the time, that's not as strong as I'd say on occasion, but not a lot.

Me: Do you think working in the north has this inherent to it?

#15: Frustration? Yes. Yes, I do. I do, actually. I think I never thought of it before but when I give it some thought, I think, yes, it's there and I think it's there because of getting back to the aspect of not being able to affect change, not being able to alter things or make things better or different, seeing the same thing over and over again whether it's hearing all the time about how bad the health care is in the north and how nurses can't do that, or whether it's Mrs. Smith coming in with a blood sugar of 30 again, after I've been through this with her and we've done all we can do for her and we have taught her and still it's 30 and still things aren't changing, and I think a year of that with 20 Mrs. Smiths, it's frustration and tiring.

Me: Do you think working here needs a specific personality type?

#15: Hmm-hmm.

Me: Do you know of nurses that did not cut it or did not make it that just up and left?

#15: No, I haven't quite honestly. I can't think of nurses that have just up and left. The majority of nurses that I have met have -- they've stuck it out, stuck with it. I don't mean stuck it out, I mean they stuck with it, and they have made it their life. I can't say that I have really encountered a nurse who's been here for a while and just that's it, can't do it anymore, can't handle it. Most of them, there's something about it that draws them to the north, but I'm trying to think of the type of personality that probably would, and yet I can't. I can't answer that.

Me: But I think people, just as a discussion of that, is people sort of make that decision because you can choose to be just term or you can choose to just come in for a little, what is that called, where you come in every now and then?

#15: Oh, relief.

Me: Relief, yes, which is sort of the choice not to be too involved.

#15: Yes. That's true. That is true.

Me: And that's fine, you can handle it that way, but this is not really your life, because they all up and leave.

#15: Yes. Yes.

Me: Or they don't, well, if they ever are really here.

#15: Yes. That is true. You know it's interesting because I haven't worked a lot in -- when I was working in the field I didn't work a lot with relief nurses, so it's not something that I've seen a lot in terms of personality types that work like that. But there comes a time after a while too where you feel like you're never really a part of the community. Never. No matter how involved you are, you are still an outsider, you will always be an outsider and in people's minds they are there not for the duration, that they will be going, they will be leaving at some point in time. The people know that and the nurses know that and it comes down to how long is my life going to be on hold here? Now, there are some people who have put their life on hold for a large number of years but they also know that they are going to be getting out, that they're going to be leaving and they're not coming back. I guess the point I was trying to make is that issue of, again, feeling trapped and feeling confined in a way that I'm here in a community that I'll never be a part of, the only way out is to take that plane, I can only go this far before I'm in bush and I can't go any further and the isolation, after a while, I think does close in on people. And if they don't get out at a point in time when that isolation starts to close in on them, then they're (inaudible). I think that's the point I was getting to where I felt I had to get on with my life and that isolation is closing in on me. When I think about going back, that's what bothers me. I really feel that my life is on hold when I go back there if I go

back for a year or two years or three years.

Me: Yes. That's something I don't really understand about what you're saying to me because that's not your home either. You say you don't want to relocate to Gibson

#15: No.

Me: Are you really relocating to Souter?

#15: Yes, I am. And if I had a choice I'd relocate. If I'm not going to be where I want to be, then I'll go to Souter not to Gibson. I want to be at home, I want to be in Winnipeg, that's where I've chosen to be now, that's where I want my life to be but it's not going to be because I can't find a job. So if I have to make a choice of where I'm going to be isolated, I'll be isolated in Souter but not in Gibson, because I find Souter less isolated than Gibson. (inaudible) to here but I don't (inaudible) out here anyway. I don't have a life here. I found (inaudible). So that's where I've chosen (inaudible).

Me: Well, I think you've covered more or less everything here. I think that you told me how you stay healthy.

#15: I think I did.

Me: Yes, I think you covered it. Well, thank you.

#15: You're welcome.

Me: Thank you for sharing this with me.

Identification of Significant Statements: Respondent # 15

My experiences working, being a nurse in the north have been very positive right from the beginning. I've enjoyed it a lot and I've learned a lot and I have found it very dynamic.

My memories of the field are very positive actually and I don't have a lot of negative memories or feelings about the work or the people.

The negative aspect of the work that I did feel, didn't come from the work itself or the job that I was doing or the people, but from management and they caused me an awful lot of stress for about two years of my career.

I found the people very interesting.

They were very different from people that I had known and worked with before.

They had a wonderful sense of humour and there was always laughter. I remember laughter in the field,

I remember feeling very accepted within the environment in which I was working with the people there

they liked me, they liked me being there and I liked them.

I'm not saying there wasn't sad times involved and there wasn't tragedy, there was all of that.

But I just found the thing that made it so positive was the people themselves, their attitude, their tragedies, being able to reach out to people and really feel like you were making a difference.

you were making a difference in a very small way, you weren't changing things in a big way, but there were times when people would leave and you felt you had touched them in some way you had affected them in some way that wasn't necessarily negative all the time.

The other thing that was positive about the experience was you were growing all the time.

Professionally, you were growing all the time.

The environment was dynamic, ever changing and you never knew from one minute to the next what you'd see.

It always kept you on the edge which I sort of liked in a way.

Like as much as it was difficult to do that, it was still almost invigorating.

And when you'd accomplished something and you had done well, which you had an abundance of, it augmented those positive feelings.

Near the end of my field work I could tell that things weren't as good as they should have been.

I was tired of seeing the same thing.

The people, I found that in both the communities I worked in, when I worked in Shamatawa, I just knew it was time to go because I could not affect change anymore and I could see that it was going no where,

that the people were going no where except downhill.

Identification of Significant Statements: Respondent # 15

My experiences working, being a nurse in the north have been very positive right from the beginning. I've enjoyed it a lot and I've learned a lot and I have found it very dynamic.

My memories of the field are very positive actually and I don't have a lot of negative memories or feelings about the work or the people.

The negative aspect of the work that I did feel, didn't come from the work itself or the job that I was doing or the people, but from management and they caused me an awful lot of stress for about two years of my career.

I found the people very interesting.

They were very different from people that I had known and worked with before.

They had a wonderful sense of humour and there was always laughter. I remember laughter in the field,

I remember feeling very accepted within the environment in which I was working with the people there

they liked me, they liked me being there and I liked them.

I'm not saying there wasn't sad times involved and there wasn't tragedy, there was all of that.

But I just found the thing that made it so positive was the people themselves, their attitude, their tragedies, being able to reach out to people and really feel like you were making a difference.

you were making a difference in a very small way, you weren't changing things in a big way, but there were times when people would leave and you felt you had touched them in some way you had affected them in some way that wasn't necessarily negative all the time.

The other thing that was positive about the experience was you were growing all the time.

Professionally, you were growing all the time.

The environment was dynamic, ever changing and you never knew from one minute to the next what you'd see.

It always kept you on the edge which I sort of liked in a way.

Like as much as it was difficult to do that, it was still almost invigorating.

And when you'd accomplished something and you had done well, which you had an abundance of, it augmented those positive feelings.

Near the end of my field work I could tell that things weren't as good as they should have been.

I was tired of seeing the same thing.

The people, I found that in both the communities I worked in, when I worked in Shamatawa, I just knew it was time to go because I could not affect change anymore and I could see that it was going no where,

that the people were going no where except downhill.

I was getting frustrated because things weren't getting better,
 things were getting worse and people weren't taking responsibility or charge for their lives,
 they always wanted you to do it for them.
 that just became too frustrating after a while, too frustrating.
 So near the end I was tired, I was very tired and it stopped being fun.
 It became mundane and, "here we go again,"
 like too much of the same thing and it was getting worse.
 Person A would come in and you thought you had affected change and then you found you didn't at
 all,
 they were wanting, again, you to do it for them.

I just found that frustrating.
 looking back, generally, in my career in nursing, that's the thing that turns me off the most is people
 that won't take responsibility for their health care,
 people that expect everything to be given to them.
 And even if I look at right across the board, that's generally the way I feel about life in general,
 that you've got to take charge here, you know.
 Nobody is going to do it for you.
 I don't mind taking charge for a while but don't ask me to do it forever and don't count on me to do
 it for you forever, because I won't do it.
 I just know that that's when my frustration starts to show.
 of course, you get tired, but I don't remember that, I don't remember the fatigue.

The only time that I really got stressed out was when management was causing me the terrible
 problems
 that was extremely frustrating for me, very, very frustrating.
 They put a lot of pressure on me
 the only thing that helped me survive that were friends that I had in the community plus local people,
 like they helped me through that but it was a very devastating experience (inaudible) perspective.
 I was just so frustrated with the organization that I couldn't take it and what I couldn't handle,
 the thing that was really, really annoying and the thing that if anything is upsetting or if anything is sort
 of breaking, will break you, that feeling of being trapped,
 that feeling that you've got a problem and you can't go anywhere with it, you can't change it, you can't
 deal with it, it's there and that's it.
 And you get into that feeling too of being trapped when you feel I can't go anywhere, this is it.
 Like I'm confined by the boundaries of this community
 you just start to stagnate
 that's when I started getting really stressed, frustrated, when I feel like I'm no longer growing.
 the situation with management was terribly devastating because you just felt that there was absolutely
 no out, there was no way of reaching past that invisible barrier of zone office
 to tell people that somebody here is affecting us in a very negative way.
 You couldn't do that, like all your points of exit were blocked and that was part of the thing,

nobody would listen, there was nobody there to talk to and nobody there to listen.
 The only person you had was your supervisor who was doing it to you
 if you went beyond her, you were defying or breaking the lines of communication and you'd be
 disciplined.
 It was a terrible situation to be in. Terrible.
 There's just nobody to talk to and nobody to share it with.

As soon as that particular supervisor left and after that whole group of (inaudible) left, it was like it
 was a weight that's gone and I can function again.
 But then about three or four years after that I started getting tired, I got tired as I said about the not
 being able to see change and that started to drag me down.

So how did you cope with that, you left? Yes. Basically, I left. I think if I hadn't have -- I got out.
 I made plans to (inaudible) into another job for a while and to get away from it.
 And I haven't been back.
 I knew it was time either to quit or take a leave
 I had to get out.
 It was just too hard to get out of bed for those night calls
 after a while the money didn't make any difference at all. It just didn't make up for it, for the stress.
 When I was in it, how did I cope? Well, I don't know. I walked, I did a lot of walking.
 I don't know how I coped. In the beginning I used to socialize a lot but then that dropped off.
 I just lost interest in that.
 I spent a lot more time to myself.
 I didn't go out as much as I did before,
 that's not coping that's succumbing, basically, to it
 had have coped I would have still been there I suppose.
 I would have gotten over it,
 but I could see it going down,
 in retrospect, now, at the time I didn't, but in retrospect I could see that I was heading down.
 It was time to get out.
 Had I not gotten out I don't know where I would have ended up.
 I really don't, because I was getting tired.

I altered my work environment
 I work at it from a different angle now.
 I like that angle because I feel again like I'm affecting change,
 I'm in a position where I can maybe make a difference and affect change.
 I'm planning on going back to the field so I don't know how it'll be.
 I've had a lot anxieties about doing that because I can almost feel the way I felt when I left.
 I'm not sure that it' a good idea

So why are you considering it? Well, money reasons. I mean practical reasons is why I'm doing it.

nobody would listen, there was nobody there to talk to and nobody there to listen. The only person you had was your supervisor who was doing it to you if you went beyond her, you were defying or breaking the lines of communication and you'd be disciplined.

It was a terrible situation to be in. Terrible.

There's just nobody to talk to and nobody to share it with.

As soon as that particular supervisor left and after that whole group of (inaudible) left, it was like it was a weight that's gone and I can function again.

But then about three or four years after that I started getting tired, I got tired as I said about the not being able to see change and that started to drag me down.

So how did you cope with that, you left? Yes. Basically, I left. I think if I hadn't have -- I got out. I made plans to (inaudible) into another job for a while and to get away from it.

And I haven't been back.

I knew it was time either to quit or take a leave

I had to get out.

It was just too hard to get out of bed for those night calls

after a while the money didn't make any difference at all. It just didn't make up for it, for the stress.

When I was in it, how did I cope? Well, I don't know. I walked, I did a lot of walking.

I don't know how I coped. In the beginning I used to socialize a lot but then that dropped off.

I just lost interest in that.

I spent a lot more time to myself.

I didn't go out as much as I did before,

that's not coping that's succumbing, basically, to it

had have coped I would have still been there I suppose.

I would have gotten over it,

but I could see it going down,

in retrospect, now, at the time I didn't, but in retrospect I could see that I was heading down.

It was time to get out.

Had I not gotten out I don't know where I would have ended up.

I really don't, because I was getting tired.

I altered my work environment

I work at it from a different angle now.

I like that angle because I feel again like I'm affecting change,

I'm in a position where I can maybe make a difference and affect change.

I'm planning on going back to the field so I don't know how it'll be.

I've had a lot anxieties about doing that because I can almost feel the way I felt when I left.

I'm not sure that it' a good idea

So why are you considering it? Well, money reasons. I mean practical reasons is why I'm doing it.

I've got to eat, I've got to work.

And part of it I'm going back because I feel like my skills are fading.

I need to go back

I'm not current anymore and I really want to keep my skills up and I feel like I'm going to lose them if I don't. So it's sort of for a refresher as well, but I don't know how it's going to go,

I have no idea but the community has really gone downhill the time that I've been gone.

I'm just not convinced that I can handle it, but we'll see.

the more I talk about it the more I realize it, the issue is control.

I couldn't handle being in a situation where I wouldn't feel like I had control of the work situation.

It would scare me.

Do you feel burned out sometimes now? Yes. Yes. I do on occasion.

I don't know if it's burned out or just frustrated.

I don't know if the two are synonymous or not, but I just get so frustrated with the system.

I get frustrated with the attitude of the not --I'm frustrated with the politics.

The grass roots individual, I still see the laughter,

I see the sparkle and I see that sad individual

but the political arena just frustrates me to no end.

That's when I just feel, I don't need this anymore.

If that's burned out, then maybe I am, maybe I shouldn't be working anymore in the north, I don't know.

But that will just make me pull my hair out and make me walk out and quit all together.

I find the nursing personnel, I enjoy working with them.

I like them and there's a lot of good ideas out there and a lot of very strong people with really strong ideas

I like people with a vision and I like people that can contribute and have good ideas and I think a lot of the nurses out there are like that, I mean generally speaking.

I think there certainly are nurses that are narrow in their thinking or narrow in their perspective and narrow in their outlook but that's a given.

I like having the power, control, I don't know.

I don't look at it as power and control, it's having that ability just to speak out and have your views heard

Frustration for me is feeling tired, unproductive.

trapped but not trapped like I felt when I was in the field when I was knowing that it was time for me to go.

When I'm frustrated, there's certainly anger, there's a quiet anger, it's not an expressed anger.

Well, yes, it is.

I become quite vocal about it but how it affects me is fatigue, yes, mainly fatigue I think is the big one, lack of interest and unproductivity,

shuffling papers from one side of the table to the other desk,
 not getting the report done that you're supposed to do,
 focusing on the things that aren't important and you sort of think (inaudible).
 That's how it manifests, and not wanting to go to work.
 That's not all the time, that's not as strong as I'd say on occasion, but not a lot.

Do you think working in the north has this inherent to it? Frustration? Yes. Yes, I do.
 I do, actually. I think I never thought of it before but when I give it some thought, I think, yes, it's
 there

I think it's there because of getting back to the aspect of not being able to affect change,
 not being able to alter things or make things better or different,
 seeing the same thing over and over again
 whether it's hearing all the time about how bad the health care is in the north
 how nurses can't do that,
 or whether it's Mrs. Smith coming in with a blood sugar of 30 again, after I've been through this with
 her and we've done all we can do for her and we have taught her and still it's 30 and still things aren't
 changing, and I think a year of that with 20 Mrs. Smiths, it's frustration and tiring.

Most of them, there's something about it that draws them to the north, but I'm trying to think of the
 type of personality that probably would, and yet I can't. I can't answer that.

there comes a time after a while too where you feel like you're never really a part of the community.
 Never. No matter how involved you are, you are still an outsider, you will always be an outsider
 in people's minds they are there not for the duration, that they will be going, they will be leaving at
 some point The people know that and the nurses know that
 it comes down to how long is my life going to be on hold here?
 Now, there are some people who have put their life on hold for a large number of years
 but they also know that they are going to be getting out, that they're going to be leaving and they're
 not coming back.
 feeling trapped and feeling confined in a way that I'm here in a community that I'll never be a part of,
 the only way out is to take that plane,
 I can only go this far before I'm in bush and I can't go any further
 the isolation, after a while, I think does close in on people.
 that's the point I was getting to where I felt I had to get on with my life
 that isolation is closing in on me.
 When I think about going back, that's what bothers me.
 I really feel that my life is on hold
 when I go back there if I go back it would be for a year or two years or three years.