

# SALUTOGENIC COPING WITH BURNOUT AMONG NURSES: A QUALITATIVE STUDY

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## ABSTRACT

Previous research has confirmed the quantitatively determined negatively significant relationship between burnout and salutogenic functioning. This study qualitatively investigates the nature of the experienced difference in the salutogenic coping of nurses with different levels of burnout. The sample consisted of 105 general nurses whose level of burnout was ranked from high to low. The five individuals with the highest and the five with the lowest burnout scores were used. An interview was conducted with each of these nurses and the data content analysed. Two main themes, namely symptoms of burnout and salutogenic coping behaviour, emerged. The high burnout subgroup reported most of the burnout symptoms and the low burnout subgroup reported the behavioural characteristics of salutogenic functioning, namely comprehension, challenge, cognitive control, problem solving, meaningfulness, commitment, manageability, control, delayed immediate gratification and optimism. It is hypothesised that burnout robs the individual of coping strengths, resources and salutogenic functioning and salutogenic functioning facilitates the necessary psychological strengths to cope with burnout. It is recommended that labour management implement these findings in employee well-ness programmes as well as in the training of negotiators and the monitoring of their performance.

## 1 INTRODUCTION

Burnout has been popularised as a behavioural phenomenon by Freudenberg (1982; 1985), Maslach (1976; 1978) and Pines (1993; Pines & Aronson 1981; 1988). The effect of burnout is found to be the highest among people in the so-called "people careers" such as social workers, police workers, managers (Maslach & Schaufeli 1993), and nurses. Golembiewski, Boudreau, Munzenrider and Luo (1996) found that

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internationally, at least 20% of nurses are categorised as having severe burnout. The reason given is the prevalence of intense feelings of tension, anxiety, embarrassment, fear and hostility (Cherniss 1995; Maslach 1982), and the potentially serious consequences of these behaviours for the individual himself or herself, and for colleagues, clients / patients and the larger institutions in which they operate (Maslach & Schaufeli 1993).

The general causes, symptoms and effects of burnout among nurses have been researched extensively (Kempe 1978; Maslach & Jackson 1982b; Mitchell & Bray 1990; Muldary 1983; Pines & Aronson 1988). Burnout correlates with illness and injury (Antoni 1985; Belcastro & Hayes 1983; Weiman 1977), stress (Handy 1990; Hinshaw Smeltzer & Atwood 1987), psychosomatic illness (Pettegrew, Costello, Wolf, Lennox & Thomas 1980), occupational stress (McGrath, Reid & Boore 1989), job, interpersonal and organisational climate stress (Bedian, Armenakis & Curran, 1981), role ambiguity, role conflict and job dissatisfaction (Norbeck 1985). Poor coping strategy has been linked with burnout internationally (Ceslowitz 1989) as well as in South African research (Badenhorst 1997; Govender 1995; Mazinbuko 1989; Nixon 1996; Van Der Merwe 1994).

Vines (1991) recommended that research in nursing should not only focus on the quantitative study of coping and coping methods to control burnout. Additionally, it should search for mediating variables such as self-esteem, motivation and personality, and include qualitative investigation. Since the 1980s the focus in the social sciences has in fact moved away from studying stress and general coping behaviour (Badenhorst, 1997; Ngwezi, 1998) from an abnormal behavioural paradigm. The movement is towards studying specific personality coping constructs from the positive psychology (Frederickson 2001; Seligman & Csikszentmihalyi 2000; Sheldon & King 2001) and salutogenesis paradigms (Antonovsky 1979; Breed 1997), including psycho-fortology as a field of study (Coetzee & Cilliers 2000). Recently, burnout is studied in terms of various so-called salutogenic coping constructs such as a sense of coherence (Leverit, Lucas & Ortlepp 2000; Palsson, Hallberg, Norberg & Bjorvell 1996). The most popular construct used in studying burnout in nursing is hardiness (Boyle, Grap, Younger & Thornby 1991; Collins 1996; De Pew, Gordon, Yoder & Goodwin 1999; Marsh, Beard & Adams 1999; Simoni & Paterson 1997; Sims 2000; Topf 1989).

A sense of coherence was found to be a major contributing factor in coping with anxiety (Hart, Hittner & Paras 1991), work-related stress and

burnout (Stechmiller & Yarandi 1992), prolonged caring for chronically ill older persons (Coe, Romeis, Tang & Wolinsky 1990), general coping in hospitals (Flannery & Flannery 1990; Jones 1991; Kalimo & Vuori 1991; Ryland & Greenfeld 1991) and coping with burnout, work load and role conflict among South African psychiatric nurses (Levert, Lucas & Ortlepp 2000). Hardiness (Kobasa 1982; Lambert & Lambert 1987) is seen as an inherent health promoting factor with a direct relevance to nursing practice - it can be taught 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. This finding has been confirmed for ICU nurses (Consolvo, Brownell & Distefano 1989; Manning, Williams & Wolfe 1988; Rummel 1991; Taylor & Cooper 1989). According to Rosenberg (1990), hardiness predicted 34% of the variance in nurses' lifestyle. Commitment as a dimension and years employed had the largest beta weights and were the most predictive of a healthy lifestyle (Boyle et al 1991; Dermatis 1989; Gillmore 1990). A South African study by Cilliers (2002) reported a strong negatively significant relationship between burnout (measured with the aid of the Maslach Burnout Inventory - Maslach & Jackson 1981, 1986) on the one hand, and a sense of coherence (Antonovsky 1987) and hardiness (Kobasa 1979) on the other hand.

Although the above quantitative studies prove that a statistical relationship between burnout and salutogenic functioning exists, the deeper psychological and qualitative experience of the burned out individual has not yet been researched. Knowledge about this experience could be valuable in understanding the role of burnout in labour relations management, especially with individuals whose work performance and efficacy become negatively influenced by a lack of psychological strengths to cope with work demands.

## **2 BURNOUT**

Burnout is described as a persistent, negative, work-related state of mind (or syndrome) which develops gradually over time in individuals who were originally highly motivated, striving, achieving and non-compromising, with good intentions and high expectations (sometimes out of touch with reality), who stretch themselves beyond the normal work boundaries for a long period of time in their quest for meaning. The individual then develops an array of physical, psychological and attitudinal symptoms, primarily emotional exhaustion, accompanied by distress, depersonalisation, a sense of reduced effectiveness, decreased motivation and the development of dysfunctional personal and societal

attitudes and behaviours at work (Chemiss 1995; Golembiewski & Munzenrider 1998; Jackson 1982; Maslach 1976; 1982; Maslach & Jackson 1982a; 1982b; 1986; Pines & Aronson 1981; 1988; Schaufeli & Enzmann 1998). Burnout is not the same as stress (Maslach & Schaufeli 1993; Pines 1993; Schaufeli & Enzmann 1998) or depression (Maslach & Schaufeli 1993).

The behavioural symptoms of burnout are well researched and documented (Golembiewski & Munzenrider 1998; Jackson 1982; Maslach 1976; 1982; Maslach & Jackson 1993; Pines & Aronson 1981; 1988; Schaufeli & Enzmann 1998), and can be summarised as follows:

- (1) *Physical* (headaches, nausea, restlessness, muscle pain, hyper-ventilation, sleep disturbances, chronic fatigue, increased heart and respiration rate, gastro-intestinal disorders, coronary heart disease, prolonged colds, flu, susceptibility to viral infections)
- (2) *Cognitive* (poor concentration, forgetfulness, making mistakes in complex and multiple tasks, rigid thinking, intellectualising problems, poor decision making)
- (3) *Affective* (helplessness, hopelessness, powerlessness, a tearful and depressed mode, low spirits, dim mood, exhausted emotional resources because too much energy has been used for too long, decreased emotional control leading to undefined fears, anxiety and nervous tension, irritability, oversensitivity, coldness, unemotional behaviour, outbursts of anger, daydreaming, fantasising, low frustration tolerance leading to aggressiveness and a negative self-concept)
- (4) *Motivational* (lessened intrinsic motivation, initiative, enthusiasm, interest and idealism, increased disillusionment, disappointment and resignation)
- (5) *Behavioural* (hyperactivity without knowing what to do about it, forgetfulness, impulsiveness without carefully considering alternatives, procrastination, doubt, indecisiveness, excessive consumption of stimulants such as coffee, tobacco, alcohol, tranquilisers, barbiturates, drugs, under and over eating, accident proneness)

- (6) *Interpersonal* (decreased empathy and involvement with and interest in others, isolation, withdrawal, negativism, irritability, hostility, suspicion, indifference, discouragement, stereotyping, hostility, a weakened level of impulse control)
- (7) *Work-related* (reduced effectiveness, performance, productivity, satisfaction, resistance in going to and doing work, a sense of failure and meaninglessness)

Coping with burnout is discussed in the literature as lying on the individual, interpersonal and organisational levels.

The *individual* has the responsibility to recognise the signs and symptoms of burnout (Muldary 1983; Pines 1993). Individual coping is described as an intra personal and action-oriented effort to manage the environmental and internal demands and conflicts, through awareness, understanding and taking responsibility for action (Lazarus, 1974; Lazarus & Launier 1978; Pines & Aronson 1981).

*Interpersonal* coping strategies refer to having and using social support systems, defined as networks of occupational relationships, which could comprise one or more of the following: emotional support (admiration, respect, liking), affirmation or appraisal (acknowledgment of the appropriate behaviour of another), and aid (direct giving of materials, information or service) (Morano 1993; Pines & Aronson 1988).

*Organisational* coping strategies refer to different organisational development (OD) inputs to promote organisational health and optimal performance (Cox 1985; Muldary 1983; Pines & Aronson 1988; Schaufeli, Enzmann & Girault 1993).

### 3 SALUTOGENIC FUNCTIONING

The salutogenic paradigm (Antonovsky 1979) focuses on the origins of health and well-ness (Latin *salus* = health / Greek *genesis* = origins), the location and development of personal and social resources and adaptive tendencies which relate to the individual's disposition, allowing him or her to select appropriate strategies to deal with confronting stressors. According to Antonovsky (1979) and Strümpfer (1990; 1995) there are many such behavioural constructs acting as mediating variables explaining coping behaviour (such as self-efficacy, locus of control, resilience and happiness). It was suggested by Rich (1991) and Sullivan (1989) that a sense of coherence and hardiness are the constructs most

relevant in the nursing field. Therefore, these two constructs are used for conceptual purposes in this research.

*Sense of coherence (SOC)*. Antonovsky (1984; 1987) defines SOC as a global orientation that expresses the extent to which the individual has a pervasive, enduring, though dynamic feeling of coherence, that the stimuli deriving from his or her internal and external environments in the course of living are structured, predictable and explicable, that the resources are available to meet the demands posed by these stimuli, and that these demands are challenges worthy of investment and engagement. The SOC predicts the extent to which the individual feels that there is a probability that things will work out well (Antonovsky, 1979). It consists of three core personality characteristics, namely:

- (1) comprehensibility (making sense of the stimuli in the environment),
- (2) meaningfulness (an emotional identification with events in the environment) and
- (3) manageability (coping with the stimuli in view of the available resources). The strength of the SOC is connected to a variety of coping mechanisms, called generalised resistance resources (GRRs) (Antonovsky, 1979), defined as any characteristic of the person, the group, or the environment that can facilitate effective tension management. According to Antonovsky (1987), work has a significant role to play in the shaping of the SOC. A work environment which is predictable, manageable, where the employee can participate in decision making and has a voice in regulating his or her work enhances the SOC because work is experienced as meaningful.

*Hardiness (HAR)*. Kobasa (1982) defines HAR as a constellation of interlocking personality characteristics that function as a resistance resource in the encounter with stress. It consists of three personality dispositions namely (1) commitment (the ability to believe in the truth, importance, and interest value of who one is and what one is doing) versus alienation, (2) control (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) versus powerlessness and (3) challenge (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) versus threat to security. The hardy personality uses an optimistic and cognitive appraisal of events which will determine the subsequent actions directed towards those events (Manning, Williams & Wolfe 1988).

The salutogenic personality profile incorporates the following behaviour (Viviers & Cilliers 1999): On the cognitive level, the individual is able to understand and view stimuli from the environment in a positive and constructive manner, to be powerfully in control and to use information towards effective decision making. On the affective level, the individual functions with self-awareness, is confident, self-fulfilled, views stimuli as meaningful and feels committed towards life in a connected and mature manner. On the motivational level, the individual is secure and motivated from within, perceives stimuli as a challenge which directs his or her energy to cope, solve problems and achieve results. The interpersonal characteristics entail the capacity to form meaningful relationships with others within a support system at work and in society.

#### **4 THEORETICAL STATEMENT AND RESEARCH QUESTION**

The central theoretical statement of this research can be formulated as follows: The individual who functions on high levels of burnout (with its above-mentioned symptoms) will not demonstrate salutogenic strengths and characteristics and will thus not be able to cope with work demands in a salutogenic manner. On the other hand, the individual who functions on low levels of burnout will demonstrate inherent salutogenic strengths and characteristics and will thus be able to cope with work demands in a salutogenic manner. The research question is whether a noticeable qualitatively experienced difference in the salutogenic coping of nurses with different levels of burnout exists. If this question is answered positively, this knowledge will help in the deeper understanding of the burnout experience and offer guidelines for future individual, group and organisational coping strategies and development. In terms of labour relations management, this knowledge could help in assisting people like managers and negotiators who are no longer able to perform their jobs and tasks effectively, because of prolonged stress.

#### **5 AIM AND DESIGN**

The research aim is to investigate the nature of the experienced difference in the salutogenic coping of nurses with different levels of burnout. Quantitative research is undertaken to measure the level of burnout and qualitative research to ascertain the nurse's coping experience.

## **6 METHOD**

### **6.1 The sample**

A convenient sample (Anastasi 1990) was used, consisting of 105 nurses from various large hospitals in Gauteng Province. Each had a three-year nursing diploma and at least 5 years' nursing experience. Only females were included with ages ranging between 28 and 57 years. There were 73 white and 32 black nurses. All were involved in general nursing and were working full-time. From these, the five nurses with the highest and the five with the lowest burnout scores were used for further qualitative investigation.

### **6.2 Quantitative measurement**

Burnout was measured with the aid of the Maslach Burnout Inventory (MBI) (Maslach & Jackson, 1981, 1986), chosen for its (1) conceptual congruence to the above definition of the construct and its (2) acceptable psychometric qualities provided in the literature. The MBI measures burnout (BO) on three subscales, namely emotional exhaustion (a reduction in emotional resources, feeling drained, used up and physically fatigued), depersonalisation (an increase in negative, cynical and insensitive attitudes towards colleagues, clients and/or patients) and a reduction in personal accomplishment (a feeling of being unable to meet patient's needs and to satisfy essential elements of job performance). Maslach and Jackson (1986) as well as Schaufeli and Janczur (1994) offer factor-analytical support for the usage of the subscales separately. Maslach and Jackson (1981; 1986) as well as Lahoz and Mason (1989) report Cronbach alpha test-retest reliability coefficients from 0,54 to 0,60 and 0,60 to 0,82 after one year. Validity is confirmed by Maslach and Jackson (1984).

### **6.3 Qualitative measurement**

A 60-minute, semi-structured interview (Miles & Huberman 1994) was conducted with 10 nurses - the five scoring highest and the five scoring lowest on burnout. The interview was tape-recorded and transcribed afterwards. The aim of the interview was to ascertain the nurse's experience of her work in terms of salutogenic coping with burnout. The interview started with one question, namely: "How do you experience your work and how do you cope with your job demands?". Hereafter, the interviewee was encouraged to give more responses by the interviewer's summarising and reflecting on the material which the respondent had

already given, using the helping models described by Carkhuff (2000) and Ivey (1971). Both these models are based on the person-centred approach used by Rogers (1975, 1982). During the interview, there was no audible or visible resistance to being part of the measurement. The interview was analysed by means of content analysis (Strauss & Corbin 1990), and specifically open coding (a process of breaking down, examining, comparing, conceptualising and categorising data). Thus, the main theme and the subthemes were determined (Jones, 1996; Kerlinger, 1986). Trustworthiness was ensured by having the results checked by two psychologists, to whom these techniques are well known.

#### **6.4 Procedure**

- (1) The staff offices of the various hospitals were contacted and informed about the research and its objective, and asked to allow access to interested staff members.
- (2) After appointments had been made, the sample attended a psychometric session in groups of up to 15, lasting about 30 minutes, where the MBI was administered.
- (3) The total sample's BO scores were ranked from high to low (resulting in a fairly normal distribution).
- (4) The Statistical (1999) Statsoft package was used to compute t-test scores to determine the significance of the difference between the 10 highest and the 10 lowest BO scores.
- (5) The interviews were conducted within one week after the administration of the MBI. The respondents did not know their BO scores.
- (6) The interviews started with the individual with the highest score, followed by the second highest and so on, until the manifesting themes formed a clear pattern with the fifth highest scoring individual. These five individuals were grouped as the "high burnout subgroup" and included three white (aged 42, 51, 35; with 14, 20, 13 years' experience) and two black nurses (aged 35, 56, with 19, 35 years' experience).
- (7) The interviews continued with the individual with the lowest score, followed by the second lowest and so on, until the manifesting themes formed a clear pattern with the fifth lowest scoring individual. These five individuals were subgrouped as the "low burnout

subgroup" and included two white (aged 32, 51; with 14, 20 years' experience) and three black nurses (aged 29, 34, 33, with 8, 10, 5 years' experience).

## 7 RESULTS

### 7.1 Quantitative result

The t-test result indicated a significant difference between the 10 high-scoring and the 10 low-scoring respondents (high:  $t = -18,98$ ,  $df = 7,9$ , probability = 0,00; low:  $t = -18-98$ ,  $df = 8,0$ , probability = 0,00). This means that the qualitative difference emerging from the interviews was valid.

### 7.2 Qualitative result

The interview brought two main themes to the fore, namely the symptoms of burnout and salutogenic coping behaviour.

#### Theme 1. The symptoms of burnout

The high burnout subgroup reported the following symptoms of burnout.

- (1) *Physically*, they were fatigued, "exhausted, tired and tense", had a lack of energy, had difficulty sleeping, suffered from headaches and vague physical pains ("I'm constantly feeling ill and finished").
- (2) *Cognitively*, they had limited knowledge about themselves, their own potential and limitations. They experienced difficulty in focusing and concentrating ("I sometimes forget who I am and where want to go in life".)
- (3) *Affectively*, they initially presented a facade of strength in the interview ("I'm not always coping that badly"). After a while, and maybe as trust developed in the interview situation, negatively experienced feelings came to the fore. These were emotional exhaustion, feeling drained, overwhelmed, anxious, frustrated, angry, sad, depressed, dissatisfied and alienated ("Sometimes my feelings are just taking over and then I feel out of control").
- (4) *Motivationally*, they had little sense of purpose, they found it difficult to motivate themselves, did not enjoy previously enjoyable activities such as interesting tasks and hobbies ("After work I only watch TV

and then fall asleep right there"). Some respondents were making plans to escape from their work situation ("Resigning is the only option for me, but then again, I can't do any other work"). The tendency was to push themselves hard and when something dramatic happened, they realised that they were not coping.

- (5) *Behaviourally*, three of the five respondents had unhealthy eating habits, smoked excessively, two suffered from sleep disorders, sleeping either too little or too much and easily became dependant upon sleeping tablets. One reported that she often cried as a symptom of feeling despondent. No one did any physical exercise ("At the end of the day there is no energy left for anything!").
- (6) *Interpersonally*, they showed decreased interest and involvement with others, experienced isolation, withdrawal, negativism, irritability, hostility, suspicion, indifference, discouragement, stereotyping, hostility and easily lashed out at colleagues and family members for no obvious reason ("if they can only leave me alone" / "Why is everyone on my case?").
- (7) *Work wise*, they felt overwhelmed and did not cope well with their roles and tasks. Some reported not meeting deadlines, that they felt disappointed in personal accomplishments as if they were not progressing ("I'm constantly on the red carpet." Two respondents reported a lack of enjoyment and wanted to leave their present work situation ("Everything in my work becomes hell"). All five respondents reported that the constant confrontation with pain, trauma, violence and death in the hospital was emotionally taxing, which led to their desensitisation and hardness ("I've only seen the dark side of life"). Interpersonally, with patients they got tired of dealing with patient' issues and began to feel negative towards patients. They seem to generalise these feelings from one patient to another ("Sometimes I don't care if they all just die"). Thus, they lost sight of the caring nature of their tasks and started focusing on "outside issues" such as employment benefits and "the inefficient payment of the job". They blame management for their circumstances. Interpersonally, towards colleagues, they felt isolated and negative ("I'm not part of the clique"). This led to shallow interactions and conflicts ("They constantly fight with me about nothing.") Working together for long hours was very stressful and led to the taking of responsibility on behalf of colleagues, which is stressful and felt claustrophobic. Small differences tended to build up to big interpersonal conflicts which made for a negative work climate and a blaming culture ("There is

not a single person who cares for me"). Sometimes the fights related to the multicultural nature of the staff component and the difficulty in adjusting to transformation indicating the lack of trust underlying this issue. These fights tended to extend into management conflicts. Staff shortages led to spending more time at work, which made it difficult to balance work and home / family life. Often these issues are taken home and played out there towards family members ("Even my family does not understand me anymore"). This led to more feelings of alienation and the avoidance of others, because they became associated with more stress. Institutionally, they experienced a lack of support and sensitivity from management and authority figures. The bureaucracy with its rules and policies was blamed for making rules and then they did not follow the rules themselves.

This behaviour corresponds with the symptoms of burnout listed in the literature (Jackson 1982; Maslach & Jackson 1984; Pines & Aronson 1988; Schaufeili & Enzmann 1998). The causes of burnout also correspond to the predictions of causes cited in literature, namely personality characteristics, work-related attitudes and organisational characteristics (Golembiewski & Munzenrider 1998). This profile reflects an individual who is not making use of all her potential, because she is emotionally and physically drained of energy. She has no access to any inherent psychological strengths. She is not trusting her own self and is progressively coping less with the demands of life and work. At work this manifests in poor performance and interpersonal contacts, enhancing the experience of not being good enough and not coping well.

The low burnout subgroup reported almost none of the above symptoms of burnout.

- (1) *Physically*, they reported having the energy to work as well as to attend to family issues and hobbies. They very seldom got bogged down by the physical demands of the job and often took on more than was expected of them.
- (2) *Cognitively*, they seemed to understand what was happening around them, and what was expected of their work role. Some individuals reported being aware of not utilising all of their potential, but still wanted to optimise this.
- (3) *Affectively*, the respondents gave the impression that they were open to emotional experiences, tried to make sense out of them and wanted to grow through the exploration of feelings and experiences.

No intense feelings of anxiety, anger, frustration, sadness or depression were reported.

- (4) *Motivationally*, they experienced a sense of purpose, tried continuously to motivate themselves, enjoyed life, work tasks and hobbies, without trying to escape from the situation. A sense of purpose and well-being was experienced.
- (5) *Behaviourally*, they tried to maintain balanced eating and sleeping patterns and tried not to become dependent upon any idea or substance. Although three of them were not regularly doing physical exercise, they were aware of the benefits when they did.
- (6) *Interpersonally*, they tried to stay in contact with people, liked being with others and showed an interest in being involved in people activities - in the work situation as well as outside of work. Although they experienced being with people as enriching, they also allowed themselves time and space to be alone, attending to their own personal needs. A sense of reality contact and an intact impulse control were reported.
- (7) *Work wise*, they felt involved in their role and tasks, met deadlines and felt that they were progressing in their careers. Although nursing brings them in contact with pain, trauma, violence and death, they tried to keep an emotional distance and talk to colleagues as often as they could about daily happenings. They tried to see each patient as an individual with their own needs, life and family. Respecting this in others facilitated an internal sense of happiness and well-being.

The responses from the low burnout subgroup showed an absence of burnout symptoms. They actually represent coping behaviour which resembles the behavioural characteristics of SOC, hardiness and happiness (as discussed above).

## **Theme 2. Salutogenic coping behaviour**

The high burnout subgroup showed a lack of the salutogenic functioning characteristics. They did not seem to understand what was happening around them ("I don't know what is happening with me"), which led to feelings of being out of control and powerlessness. Their environment did not make emotional sense to them and they denied their negative and complex feelings. There was a lack of commitment, and they felt alone and alienated from others. They struggled with managing their personal

and work life ("I just want to keep my head above water"), they used flight reactions in the mind ("I just wish this will go away") or in contemplating leaving the job and even the profession, they operated from an external locus of control, they denied choices and feared challenges because they felt this threatened their security.

The high burnout group seemed to have no salutogenic resistance resources such as understanding, insight and control available for effective coping with the demands of their job.

The low burnout subgroup reported the following characteristics of salutogenic functioning, categorised as comprehensibility, challenge, cognitive control, problem solving, meaningfulness, commitment, manageability, control, delayed immediate gratification and optimism.

- (1) *Comprehensibility*. They reported a deliberate effort to learn more about the task content, nursing in general ("I am studying very hard towards my degree") and about colleagues from different cultural backgrounds ("I've become good friends with two black nurses"). They tried to look at situations and people objectively and to put things into perspective. This helped to cope with the overwhelming demands of life and work. There was a realisation that the work situation was becoming increasingly complex and stressful and that coping had to do with understanding the situation ("I realise that if I don't work hard and constantly improve myself I will stay behind").
- (2) *Challenge*. Life and work issues were approached with acceptance. They tried to frame change as a challenge, a learning experience and a stimulus to grow and develop. Therefore, accomplishments were experienced as satisfying, even difficult situations in the caring for patients and their families ("Although this is hard work, the rewards are endless").
- (3) *Cognitive control*. Their coping style was characterised by objectively standing back and rationally trying to understand that "one can only do what one can do". The next step seemed to be to deliberately take control over one's own resources and not taking responsibility for other people's life issues. This seemed to lead to the realisation that the self has power over own circumstances. One respondent reported that by (in her own mind) giving management freedom to control their own issues, her own experience of self-control was facilitated (a type of psycho-dynamic coping mechanism).

- (4) *Problem solving.* Problems were approached with a sense of reality, acknowledging differences and accepting responsibility for the self, and for one's own effect on others and issues. One respondent reported that this resulted in others following suit ("Perhaps I'm playing some kind of leadership role"), which enhanced enjoyment and a sense of reward for all involved. Two of the respondents reported using a strong cognitive approach to planning - defining the problem, evaluating alternatives and anticipating consequences ("This relieves me to concentrate on other issues").
- (5) *Meaningfulness.* They reported operating from an orientation where life is seen as something that follows its own course ("To give up control, leads to feeling in control"). Satisfaction and enjoyment were to be found in small things. They tried hard to use self-observation, sensitivity and to experience their feelings with openness - trying to understand feelings and their origins.
- (6) *Commitment.* They tried to make sense out of their choices and to take responsibility for them in order to make emotional sense out of life and work. They were committed to stay in nursing although they sometimes found it difficult - staying with the difficult here-and-now situation seems to make the difference ("Nursing is my passion"). They were aware of a calling and a larger purpose behind the work, although it does not always seemed so in the day-to-day activities.
- (7) *Manageability.* They reported that they coped with work stimuli in view of the available resources. Participation in work activities and feeling listened to by others, makes the most difficult day bearable and even filled with learning opportunities ("There is always something to learn").
- (8) *Control.* They reported feeling influential in the face of the varied contingencies of life. When helplessness and powerlessness appears, they tried to be aware of its effects and worked at countering the negative effect on their self-esteem.
- (9) *Delayed immediate gratification.* They showed awareness of their own internal processes and they showed the ability to delay the gratification of immediate needs ("I realise the work is not only about myself").

(10) *Optimism*. They tried to make an optimistic and cognitive appraisal of events which seemed to determine the subsequent actions directed towards those events ("When I see other people's suffering, I am so thankful").

## 8 CONCLUSION AND RECOMMENDATIONS

The results showed that the individual with a high level of burnout and its behavioural symptoms experiences work negatively and does not cope with job demands. The symptoms of burnout and especially the lack of psychological energy limit the individual's resistance and coping resources to such an extent that she gives up. This behaviour results in reduced work performance, productivity and job satisfaction. Especially in positions where the lives of others (colleagues, clients of patients) are in danger, the burned out employee can cause irreparable harm and even death, which could lead to court cases against him or her or the organisation. The qualitative results above indicate that the individual's experience represents anti-task behaviour, which influences the whole department or organisation. On the other hand, the individual with a low level of burnout has access to internal resistance resources and salutogenic strengths that enable her not to become a victim of job demands and pressures. She seems to understand herself and her environment, makes sense out of situations and happenings and then reacts from an internal locus of control in coping effectively. This reaction even further strengthens her ability to act more effectively, intra and interpersonally. Her experience of work is that she is in control, she shows commitment towards her profession and task, and establishes and maintains effective relationships with her colleagues.

It is hypothesised that burnout robs the individual of coping strengths, resources and salutogenic functioning whereas salutogenic functioning facilitate the necessary psychological strengths to cope with burnout.

It is recommended that general, labour, training and development management take cognisance of the role of burnout in organisations in terms of employee well-being. The results suggest that intense, continuous and lengthy periods of stress as experienced by "people workers" could result in the above symptoms, negative affecting efficiency in concentration, problem solving and interpersonal relationships. In terms of labour relations management, the negotiator's role fits the above, operating in intense and constant people contact, listening to others, trying to influence them, win them over and solve disputes and conflicts. This strenuous work could easily lead to burnout and if not attended to in

time, will leave the individual hopeless, helpless and ineffective. If performance is monitored and these symptoms noted in time, the individual could be assisted in countering them effectively. The stimulation of salutogenic functioning in organisational, management and staff development will help to optimise the general resistance resources of negotiators to enable them to facilitate effective performance.

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