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EXPERIENCES OF BURNOUT SYNDROME AND THE PROCESS OF RECOVERY

A Qualitative Analysis of Narratives Published in Autobiographies**

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Burnout syndrome limits work capacity and the ability to manage a social and family life. Such limitations may lead to alienation from oneself and can result in frustration and anger. The recovery process may include a search for quick fixes from professionals but responsibility is in the hands of the ill with support from professionals, family, and work. Learning about limitations, the need to rest and accepting illness, are vital in the recovery process, but they are also associated with feelings of shame and blaming oneself for causing one's own burnout by neglecting bodily signals.

Objective: Burnout syndrome affects the individual as a whole because it involves emotional exhaustion, depersonalization, and a low sense of personal accomplishment. Research into burnout syndrome has predominantly focused on treatment outcomes measured using quantitative methods. The existing qualitative research has deepened theoretical insights from a lifeworld perspective, although, methodologically speaking, previous qualitative studies have been restricted to interviews. The qualitative interview method is somewhat limited. Hence, the objective of the present study was to analyze how autobiographers narrate their experiences of burnout syndrome and to describe their recovery process.

Design: An inductive qualitative approach with a descriptive design was used to gain insights into the authors' experience of burnout and recovery process, as expressed in writing.

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Ethical Considerations: Because this research is not considered human subjects research, vetting by an ethics board was not necessary.

Setting/Subjects: The data comprised six autobiographies written by authors from Sweden.

Results: The results are presented in three categories: 1) descriptions of estrangement from one's own body, 2) descriptions of how the phenomenon is manifested in everyday life, and 3) descriptions of recovery processes.

Conclusion: Burnout syndrome intersects both work life and family life and reveals the individual as a whole, integrated being. It is vital for healthcare professionals to adopt a person-centered approach that sees the individual as an integrated whole, consisting of body, mind, and soul.

Keywords: burnout syndrome; health behavior; narrative; qualitative research; recovery; work-life balance

1. Introduction

The term 'burnout' was coined in the mid-1970s (FREUDENBERGER 1974; SCHAUFELI et al. 2009). The onset of burnout syndrome marks a protracted process that involves diffuse symptoms in three areas: emotional exhaustion, depersonalization/cynicism, and low sense of personal accomplishment (MASLACH et al. 2001). Burnout is closely linked to work-life environments, and correlated factors have been emphasized in previous research; for example, job demands, a sense of individual control at work, and social support from colleagues and managers (BAKKER & COSTA 2014; HÅKANSSON & AHLBORG 2017; LINDEBERG et al. 2011). Other significant variables are, for example, role conflicts and work role ambiguity (PIKÓ & MIHÁLKA 2017). Our assumption is grounded in integrative nursing and the unitary paradigm, which posit that human beings are whole systems, inseparable from their environments (KOITHAN et al. 2017). Based on the reflection that burnout syndrome affects the whole human being, in the present article, we have analyzed narratives written in the first-person perspective, as presented in autobiographies.

2. Background

SCHAUFELI (2018) investigated burnout in 35 European countries based on a random sample of almost 44,000 individuals. In that study, it was reported that in countries where the levels of burnout are high, people are less happy, feel less engaged at work, and are less satisfied with their jobs. In relation to those results, the study also stressed that higher levels of burnout were found in countries where work was considered to be highly valued and important. In an earlier paper, SHANAFELT and colleagues (2015) examined the prevalence of burnout and satisfaction with work-life balance among physicians. They reported that only 41% of participants felt that their work schedule left enough time for personal and family life. Similarly, other studies have also shown that work-related stress affects family and social life (HÅKANSSON & AHLBORG 2017; OSHIO et al. 2017). Moreover, a systematic review showed that the development of emotional exhaustion is more likely to be seen among individuals with jobs that involve high demands and service-related professions (SEIDLER et al. 2014). Healthcare staff are exposed on a daily basis to stressful situations, not only

due to high workload, but also because they cannot control patient flows, patients' rapidly deteriorating health and moral distress. Hence, many publications have investigated burnout among physicians (ROTENSTEIN et al. 2018), nurses (CAÑADAS-DE LA FUENTE et al. 2015), midwives (CREEDY et al. 2017), physiotherapists (PAVLAKIS et al. 2010), social workers (HRICOVÁ et al. 2020) and dentists (JIN et al. 2015).

Cross-sectional studies, longitudinal studies, and meta-analyses have led to important insights into the theoretical body of knowledge on burnout regarding, for example, prevalence and risk factors (ALARCON et al. 2009; GARROSA et al. 2011; MASLACH et al. 2001). However, considerably fewer studies have investigated burnout from a life-world perspective: the narrative of subjective experiences. Results from some qualitative studies have deepened our understanding of how individuals experience burnout from a first-person perspective. KAVALIERTOS and colleagues (2017) interviewed staff in palliative care about their experiences of burnout and how its symptoms affected their work with patients. Another qualitative study by SALMINEN et al. (2015) analyzed interviews to describe experiences of what participants considered to be beneficial to their recovery in burnout rehabilitation. Clients' insights into being responsible for their own well-being was a key finding, seen in metaphors such as 'my well-being in my own hands'. Moreover, ARMAN and colleagues (2011) adopted a hermeneutic approach and interviewed 18 people about their burnout experiences. They demonstrated the burnout crossroads in terms of a collapse: 'The breakdown is often experienced as a release. Suddenly, or in due time, the person enters a sphere of "disarming" or "leaving the scene".' (ARMAN et al 2011, 299).

Burnout rehabilitation falls into three categories: person-directed interventions, organization-directed interventions, or a combination of both intervention types (AWA et al. 2010; BORZA et al. 2012; PETERSON et al. 2008). Person-directed interventions focus on teaching the individual to recognize stressors and use coping techniques; for example, relaxation. Organization-directed interventions are more focused on changing the working environment and preconditions (MARINE et al. 2006). Regarding the reduction of emotional exhaustion, a review study on job burnout in mental health providers found that person-directed interventions were more effective than organization-directed interventions (DREISON et al. 2018). However, many studies have looked at the combination of these two approaches (BORZA et al. 2012; WESTERMANN et al. 2014). Care models in healthcare have undergone changes during the past fifty years in terms of philosophies and approaches; the transition has gone from being medically oriented, to patient-centered, and further to the contemporary approach of person-centered care (LOUW et al. 2017). Key features of the person-centered approach are to take the perspective of the patients' own beliefs and values (MCCORMACK & MCCANCE, 2006) and to increase their agency (BANDURA 2000). Hence, the person-centered approach presupposes a shift in positions in which the care-provider needs to be skilled in effective communication so as to facilitate partnership and strive toward health promotion (CONSTAND et al. 2014). Thus, MCCORMACK and MCCANCE (2006) emphasized the areas of sympathetic presence, engagement, sharing decision-making to create a therapeutic culture, providing a feeling of well-being and, thus,

promoting satisfaction with care. In summary, the bulk of the previous research has investigated burnout syndrome and treatment using quantitative methods, while some qualitative seminal works have deepened our insights through the analysis of interview narratives. However, the qualitative interview method is somewhat limited (ATIENO 2009). In the present inquiry, the aim was twofold: to analyze how autobiographers narrate their experiences of burnout syndrome and to describe their recovery process.

3. Methods

3.1. Design

We used an inductive qualitative approach that was adapted using a descriptive design (CRESWELL & POTH 2018), as we wanted to gain insight into people's experiences of burnout. The inductive approach was chosen because we wished to analyze the data without a theoretical filter. However, given our own previous theoretical knowledge and experiences of encountering patients with burnout syndrome as nurses, we acknowledge that it is not possible to fully set aside our pre-understandings. However, through internal discussions, we tried to illuminate our experiences and pre-understandings to better understand how these might impact the analysis. Our underlying epistemological assumptions are in agreement with SHAPIRO (2011), who stated that 'A patient's story is rarely "just a story," but is rather the conscious and unconscious representation and performance of intricate personal motives and dominant meta-narrative influences' (SHAPIRO 2011, 68).

3.2. Sample

In accordance with the qualitative approach and the purpose of the review, we chose to use a purposive sample. The inclusion criteria were: autobiographical books of a minimum of 100 pages, written in the first person, and recently published. Because our first language is Swedish, we wanted to include books written in Swedish or translated into Swedish. Considering the cultural variation across societies, we wished to include a rather homogeneous sample and, hence, restricted it to experiences from Europe, although to achieve heterogeneity in the sample, which is desirable in qualitative studies, we included books written by both men and women who have varying life histories, ages, and occupations (see *Table 1*).

Table 1
The analyzed autobiographies

<i>Title</i>	<i>Author</i>	<i>Year</i>	<i>Pages</i>	<i>Profession</i>	<i>Family</i>
Dare to be afraid: A book about burnout syndrome (Swedish title: <i>Våga vara rädd - en bok om utmattningssyndrom</i>)	Emma Holmgren	2015	154	Division head & student	Married & two children
Burnout: The way back as a person and an athlete (Swedish title: <i>Utbrändheten: och vägen tillbaka som människa och idrottare</i>)	Marcus Streiffert	2015	151	Business student & elite cyclist	Parent
Don't feed the monkey: My way out of burnout syndrome (Swedish title: <i>Mata inte apan: min väg ur ett utmattningssyndrom</i>)	Pia Andersson	2016	148	Child educator	Married & two children
An end, a beginning: A psychiatrist's thoughts about his own burnout syndrome (Swedish title: <i>Ett slut: en början - en psykiatrikers funderingar kring sitt utmattningssyndrom</i>)	Niklas Nygren	2017	144	Psychiatrist	Married & two children
With my bravery: Getting through burnout syndrome (Swedish title: <i>Med mitt mod genom utmattningssyndrom</i>)	Eva Svärd	2017	175	Entrepreneur & advisor	Married & two children
Help, I'm burned out (Swedish title: <i>Hjälp jag är utmattad</i>)	Clara Lidström & Erica Dahlgren	2018	190	Blogger/author Journalist/Swedish Public Radio	Married & two children Married & two children

3.3. Data collection

A thorough, but not systematic, search was conducted for books in library search engines, bookstores and on Google (www.google.se). The main Swedish key words were 'utmattning', 'utmattningssyndrom', 'utbränd' [burnout, burnout syndrome]. Books could be included even though a key word was not in the book title. We found 13 books that we considered as highly relevant to our purpose. Seven books were excluded from the first review: one was written by a journalist, two were a collection of poetry, two were shorter texts without a coherent narrative, one did not correspond to our purpose and the final excluded book was a self-help book. After excluding the seven books, we held a discussion and reached the conclusion that the remaining six books were all relevant to our study purpose and they met the inclusion criteria (described in the Sample heading). To further review the six books, we read ten pages from each book, some pages from the beginning, some from the middle, and some from the end. This final review was not determined by any specific criteria but rather formed a basis for a final decision, based on a consensus arrived at from joint

discussions. The strategy of reading parts of the books while thinking of the study's purpose verified that all the books were relevant to the aim of the review. After the final review of the books' relevancy, the entirety of the books were read.

3.4. Data analysis

The process of analysis followed the steps described by GRANEHEIM and LUNDMAN (2004). Thus, the first two authors initially read the six books as a whole individually twice to get an overview of the content. Then, both authors extracted shorter paragraphs and quotes relevant to the aim. These excerpts were the first units in our analysis, called 'meaning units' (see *Table 2*). GRANEHEIM and LUNDMAN define meaning units as 'constellation of words or statements that relate to the same central meaning' (2004, 106). Since meaning units are wordy, these were reduced in size without losing their quality (see the second column in *Table 2*). During this process, the condensed meaning units were discussed between all three authors. The condensed meaning units were large, and to analyze the data the text was abstracted, although without losing its intended meaning. The goal was to identify codes that described experiences of burnout syndrome and the autobiographers' recovery process. All the abstracted extracts were given a code. Next, codes were reviewed and discussed, allowing us to identify patterns in the plethora of codes. These patterns formed tentative subcategories. From the discussions and illustrations that emerged while using a white-board, subcategories were grouped into more abstracted pattern structures. To establish the credibility of the analysis, we critically reviewed how the subcategories were related to their over-arching category. Furthermore, we critically reviewed the internal homogeneity within each subcategory and the external heterogeneity between subcategories and categories. To establish transparency in the analysis, *Table 2* illustrates the analytic process of abstraction from meaning units, condensed units, codes, subcategories, and categories. In addition, *Figure 1* is an overview of the distribution of meaning units per category for each book. For example, in NYGREN's (2017) book, we found 110 meaning units in total. All three categories (see Result) were represented, and almost equally distributed. In comparison, in STREIJFFERT's (2015) book, the second category – descriptions of how the burnout manifests itself in everyday life – was identified to a lesser extent, while STREIJFFERT elaborated more voluminously on describing the estrangement of one's own body and the recovery process.

Table 2
Examples of the analyzed data

<i>Meaning units</i>	<i>Condensed meaning units</i>	<i>Codes</i>	<i>Subcategories</i>	<i>Categories</i>
When I eat, I eat. When I take a walk, I take a walk. When I'm with my kids, I'm with my kids. I keep my attention more on what is actually happening in life.	When I eat, I eat. When I take a walk, I take a walk. When I'm with my kids, I'm with my kids. My attention is on what is actually happening.	Being in the here and now.	Acceptance and learning about rest and recovery.	<i>Description of recovery processes</i>
While sick-listed I went to meditation one evening a week. I found a calm place there among others who also needed a moment of peace and quiet. A feeling of community was created in the silence.	Went to meditation. Found a calm place among others who needed peace and quiet. Created community in silence.	Stillness and quiet.	The healing power of nature and activity.	
In our first meeting, the insurance office asked if my kids were a burden or relief regarding my burnout. To me both are true, and feeling that way feels horrible. Naturally they give me enormous joy, but it's hard to be strong for my kids when I feel so small on the inside	The insurance office asked if my kids were a burden or relief. To me both are true, and feeling that way feels horrible. They give me great joy, but it's hard to be so small on the inside when I want to be strong.	Experiencing that one's children can be a burden.	Limited ability to maintain social relationships.	<i>Description of how the phenomenon manifests itself in everyday life</i>
One change I made early on was to create good routines and try to structure my days.	Create good routines and try to structure one's days.	Work toward a sustainable future, structure and routine.	Strategies and adjustments in everyday life.	
I did not take sick leave, but was back at work the next day. That is what it is like to be Superman. Little did I know that my strength was also my kryptonite.	I did not take sick leave, but was at work the next day. That's how it is to be Superman. My strength was also my kryptonite.	Narrow-mindedness made my strength my weakness.	The body's signals and disobedience.	<i>Description of alienation over one's own body</i>
Long before I got fatigue syndrome written in my medical certificate, I was sick in the body. Finding balance again has been, and still is, an ongoing process that takes much longer than I could have imagined.	Long before I got fatigue syndrome written in my medical certificate, I was sick in the body. Finding balance again is an ongoing process that takes much longer than I could have imagined.	The feeling that something is wrong in the body comes long before the diagnosis.	Bodily resistance	

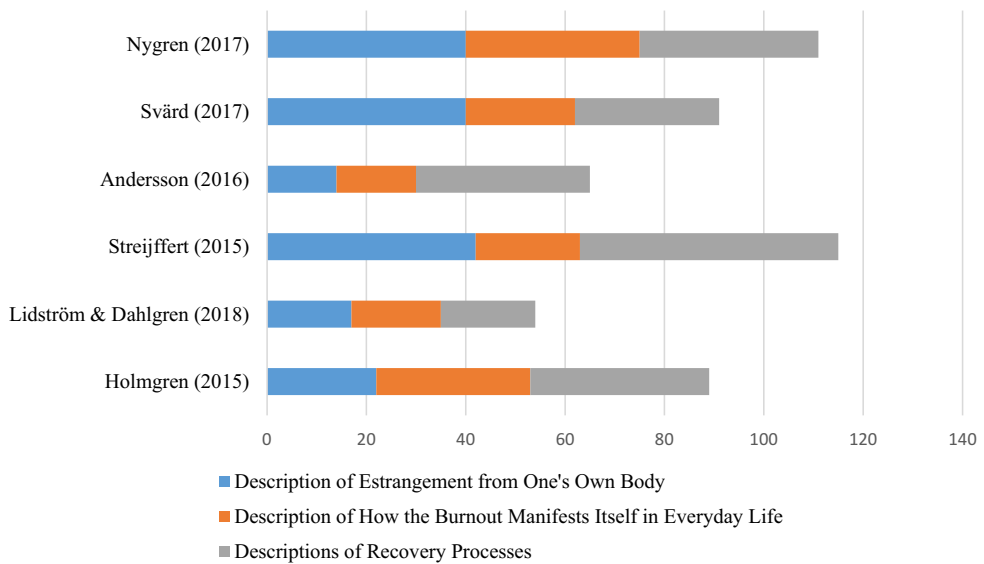


Figure 1

Overview of the distribution of meaning units per and category for each book

4. Results

The results are presented in three categories: 1) descriptions of estrangement from one's own body, 2) descriptions of how the phenomenon is manifested in everyday life, and 3) descriptions of recovery processes.

4.1. Descriptions of estrangement from one's own body

The body's signals and disobedience. All authors described the insidious signals of being constantly tired. Even though the brain was malfunctioning, they pushed themselves at high speed, resulting in feelings of exhaustion and a complete lack of energy. Other bodily signals were also described, such as a weakened immune system, headaches, numbness, shaking, and a sense of being cold in the extremities as well as a hot feeling in the head; also described were certain cognitive perceptions and the ability to focus on tasks. When the brain went on strike, they described a passivization of the body that they were not able to control. The feelings of no longer being able to control their own bodies they described as shocking. All of them described the body's signals and disobedience as being so strong that they wished they had been affected by a visible, physical illness instead of this bodily devastation (ANDERSSON 2016; HOLMGREN 2015; LIDSTRÖM & DAHLGREN 2018; NYGREN 2017;

STREIJFFERT 2015; SVÄRD 2017). Even though signals of burnout were imminent, one author wrote about her last attempts to override the signals by pushing herself.

I don't feel like I've walked or run into a wall, but like I'm still running and pushing the wall in front of me. It feels like I'm going to keep running, and if I just run a bit farther, I'll be able to run through the wall and come out on the other side. If I just try harder. If I just run faster. If I just go into a higher gear. (SVÄRD 2017, 19)

Perception and vulnerability to stimuli. The authors described a loss of patience and a crippling fatigue regarding all cognitive impressions. During the worst phases, everything was described as a struggle in quotidian life, such as the sound of a fan, background chatter, and the sound of traffic (ANDERSSON 2016; HOLMGREN 2015; LIDSTRÖM & DAHLGREN 2018; NYGREN 2017; STREIJFFERT 2015; SVÄRD 2017). NYGREN'S book depicted the inability to shut out cognitive impressions: 'It's like my filter function is gone or impaired. I can't "turn off" the sound around me' (2017, 95).

Emotional and mental imbalance. The physical symptoms began to slowly affect their brains, including increased memory loss and the feeling of no longer being able to function in social situations. The feeling of losing oneself led to anger and to constant feelings of inadequacy, worthlessness and failure, resulting in the feeling that everyday life was somehow unrealistic (ANDERSSON 2016; HOLMGREN 2015; LIDSTRÖM & DAHLGREN 2018; NYGREN 2017; STREIJFFERT 2015; SVÄRD 2017). Moreover, they described being very sensitive to setbacks; LIDSTRÖM and DAHLGREN (LIDSTRÖM & DAHLGREN 2018) recounted the desire to be helped by higher powers to relieve anxiety and to feel hope for the future.

4.2. Descriptions of how the burnout manifests itself in everyday life

Feelings of restrictions in everyday life. Several of the authors described an ambitious personality that has always existed, ever since childhood. The feeling of no longer being able to perform in the same way as before also caused the feeling of losing part of one's identity. The disease made them unable to perform the most basic tasks in everyday life, and they narrated the insidious insight that they had prioritized the needs of others while ignoring their own needs (ANDERSSON 2016; HOLMGREN 2015; NYGREN 2017; STREIJFFERT 2015). Even the most basic needs and tasks were affected and sometimes neglected. The authors described how they were restricted in doing household tasks, such as watering flowers and cleaning. Being restricted in this way aroused feelings of shame. Upon reflection, maintaining a well-polished veneer was a contributing factor to the burnout syndrome. The 'invisible disease' and the expectations of those around them contributed to more demands, and the setbacks came more often than before. All attempts to overcome the restrictions, by keeping up with everyday tasks, led them deeper into the old behaviors that had caused the disease (ANDERSSON 2016; HOLMGREN 2015; LIDSTRÖM & DAHLGREN 2018; NYGREN 2017; STREIJFFERT 2015; SVÄRD 2017).

Limited work capacity. The authors reported that work had been closely tied to their identities, resulting in a strong sense of responsibility and duty to work and colleagues. As a consequence of the severe symptoms, they went on sick leave, which physically separated them from work. Sick leave was perceived as somewhat transient. They conceived of themselves as irreplaceable at work, resulting in their continuing to work despite the symptoms (ANDERSSON 2016; HOLMGREN 2015; LIDSTRÖM & DAHLGREN 2018; NYGREN 2017; STREIFFERT 2015; SVÄRD 2017).

Limited ability to manage a social and family life. Maintaining social relationships while being affected by burnout was described as complex. Because they did not recognize themselves anymore, they feared that relatives would abandon them. Moreover, that same alienation from oneself could result in anger, which was sometimes directed toward relatives; this increased the fear of being abandoned, resulting in both fear and anxiety (ANDERSSON 2016; HOLMGREN 2015; LIDSTRÖM & DAHLGREN 2018; NYGREN 2017; STREIFFERT 2015; SVÄRD 2017). Several authors described withdrawing themselves from social gatherings in general, but their social relationships with family members were also affected. Authors who had children described the problems they faced, for example NYGREN wrote: 'Being a parent puts demands on you that you can't escape through sick leave' (2017, 44). As a result of the burnout, the authors described experiences of emotional storms that affected their ability to be present and participate in family life. Due to their restricted ability to operate at full pace, they described feelings of frustration over family-related insufficiency and the need to live life at a much slower pace, thus leading to conflicts within the family. Moreover, there were narratives of feeling that the children were a burden and of not being able to give them love and care. They reported that the children had to take more responsibility, which led to feelings of guilt and a sense that they needed to compensate for their shortcomings.

Strategies and adjustments in everyday life. One recurring statement concerned the need to establish routines and structure in everyday life (ANDERSSON 2016; HOLMGREN 2015; LIDSTRÖM & DAHLGREN 2018; NYGREN 2017; STREIFFERT 2015; SVÄRD 2017). One strategy was to verbalize or write about their feelings (NYGREN 2017; STREIFFERT 2015; SVÄRD 2017). Additionally, setting boundaries they described as important, as was daring to say no (ANDERSSON 2016; NYGREN 2017; STREIFFERT 2015; SVÄRD 2017). Professional training in stress management was helpful in finding strategies to adjust everyday life (ANDERSSON et al. 2016; HOLMGREN 2015; LIDSTRÖM & DAHLGREN 2018; NYGREN 2017; STREIFFERT 2015; SVÄRD 2017). NYGREN described this as follows:

The situation can be likened to carrying a backpack that officially weighs 15 kg, but that is constantly being filled with unofficial extra weight. Weight that doesn't count when the total burden is determined... Taking a course on working more efficiently might help me pack my backpack in a smarter way. Still, it's the same weight. (2017, 22)

4.3. Descriptions of recovery processes

Professional and non-professional support. Reassuringly, the authors described their need for support from healthcare professionals during their process of recovery. The way professionals approached them was considered important. They claimed that professionals who gave them time and included them in care plans increased their self-esteem and self-confidence (ANDERSSON 2016; HOLMGREN 2015; LIDSTRÖM & DAHLGREN 2018; STREIFFERT 2015; SVÄRD 2017). Initially, they reported having wanted quick fixes from professionals, but along their path to recovery, they realized they were being given tools to help them rebuild a sustainable quotidian life (ANDERSSON 2016; LIDSTRÖM & DAHLGREN 2018; NYGREN 2017; STREIFFERT 2015; SVÄRD 2017). Even though professional support was necessary, the sense of having a home and the behaviours physical presence of their family both strongly supported the recovery process. Support from relatives and everyday life's maintenance promoted the possibility of rest (ANDERSSON 2016; HOLMGREN 2015; LIDSTRÖM & DAHLGREN 2018; SVÄRD 2017).

The healing power of nature and engagement in activities. Being out in nature became an important part of the recovery process. All of the authors described nature as offering opportunities to leave the outside world, and to think and reflect without external disturbances. Being alone with one's thoughts they considered vital to the recovery process (ANDERSSON 2016; HOLMGREN 2015; LIDSTRÖM & DAHLGREN 2018; NYGREN 2017; STREIFFERT 2015; SVÄRD 2017). HOLMGREN (2015, 122) put it like this: 'I see the things around me in another way; I can pause in the natural environment and become fascinated with a bumble bee collecting nectar from my currant bush.' Thus, spending time in nature and engaging in spontaneous activities, such as photographing, drinking coffee, or picking mushrooms, gave a sense of harmony and allowed one to rest both body and mind. Likewise, exercising by walking and exercising in general was said to benefit their recovery process as a way to reconnect with the body (ANDERSSON 2016; HOLMGREN 2015; NYGREN 2017; STREIFFERT 2015). Other kinds of group activities, such as yoga and meditation, were reported to have positive effects on their well-being and giving a feeling of community. Mindfulness and the realization that it was the brain that needed to rest, not the body, reoccurred upon awakening, and it became easier to accept one's current mood and facilitated the ability to take command of the illness (ANDERSSON 2016; HOLMGREN 2015; LIDSTRÖM & DAHLGREN 2018; NYGREN 2017; SVÄRD 2017).

Acceptance and learning about rest and recovery. The authors described a correlation between insights, learning about their need to rest and accepting the disease. However, accepting the disease was sometimes associated with feelings of shame and blaming oneself for causing the burnout to oneself by neglecting bodily signals. SVÄRD described such learning and growth in awareness as follows:

It's true that actually, despite my burnout, I'll have a passion for things my whole life, but thanks to my burnout syndrome, I'll be responsible and turn down the passion a bit, in everyday life, every day, taking care that I recover properly and regularly. (2017, 25)

Recovery was described as a non-linear process that included both progress and recession, which some authors found to be a tough experience. Having been burned out stood depicted as one of the most demanding events in life, but with these new experiences, they believed they were more prepared for the rest of their life (ANDERSSON 2016; HOLMGREN 2015; LIDSTRÖM & DAHLGREN 2018; NYGREN 2017; STREIFFERT 2015; SVÄRD 2017).

5. Discussion

The aim of the present study was to analyze how autobiographers narrate their experiences of burnout syndrome and to describe their recovery process. As mentioned in the literature review, burnout syndrome is a protracted process that manifests itself in emotional exhaustion, depersonalization, and a low sense of personal accomplishment (MASLACH et al. 2001). This also accords with our findings in that the authors clearly described an estrangement from their bodies in terms of bodily/corporal signals, being sensitive to stimuli and emotional imbalance. As we report in the findings, the symptoms of burnout encompass the whole person, and the inability to function as they had previously remains a highly restricting factor in their everyday life. In line with the unitary paradigm and a holistic perspective on the human being, the individual is a whole system that cannot be separated from their environment (FRISCH & RABINOWITSCH 2019; KOITHAN et al. 2017). Moreover, the principles of integrative nursing contend that human beings possess an innate capacity for health and wellbeing, and our results showed that one main barrier to be overcome was accepting the burnout syndrome and accepting the way its symptoms controlled and limited quotidian life, both in work and family. All of the authors had demanding jobs that included responsibility and required daily human interactions; they all felt they had to perform at the highest level. The results showed that their work gave them energy, and that this made them work even more. As previously mentioned, demanding jobs constitute a risk factor for burnout syndrome as performance is constantly in focus, being measure of ambition level (ARMAN et al. 2011). The job was seen as a risk factor no matter how the individuals loved their jobs – in fact, there was often a sense of inadequacy and a sense of duty linked to work. Therefore, many see the work as a contributing cause of their burnout (ARMAN et al. 2011). In addition to our findings regarding the narratives, we emphasize the importance of managers taking into account factors associated with burnout syndrome in the workplace when designing and reformulating workers' job descriptions; these factors include the level of job control, resources of recognition, feedback and participation (SCANLAN & STILL 2019).

We argue that with an awareness of these problems, managers can intervene via being sensitive to early warning signs exhibited among workers. For example,

a decrease in cognitive ability means a decrease in efficiency. In one study, psychiatrists' limitations at work were investigated as a result of initial burnout syndrome; it was shown that the number of patient visits was reduced and that psychiatrists were not working as effectively (GÜL et al. 2017). In our study, we presented similar findings in terms of how the authors described the loss of interest in their jobs, or how simple tasks could become overwhelmingly difficult. Moreover, similar descriptions are supported by several studies demonstrating that job dissatisfaction contributed to poorer health and well-being, but also in the long term to prolonged sick leave and negative impact in the recovery process (HÅKANSSON & AHLBORG 2017; HANSSON et al. 2006; HOLMGREN et al. 2009; LINDEBERG et al. 2011; MAGNUSSON HANSON et al. 2008; OSHIO et al. 2017). Hence, we argue that managers who adopt a preventive strategy may benefit their companies economically via enhanced employee workplace satisfaction and increased health.

For those experiencing burnout, the results emphasized the personal economic aspect in relation to fighting for employees' right to be on sick leave and receive compensation from the Social Insurance Office. Studies have shown that burnout-related economic stress affects family life negatively – both in social interactions and income (HÅKANSSON & AHLBORG 2017; HANSSON et al. 2006; HOLMGREN et al. 2009; LINDEBERG et al. 2011; MAGNUSSON HANSON et al. 2008; OSHIO et al. 2017).

Moreover, our results showed that the authors' attitudes toward family life were ambiguous. The family is held to be their main support and source of happiness, but at the same time, the presence of family members may also force the person to interact with others. One study from England examined how the pressure to be the perfect mother affects career and fatigue. These mothers were often highly educated and therefore had high career ambitions, which were seen as two risk factors for burnout (MEEUSSEN & VANLAAR 2018). Our results showed a continuous pattern of high ambitions and careers balanced with a well-functioning family life, where all individuals but one were married and had two children. In connection with fatigue syndrome, both career and family life broke down, and during the recovery process, they had to work to rebuild both parts from the ground up, but with different conditions and goals.

Little qualitative research has been done on burnout, although various research groups from both Finland and Sweden have collected data on the lived experiences of burnout through interviews (ARMAN et al. 2011; JÄRVIKOSKI et al. 2013; SALMINEN et al. 2015). These qualitative studies have further added an understanding of the lived experiences of suffering from burnout syndrome and the process of rehabilitation and recovery. Many similarities exist between those studies' results and the results presented here. Hence, at a thematic level, we were not able to add any new dimensions to our understanding of lived experiences, but rather the different analyses fortify the knowledge base. SALMINEN and colleagues (2015) conducted a two-year longitudinal study on narratives of burnout and recovery. They found that the most important factor for recovery was 'agency', which is also in line with the main theme outlined by KAVALIERATOS and colleagues (2017, 736) 'My well-being in my

own hands'. Similar to our findings, that view was displayed through a gradual understanding that a quick fix is not the answer; during the recovery process, the authors realized they had been given tools with which to rebuild a sustainable everyday life. Thus, individual responsibility stands out as a key feature. Personal responsibility has been emphasized in the recovery research (SLADE 2009). Lastly, burnout syndrome is an escalating and highly complex phenomenon affecting both the individual and community levels. Even though more research is needed, the present study has shed light on the many aspects of burnout grounded in the narrator's experiences. Our hope is that person-centered care will play a greater role among healthcare providers, helping them to improve the conditions for good communication and participation throughout the recovery process.

6. Strengths and limitations

This study is based on a qualitative content analysis of autobiographies written in the first-person. One special strength of this approach was the reflected narratives of people who had experienced and lived with the investigated phenomenon of interest. Qualitative studies in this field of research are scarce, but to further complete our understanding of the experiences, we chose to approach data collection slightly differently. We argue that autobiographies have the ability to complete the narrative in a way that interviews do not. In interview studies, participants are typically interviewed once, while much of the detail may be overlooked. One weakness is that we as researchers are not able to pose follow-up questions to the narrators and are limited to the written text. Hence, one possible addition to only analyzing the books would have been to also interview the authors. All of the examined autobiographies are written by people living in Sweden. This rather narrow perspective might entail a risk that the findings are not transferable to understanding the burnout syndrome of people living in other countries; however, it is inherent to qualitative methodology to not claim external validity, just as it is done in quantitative research.

7. Conclusion

The present study contributes to a deeper understanding of the lived experiences of burnout syndrome and the recovery process that follows. The study has relevance both to further understanding the complexity of the human being as a whole system, inseparable from their environment (KOITHAN et al. 2017) and to promoting the strength of the narrative (SHAPIRO 2011). We also conclude that recovery is a nonlinear process that takes time and effort. Healthcare professionals may use the present article to feel confident in approaching a patient's narrative and help them produce a story based on personal experience. Continuing research may therefore focus on producing a storyline in the nurse-patient relation and further investigating what is beneficial to the development of such a narrative.

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