The Lived Experience of Transcending Burnout as described by Community Mental Health Nurses working within a Crisis Assessment and Treatment Team (CATT) Service.

A thesis submitted in accordance with the regulations of the Royal Melbourne Institute of Technology University in fulfilment of the requirements for the degree of Doctor of Philosophy.

By: Alistair Ross.

B. Nursing, Grad Dip MH Nursing, Master of Mental Health Science.

Senior Supervisor: Associate Professor. Phillip Maude.

Supervisor: Associate Professor. Anthony Welch.

School of Health Sciences
College of Science, Engineering and health
RMIT University
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Declaration

I declare that this thesis is my own work and has not been submitted in any form for another degree or diploma at any university or other institute of tertiary education. Information derived from the published and unpublished work of others has been acknowledged in the text and a list of references is given.

_____________________________________

Alistair Roald Ross

2013
Abstract

This research study was undertaken in order to explore the phenomenon of transcending burnout as described by mental health nurses working as part of Crisis Assessment and Treatment (CAT) Teams (operating in the community) including Enhanced CAT (ECAT) Teams. Community mental health nursing has repeatedly been reported to be a highly stressful and demanding working environment with community mental health nurses being considered to be at high risk of becoming burnt out. This has the potential to contribute to deterioration in the quality of care or service being provided, high rates of job turnover and workforce instability, absenteeism, and low individual and team morale. At a personal level burnout contributes to a variety of personal issues including physical and emotional exhaustion, insomnia, increased use of alcohol and drugs, and marital and family problems. Nurses working on CAT Teams are at high risk of burnout due to the high levels of acuity, risk and unpredictability in the consumers they provide care for.

A descriptive phenomenological approach in the Husserlian tradition was chosen to guide the research process with Colaizzi’s (1978) method utilised to structure the data analysis process. Data was collected via in-depth, semi-structured interviews with 12 participants. Nine emergent themes were explicated: (1) Personal Strength: Grim Determination, Pragmatism and Optimism, (2) Reaching for Support, (3) Weathering the Storm, (4) Making Sense of the Personal Non-Sense and Re-Finding Clinical Meaning, (5) Regaining Balance and Lost Control, (6) Transcending Through Connection with the World Outside, (7) Rebuilding the Boundaries and Affirming Realistic Expectations, (8) Transcending Burnout as the Road Goes Ever On and (9) Increasing Confidence in Credibility.
Ultimately, transcending burnout involved the participants undergoing an intense though achievable journey. In the earliest phase of the experience, the experience of transcending involved hanging on using whatever came to hand, be it person qualities or reached out reflexively to those around them. As the experience evolved there was a gradual change in the participant’s state of motion, shifted slowly from just holding their position to being able to exert some push back against the adversity that they were facing. In the final phase of the experience individuals experience of transcending broadened out as relationships and activities in the wider world were re-claimed as a source of positive emotion leading to the repairing and rebuilding their intrapersonal and interpersonal boundaries. Most importantly, the participants in the study showed that transcending burnout was possible, with their experiences having the potential to inform future professional developments in both clinical and educational practice.

**Key Words:** Transcending, Burnout, Crisis Team, Mental Health Nursing,
Acknowledgements

I would like to begin with a heartfelt thank you to the participants in this study. Crisis Assessment and Treatment (CAT) Team nursing is extremely challenging and difficult work and I thank you all for sharing your experiences so that this study was possible.

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# Table of Contents

Abstract ...................................................................................................................... iv

Acknowledgements ................................................................................................. vi

Table of Contents..................................................................................................... vii

List of Tables .......................................................................................................... xv

List of Figures .......................................................................................................... xvi

Chapter One: Introduction and Background to the Study ................................. 1

Background to the Study ....................................................................................... 1

Discussion of the Phenomenon of Burnout ......................................................... 5

Stress, Burnout and Community Mental Health Teams ..................................... 8

Burnout and Crisis Assessment and Treatment (CAT) Teams ....................... 13

Overview of the Notion of Transcending ............................................................. 14

Transcending related to the concept of adversity ........................................... 16

Transcending related to the concept of illness ............................................... 17

Transcending related to the concept of extreme human adversity ............... 19

Transcending related to the concept of transition ........................................... 21

Transcendence and Self-Transcendence ......................................................... 22

Self-Transcendence in nursing ........................................................................... 23

The Notion of Transcending Burnout ................................................................. 26

Aims and Objectives of the Study ..................................................................... 28

The Research Question ....................................................................................... 28

Significance of the Study .................................................................................... 29

Overview of Thesis .............................................................................................. 31
Chapter Two: Preliminary Literature Review

Phenomenology and the Literature Review

The Preliminary Literature Review

Overall search strategy

Preliminary Literature Review: Burnout in Community Mental Health Teams

Preliminary literature review strategy: burnout

Initial investigations: literature from the 1990’s

Stress and burnout in community mental health nursing

Stress and burnout in community mental health and other settings compared

A comparison of burnout in inpatient and community mental health nursing

A comparison of mental health and non-mental health areas of community nursing

Stress and forensic mental health nursing

Strategies in the Management of Burnout

Summary of the Literature on Burnout in Community Mental Health Teams / Nurses

Literature Review: Transcending as Human Experience

Preliminary literature review strategy: transcending as human experience

The Human Experience of Transcending

Literature related to the Lived Experience of Transcending Illness and Adversity

Literature related to transcending illness

Literature relating to transcending in the context of human adversity

Literature related to the Lived Experience of Transcending Burnout in Nursing

Summary of the Literature on Transcending as Human Experience

Summary of the Chapter
Chapter Three: An Overview of Crisis Assessment and Treatment (CAT) Teams…77

Mental Illness and Health Care Delivery in Victoria, Australia……………………77

Overview of the evolution of Crisis Assessment and Treatment (CAT) Teams………80

The Contemporary Role of the CAT Team………………………………………………...86

   The provision of 24 hour a day urgent community based assessment…………...88

Undertaking the role of ‘gatekeeper’ for hospital admission triage…………….…92

   The provision of intensive community treatment and support as an alternative
   To Hospitalisation……………………………………………………………………..95

   The provision of an onsite presence in hospital emergency departments………..98

CAT Teams and the ‘Crisis’ Misnomer……………………………………………………101

The contemporary role of the CAT Team nurse……………………………………..103

Summary of the Chapter…………………………………………………………………104

Chapter Four: Overview of the Selected Methodology: Phenomenology…………105

Philosophical Underpinnings of the Study……………………………………………105

Phenomenology……………………………………………………………………………106

Descriptive Phenomenological in the Husserlian Tradition………………………..108

   Husserl’s notion of universal essences………………………………………………109

   Phenomenological reduction………………………………………………………….110

   Phenomenological intuiting…………………………………………………………..112

Phenomenology as a Research Method: The Duquesne School of Phenomenology……113

Descriptive Phenomenology: Paul F. Colaizzi’s Model of Data Analysis………..116

Phenomenology and Nursing……………………………………………………………118

Summary of the Chapter…………………………………………………………………121
Chapter Five: The Research Method and Process ........................................ 122

Focus of the Research ........................................................................... 122

Selection of Methodology ..................................................................... 123

Selection of Participants ...................................................................... 125

Accessing the Participants ................................................................... 128

Insider Outsider Considerations .......................................................... 130

Preparation for the Interviews ............................................................. 132

Information Collection ......................................................................... 135

Guiding and Following: The Interview Questions and Dialogue ............. 138

Information Analysis; Colaizzi’s Method ............................................... 142

The pre-analysis preparation ............................................................... 144

Step one: Acquiring a feeling for / making sense of the descriptions ....... 144

Step two: Extracting significant statements ......................................... 145

Step three: Spelling out the formulated meaning from each significant statement ................................................................. 146

Step four: Aggregating formulated meanings into clusters of themes ...... 148

Step five: Integration of all analysis into an exhaustive description of the phenomenon .............................................................................. 149

Step six: Formulation and description of the essential structure of the phenomenon .............................................................................. 157

Step seven: Returning to the participants to validate the findings .......... 158

Ethical Issues and Considerations ......................................................... 158

Respect for autonomy and individual responsibility (informed consent) ... 159

Respect for privacy, anonymity and confidentiality .............................. 160

Respect for justice and beneficence .................................................... 161
Chapter Six: Study Findings: The Participants Lived Experience of Transcending Burnout

Overview of the Participants

The Emergent Themes

Theme One: Personal strength: grim determination, pragmatism and optimism

Theme Two: Reaching for support

Theme Three: Weathering the storm

Theme Four: Making sense of the personal non-sense and re-finding clinical meaning

Theme Five: Regaining balance and lost control

Theme Six: Transcending through connection with the world outside

Theme Seven: Rebuilding the boundaries / setting and affirming realistic expectations

Theme Eight: Transcending burnout as the road goes ever on

Theme Nine: Increasing confidence in credibility
Theme Four: Making Sense of the Personal Non-Sense and Re-Finding

Clinical Meaning ................................................................. 243

Theme Four: Discussion relating to the literature ......................... 243

Theme Five: Regaining Balance and Lost Control ....................... 249

Theme Five: Discussion relating to the literature ......................... 249

Theme Six: Transcending through the World Outside .................. 251

Theme Six: Discussion relating to the literature ......................... 252

Theme Seven: Rebuilding the Boundaries and Affirming Realistic Expectations .................. 256

Theme Seven: Discussion relating to the literature ......................... 256

Theme Eight: Transcending as the Road Goes Ever on .................. 257

Theme Eight: Discussion relating to the literature ......................... 258

Theme Nine: Transcending Burnout through increasing Confidence in Credibility ............... 261

Theme Nine: Discussion relating to the literature ......................... 262

Summary of the Findings related to Key Concepts in the Literature .......... 263

Summary of the Chapter .......................................................... 266

Chapter Eight: Implications of the Study Findings and Researcher Reflection ............... 267

Strengths of the Study .......................................................... 267

Limitations of the Study ........................................................ 268

Personal Research Implications and Recommendations .................. 270

Personal research recommendation one .................................. 270

Personal research recommendation two .................................. 271

Personal research recommendation three .................................. 271

Clinical Practice Implications and Recommendations .................. 272
Clinical practice recommendation one ................................................. 273
Clinical practice recommendation two ................................................. 273
Clinical practice recommendation three .............................................. 274
Clinical practice recommendation four .............................................. 274
Clinical practice recommendation five .............................................. 274
Clinical practice recommendation six .............................................. 275

Future Research Implications and Recommendations .......................... 275
Clinical research recommendation one .............................................. 276
Clinical research recommendation two .............................................. 276
Clinical research recommendation three .......................................... 276
Clinical research recommendation four .......................................... 277

Postscript
Reflections on the Journey ................................................................. 278
Taking the hidden paths that run: final reflections of the candidate ......... 280

References .................................................................................................. 282

Appendices
Appendix A: RMIT Ethics Committee Approval .................................... 320
Appendix B: Overview of the Participant Group .................................... 321
Appendix C: Plain Language Statement .............................................. 333
Appendix D: Informed Consent Form ................................................... 335
Appendix E: Participant Significant Statements .................................... 337
List of Tables

Table One: Definition of Key Terms

Table Two: Burnout in Community Mental Health Nursing Literature
Search Summary (1996–2008)

Table Three: Transcending as Human Experience Literature Search
Summary (1996-2008)

Table Four: Significant Statements, Formulated Meanings and Theme Clusters

Table Five: Burnout in Community Mental Health Nursing Literature
Search Summary (2009–2013)

Table Six: Transcending as Human Experience Literature
Search Summary (2009-2013)

Table Seven: Theme Specific Literature Search Summary
List of Figures

Figure One: Visual representation of the lived experience of Transcending Burnout….216
### Definition of Key Terms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Term</th>
<th>Definition</th>
</tr>
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<tbody>
<tr>
<td>CATT</td>
<td>Crisis Assessment and Treatment Team</td>
<td>A community mental health team responsible for the initial assessment (in the community or emergency department) community treatment of a person experiencing acute mental illness within a set catchment area.</td>
</tr>
<tr>
<td>ECATT</td>
<td>Enhanced Crisis Assessment and Treatment Team</td>
<td>Subset of the CAT Team that undertakes all psychiatric assessments in the emergency department setting.</td>
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</table>
| CAT Team Nurse | Registered nurse working on a CAT / ECAT Team | Nurses employed on CAT Teams usually work a combination of CAT shifts in the community and ECAT shifts in the emergency department setting. 
Note: The term CAT Team nurse is utilised in the thesis to refer to nurses working across both CAT and ECAT settings. |
| CPN       | Community Psychiatric Nurse               | A term used to describe all psychiatric nurses working in the community across a variety of clinical settings.                             |
| CMHN      | Community Mental health Nurse             | A term used to describe all mental health nurses working in the community across a variety of clinical settings. 
NB: the terms psychiatric nurse and |
mental health nurse are used interchangeably in the profession.

<table>
<thead>
<tr>
<th>Consumer</th>
<th>Mental Health Service consumer</th>
<th>An individual who receives care from a mental health service provider.</th>
</tr>
</thead>
<tbody>
<tr>
<td>AMHS</td>
<td>Area Mental Health Service</td>
<td>A grouping of specialist mental health services including inpatient and community that provide all components of mental health care to a geographically defined population with</td>
</tr>
<tr>
<td>MST</td>
<td>Mobile Support and Treatment Team</td>
<td>A community mental health team responsible for the provision of medium-term high intensity case management and provision of care for consumers with severe mental illness.</td>
</tr>
<tr>
<td>CCT</td>
<td>Continuing Care Team</td>
<td>A community mental health team responsible for the provision of long-term low intensity case management and provision of care for consumers with severe mental illness.</td>
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Chapter One

Introduction and Background to the Study

This research study has been undertaken to explore the phenomenon of transcending burnout as described by mental health nurses working as part of either a Crisis Assessment and Treatment (CAT) Team (operating in the community) or an Enhanced CAT (ECAT) Team (operating within Emergency Departments of major metropolitan Melbourne Hospitals). This chapter begins by examining the context from which the ideas for the study initially emerged and then coalesced into the firm vision that would be the final project. In order to provide a contextual understanding underpinning the project an account of the researcher's professional background is provided. The phenomenon of burnout as it applies to this study is outlined and explored, with a particular focus placed on burnout in nurses working in acute community settings. The chapter also undertakes a detailed discussion around the phenomenon of 'transcending' given its central role in the study. Beginning with a broad overview this exploration further examines the concept of transcending related to illness, adversity and transition as these areas had particular relevance to the phenomenon researched in this study. The aims and objectives of the study are outlined before the chapter continues with an explanation of the significance of the study before concluding with an overview of the thesis structure.

Background to the Study

This researcher's interest in the experience of 'burnout' by CAT Team nurses was first stimulated thirteen years ago while working as a CAT Team nurse on an outer Melbourne metropolitan CAT Team. As a significant element of the public mental health care system in
Victoria (Australia), the role of the CAT Team is to initially assess (in the community or emergency department) and potentially treat a broad cross section of persons experiencing acute mental illness. The team that the author worked on provided this service in conjunction with a wide variety of associated community services and resources to provide effective management to a large outer metropolitan community with a population of approximately 350,000.

Mental health nursing has been reported to be a highly stressful and demanding working environment (Sherring & Knight, 2009, Singh, 2011, Cowman & Ward, 2007; Edwards & Burnard, 2003; Taylor & Barling, 2004). Whilst working as a CAT Team nurse this researcher had first-hand experience of working in an environment that involved extremely unwell mental health care consumers who often posed a threat to themselves as well as to others at times (including the researcher himself on occasion). Assessments and visits were often conducted in complicated home environments with anxious, confused and even hostile carers in attendance. Furthermore, the volume of work referred to the CAT Team along with limited resources for treatment contributed to a complex and anxiety provoking clinical working environment for CAT Team nurses. This is further exacerbated in the CAT Team working environment where the unique stressors encountered are generally acknowledged to contribute to the development of a variety of emotional problems including burnout amongst CAT Team nursing staff (Rose & Glass, 2006; Rose & Glass, 2005, Majomi, Brown & Crawford, 2003).

Over the course of the initial two years working in this environment the researcher became increasingly aware of the high level of turnover in nursing staff on the CAT Team: indeed over this timeframe there was a significant turnover of CAT Team nursing staff. The reasons for this varied, and included personal issues and career promotion, however, from the researcher’s observations there also appeared to be a significant degree of burnout involved in these staff
departures. The observation of burnout in these CAT Team nurses was not limited only to staff that had left the CAT Team, but was also commonly evident amongst staff that remained. Many of these nurses described feeling chronically affected by burnout. These observations ultimately lead to the researcher completing a Master’s Thesis (Ross, 2003), which involved a study examining the lived experience of burnout as described by nurses working on CAT Teams in metropolitan Melbourne. The study uncovered nine key themes and produced a comprehensive description of the phenomenon of burnout as described by CAT Team nurses.

For the researcher the results of this study lead to the emergence of a number of new questions about other aspects of an individual’s lived experience associated with burnout. The researcher’s curiosity was drawn to a number of nurses in this study who had experienced episodes of burnout, but rather than leave the service or remain affected they had described having successfully worked through these episodes. This in turn led the researcher to wonder about specific experiences that may occur at different points along the experiential continuum, and in particular about the nature of ‘rising above’ or ‘moving beyond’ the experience of burnout. For the researcher the Masters project had generated genuine insights into the lived experience of burnout; however the process of interacting with the participants during the interview process had set into motion a new process of speculation. Contact with the participants describing the various different stages of their experience of burnout (during, immediately following, and looking back at the experience in retrospect) had raised specific questions for the researcher. What was the lived experience of ‘getting over’ or moving past the phenomenon of burnout as described by CAT Team nurses? How were the complex challenges associated with burnout being overcome or ‘survived’ by the individual mental health nurse working on a day-to-day basis in the acute CAT Team setting?
The process of further developing the ideas underpinning the study was also influenced by the researcher’s observations of the environment around him, given he was practicing as a CAT Team nurse through this period of the study’s development. In the researcher’s anecdotal experience the most common way for nurses in the CAT Team setting to cope with becoming burnt-out at work had been to leave the position and work environment and seek a ‘fresh start’ elsewhere. Certainly in the thirteen years that the researcher had spent working in the same mental health service in metropolitan Melbourne there had been a very high turnover of nursing personnel. Moving on to ‘greener pastures’ was the norm for many nurses when they felt unable to cope and whilst it may have helped these individuals cope with stress it had a poor impact on the overall delivery of care with clinical teams in a constant state of flux as there was an almost constant movement of nurses moving in and out of the service.

In contrast to this the researcher also noted a small though significant number of CAT Team nurses who described having experienced burnout in their workplace, but had continued working in the same role and clinical context. These nurses had managed to somehow move through this experience and emerge from the other side having been able to overcome or move past it. This notion held particular interest for the researcher as it suggested that not only could the phenomenon of burnout be experienced, but that it was possible for an individual to experience overcoming, or rising beyond burnout as a distinct phenomenon in its own right. Further reflection on this resulted in the development of the following research question:

- What is the experience of overcoming, or moving through and past burnout for nurses working on a CAT Team?
- How did the individual perceive this experience of overcoming, or moving through and past it [burnout]?
It was therefore a desire on the part of this researcher to explore and better understand the phenomenon of overcoming burnout that informed and drove the development of the proposal that led to this study being undertaken. In order to conceptualise this an overview of the phenomenon of burnout is provided.

**Overview of the Phenomenon of Burnout**

The experience of ‘burnout’ in human service professionals is a phenomenon that has emerged as a significant issue of concern since the mid-1970’s (Evans, 2013), and since that time “the subject of nurses’ burnout has received extensive and continuous research attention” (Maslach-Pines, 2000, p. 23). The degree of interest in this phenomenon is closely related to the personal nature of burnout; to the apparent negative impact on an individual clinician’s quality of life and their ability to provide effective health care delivery to consumers under their care.

In their seminal work on the topic, ‘burnout’ is defined by Maslach, Jackson and Leiter (1996) as “a psychological syndrome of emotional exhaustion, depersonalisation, and reduced personal accomplishment that can occur among individuals who work with other people in some capacity” (p. 192), and has been documented in a wide variety of human service professions, including the police force, teaching, counselling, and nursing (Coffey & Coleman, 2001). The phenomenon of burnout has been identified as a consequence of spending significant periods of time in intense personal interaction with other people, where the interaction itself is informed by the consumer’s current problems. As these interactions focus primarily on dealing with these problems they “are charged with feelings of anger, embarrassment, fear, or despair ... solutions for the client’s problems are not always obvious and easily obtained, the situation becomes
more ambiguous and frustrating” (Maslach, Jackson, & Leiter, 1996, p. 192). This in turn leads to the development of three principle aspects of the phenomenon, namely: [1] *emotional exhaustion*; which is defined as the point at which “emotional resources are depleted, workers feel they are no longer able to give of themselves at a psychological level” (Maslach, et al., 1996, p. 192), [2] *depersonalisation*; “negative, cynical attitudes and feelings about one’s clients”, (Maslach et al., 1996, p. 192), and finally [3] *reduced personal accomplishment*; “the tendency to evaluate oneself negatively, particularly with regard to one’s work with clients” (Maslach, et al., 1996, p. 192). There remains significant debate regarding the parameters of the experience and whilst there “is no universally agreed definition” (Faber as cited in Happell, et al., 2003, p. 40) there have been a number of studies exploring burnout in the mental health setting (Carson et al., 1995; Coffey, 1999; Coffey & Coleman, 2000; Happell, et al., 2003; Prosser et al., 1996; Schafer, 1992) that have utilised this descriptive framework as the basis for their inquiry. An earlier description of burnout is provided by Cherniss who defined burnout as “a process in which a previously committed professional disengages from his or her work in response to stress and strain experienced in the job” (Cherniss, 1980: p18 cited in Sherring & Knight, 2009, p. 1234). The definition provided here clearly reflects the key elements in the burnout process as observed by the researcher wherein a previously motivated and compassionate CAT Team nurse becomes disconnected from their work as a consequence of the stress and strain caused by the work itself.

What is certainly clear is the impact that the phenomenon of burnout has had upon the overall recruitment and retention issues facing the mental health workforce, in particular, the profession of mental health nursing at both national (Barling, 2001; Happell, Martin & Pinikahana, 2003; Taylor & Barling, 2004; and International levels (Edwards, et al., 2000, 2001, 2006; Edwards & Burnard, 2003; Hannigan et al., 2000). The researcher is not suggesting that this turnover is
entirely related to nurses becoming burnt-out and leaving their jobs to seek ‘greener pastures’ elsewhere. The wide diversity of people who choose to work in any healthcare industry and the plethora of unique factors and characteristics that impinge upon each of their professional and personal lives mean that each event of staff turnover will be particular to that person’s situation. This aside, the link between burnout and nursing turnover has been clearly described (Edwards, et al., 2000, 2001; Hannigan et al., 2000), and for many health professionals who experience the phenomenon of burnout, the process of overcoming this destructive phenomenon involves completely removing themselves from the workplace (as the source of the perceived phenomenon), and seeking new employment elsewhere. The aftershocks of this process, which had at first appeared to alleviate the person’s subjective distress, are substantial for both the person and the healthcare service where they are employed. The individual nurse is faced with the upheaval of seeking a new job, having to start in a new working environment where they have no knowledge of the corporate culture, and with new colleagues they don’t know. The employer is faced with losing an experienced clinician who knows the corporate culture of the service, the consumers, and the staff, and has a proven track record in delivering the type of nursing care particular to that team environment. Ultimately, the cost of losing a clinician to burnout is substantial for both the individual and the organisation. Therefore the value of improving the mental health nursing profession’s understanding of the process of overcoming burnout cannot be understated, particularly given it has the potential to improve support interventions intended to combat the impact of burnout upon health care clinicians.

Considering that effective practice in mental health nursing is reliant on the clinician’s ability to interact and communicate with the consumers under their care, the introduction of feelings and attitudes such as emotional exhaustion, depersonalization and reduced personal accomplishment (Melchior, et. al., 1996 cited in Evans, 2013) are of significant concern. These syndromes
constitute a clear barrier to any form of therapeutic interaction, thus compromising the 
individual’s ability to provide enthusiasm and compassion both for the consumers they care for 
and their professional work as a whole. The consequences of burnout in mental health nurses 
are also potentially serious, not only for those individuals experiencing such a phenomenon, but 
also for the consumers they are caring for along with their co-workers, families, and the 
institution/s in which they are employed. Documented effects of burnout include “a 
deterioration in the quality of care or service provided… a factor in job turnover, absenteeism, 
and low morale…self-reported indexes of personal dysfunction, including physical exhaustion, 
insomnia, increased use of alcohol and drugs, and marital and family problems”(Maslach, et al., 
1996, p. 193), role conflict and “punctured equilibria” (Majomi et al., 2003, p. 531), as well as 
increased tiredness and difficulties sleeping, problems setting boundaries and limits within the 
individuals personal and private lives (Taylor & Barling, 2004, p. 123), and “provision of 
suboptimal care as well as increased staff turnover” (Sawatzky & Enns, 2012, p. 699). All of 
this highlights the serious nature of such a condition for providers of human services, especially 
those working in high acuity, crisis focused professions.

Stress, Burnout and Community Mental Health Teams

The issue of burnout within a community mental health setting is no less significant with 
community clinicians often having to deal with many additional problems associated with away 
from many of the resources available in hospital settings. Studies looking at burnout in 
community mental health teams began emerging only several years after the shift in service 
provision focus from inpatient to community services. As early as 1991 (Rees & Smith, 1991) 
mental health nurses working in community settings were considered to be “one of the 
professional groups in the health service that experiences high levels of stress (Edwards, et al.,
2001, p. 805), whilst in 1995 Carson et al., (1995) reported that community mental health nurses in the United Kingdom were experiencing high levels of stress as measured using the Maslach Burnout Inventory. Onyett, Pillinger and Muijen (1997) described high levels of burnout in community mental health clinicians, in particular reporting high levels of emotional exhaustion amongst various disciplines within the team including nursing. This was further echoed by McLeod (1997) who in examining work stress in community mental health nurses reported “high levels of stress in a significant number of CPNs in the sample, which manifested itself in feelings of anxiety, or ill-health” (p. 573), suggesting a working environment that was intrinsically stressful with an associated risk of burnout. The issue of burnout within community mental health teams was also the focus of research by Wykes, Stevens and Everitt (1997) who stated that “community mental health team workers do show evidence of high levels of burnout” (p. 405) with the following implications for the broader delivery of mental health care in the community: “community care depends for its success on high quality care from committed staff and these results clearly cast doubt on the sustainability of such care with such high levels of burnout” (p. 409). The study reported that the main cause of stress was “the levels of minor stressors experienced in the workplace” (p. 405), highlighting the notion that it is the nature of community mental health care specifically that contributes to increased stress and burnout. This reflects one of the key assumptions of this study that the experience of burnout and subsequently of transcending burnout in CAT Team nurses is linked intrinsically to the unique nature of the stressors encountered in their working environment, providing support to the rationale for the study mode and location.

A review of the literature on stress and burnout in community mental health teams was undertaken by Edwards, Coyle and Hannigan in 2000. They concluded that healthcare professionals (in general) working in community mental health teams were “experiencing
increasing levels of stress and burnout as a result of increasing workloads, increasing administration and lack of resources” (p. 7). In examining the limitations of the literature included in the review, the authors identified small sample sizes and inconsistent use of measurement tools as being the main issues in limiting the capacity to draw broader conclusions regarding burnout in community mental health nurses. A similar review of the literature from 1997 - 2010 published in 2011 by Onyett concluded that the literature continued to report that clinicians practicing in community mental health teams experienced high levels of emotional exhaustion, though regardless of this team morale in general did not appear to have deteriorated as a consequence. This provides an interesting insight into the nature of the clinical environment experienced by clinicians working in the community suggesting that good team morale plays a significant role in counter-acting the stress experienced by clinicians. In terms of their contribution to the development of this study the reviews by Edwards, Coyle and Hannigan (2000) and Onyett (2011) provide bookends summarising the key issues relating to burnout in community mental health teams and reinforced the high levels of stress and burnout faced by clinicians working in the acute community setting due to the unique nature of the practice environment and relationships that occur therein. That said, the conclusions they drew were limited in their relevance to this study as they looked at multidisciplinary community clinicians across a broad range of community settings rather than focusing specifically on community mental health nurses working exclusively in an acute setting.

One of the key areas of focus with burnout in community mental health teams has been specific contributing factors associated with the unique nature of the working environment. The defining quality of most community mental health service delivery is that it is undertaken in the consumers own home setting often drawing in their immediate friends, family whilst interacting with their broader community (including other health care providers). This requires community
mental health team clinicians (including nurses who make up the majority of such teams) to provide care across a wide range of environments, encompassing broad ranges of socio-economic, educational and broader health well-being leading to a multitude of challenges specific to each consumers individual environment.

As a result of this complex working environment there have been a range of factors identified that are seen to be significant in the development of burnout. Carson et al., (1995) described the lack of existing services (to accept new consumers) along with limited referral options (for consumers exiting community mental health team service provision) as being the biggest causes of stress. This notion was supported by McLeod (1997) who identified that a lack of resources and facilities available in the community was important as it made the delivery of effective care much more difficult. Edwards, Coyle and Hannigan (2000) concluded that stressors contributing to burnout in community mental health nurses could be divided into three main areas “stressors intrinsic to the job itself … role based stressors … stressors concerning relationships with others” (p. 11). At a practical level these might include the nature of practicing with acutely unwell consumers constantly in crisis and often exhibiting significant levels of risk to themselves and/or others (stressors intrinsic to the job itself), the demands upon community mental health clinicians in responding to high levels of consumer demand with limited community resources in the care of individuals often suffering with chronic mental illness (role based stressors) and the complex relationships with consumers, carers and other services providers and emergency services (stressors concerning relationships with others) that this entails.

More recently Sorgaard, Ryan, Hill and Dawson (2007) reported that “community teams experienced more organisational problems, higher work demands, less contact with colleagues,
but also better social relations and more control over their work” (p. 801). The study again highlights the unique nature of the stressors faced by clinicians working in the acute community setting, paying attention to both the negative and positive elements in community practice. The influence of organisation factors upon job burnout in community mental health staff was also reflected in a study completed by Lasalvia et al., (2009) that sought to challenge the pre-existing notion that “burnout has been considered more a personal problem than an organisational one” (p. 537) based upon the concept that “recent research has expanded the theoretical burnout framework to include perceived organisational sources of stress” (p. 537). The study again described high levels of burnout amongst the community mental health staff surveyed with around two-thirds of clinicians involved in the study reporting “high levels of emotional exhaustion” (p. 541) whilst one in four describing “high levels negative cynical attitudes and feelings about service users and perceived low professional efficacy” (p. 541). The authors suggested that occupational factors are significant contributors to the development of burnout, and in particular described staff at highest risk of becoming burnout-out were those with high levels of direct consumer contact as well as having spent long periods in the field. This last finding is significant to this study as it reaffirms the increased risk of burnout faced by CAT Team nurses given that the role is traditionally filled by nurses with more experience having spent a significant period of time in the field and involves high levels of face-to-face consumer contact in day-to-day practice.

It is important to note that none of these studies were specific to CAT Teams, which are a subtype of community mental health team focusing on crisis assessment and treatment of the acute phase of mental illness in the community (see Chapter Two for comprehensive exploration of the evolution and role of CAT Teams in Victoria). As such they provide a useful understanding of burnout in community mental health teams in general however the contemporary literature’s
contribution is limited by its lack of specific focus on the unique context of the CAT Team setting.

**Burnout and Crisis Assessment and Treatment (CAT) Teams**

The nature of the community mental health service delivery means that CAT Team nurses are constantly working in a high stress environment, assessing and treating people who are acutely unwell with any one of a variety of forms of mental illness (psychosis, depression, hypomania, personality disorder etc.), and who are often at considerable risk to themselves and/or to others. Given that CAT Teams are designed for crisis assessment and intervention, once the consumer's degree of acuity and/or risk begins to subside, they are referred on to other treatment providers, such as General Practitioners, Private Psychiatrists / Psychologists, or other counsellors for ongoing management. As a result CAT Team nurses are constantly engaged in the care and management of highly unwell, ‘at risk’ consumers, placing them at significant risk of burnout due to the constant level of high stress in their working environment.

In recent times there has been an increase in the evidence (Happell, 2008; Rose & Glass 2006; Taylor & Barling 2004; Edwards & Burnard 2003; Barling 2001) emerging suggesting that the phenomenon of burnout is occurring in community mental health team nurses. These studies have highlighted a number of problematic consequences associated with burnout, including resulting in increasing staff turnover, difficulty in recruiting suitable applicants into vacant CAT Team positions, absenteeism (‘mental health days’), exhaustion (physical and emotional) and low job satisfaction. Added to this are the pressures of working in an under resourced public health care system, current shortages in skilled mental health nursing staff, (Evans, 2013) and the poor long term prognosis of many forms of mental illness, all of which places any nurse
working in this environment at high risk of becoming ‘burnt out’ (Happell, 2008; Barling, 2001).

Overview of the Notion of Transcending

In order to further develop the study a way of identifying and describing the experience of overcoming burnout casually described by those CAT Team nurses (as previously discussed) had to be developed. This would allow the study to explore and describe the experiences of CAT Team nurses who had been able to live through and move past an episode of burnout whilst remaining in the clinical role. From a pragmatic level this would be critically important, as it would define the type of experience being researched, guide the recruitment process and underpin the entire analysis process. After consideration of a number of approaches to the topic, the concept of transcending was chosen to describe the essential feature of the phenomenon under inquiry and as a way of conceptualising the aspect of human experience to be explored. It emerged as an apparent gap in the literature as the researcher was unable to locate any research studies that had approached the experience of overcoming burnout from this perspective. The persistent and problematic nature of this issue (as reiterated in Onyett’s 2011 review of stress and burnout in community mental health teams) also indicated that a different approach would be warranted in order to better understand this phenomenon.

It was important that the notion of transcending [as it applied to the study] be clearly described and delineated, as there are a number of variations or close approximations that may potentially be confusing for potential participants. It is also possible that a lack of clarity in identifying and accessing the phenomenon under examination may ‘muddy the water’, causing the data collection process to be miscued, and in doing so pollute what might otherwise have been rich
descriptive data. This concept allowed the research an underpinning notion that was both broad and accessible enough to allow potential participants to relate to it whilst possessing the necessary specificity essential to ensure that data collection and analysis would maintain the necessary focus and detail required for the study.

The notion of transcending, applied as a conceptualisation and description of a particular human experience, is a complicated one that tends to transgress a number of different areas of human understanding. Derived from the Latin *transcendere*, the Australian Macquarie Dictionary 5th Ed (Delbridge, et al., 2009) provides the following definition for the word transcend; “be beyond the range of or domain or grasp of (human experience, reason, belief, etc.); excel, surpass” (p. 667). This is however accompanied by the wider notion of *Transcending* and *Transcendence* that is commonly linked to a wide range of human ideas and practices, particularly various forms of mathematics, philosophy, religion and meditation (Beckley, 2006). When considering the implications of this particular definition as it applied to this study, attention is drawn to the idea of surpassing (the domain or grasp) of the human experience (of burnout). This suggests that the individual is able to move through or go beyond the range or grasp of a human experience (in this case burnout), and not remain trapped within the parameters of the experience. The definition also reflects the nature of the human experience may be broad and variable in the content of its characteristics (range) and may also act to hold, detain or even trap its (possible) unwilling participant within the clutches (grasp) of the experience itself.

Philosopher Simone de Beauvoir (1974), when exploring the phenomenon of transcendence concluded that lived experience is fundamental in all human understanding which provides the basis for all meaningful human action and interaction in the world (Kvigne & Kirkevold, 2002,
p. 81). In her book *The Second Sex* (de Beauvoir, 1974) she explored the notion of transcendence stating:

Transcendence captures the idea that people are directed beyond themselves towards something else, something more, by their intentional consciousness. They have an urge to go beyond what is given, i.e. the circumstances that they find themselves in. Transcendence finds expression in actions and projects with a clear content and target. Transcendence is not the same as developmental changes related to growth. It requires conscious and purposeful action performed by a conscious, creative human subject (De Beauvoir, 1974 as cited in Kvigne & Kirkevold, 2002, p. 81).

This concept adds to the idea that the phenomenon of transcending involves an intentional and consciously driven process whereby the individual moves through or beyond the limitations and confines of the situation and circumstances that they find themselves in towards a ‘better’ state beyond. It implies that this is not a random or unconscious act, but rather occurs within, and as a consequence of, the individual’s own intended creative processes.

**Transcending related to the concept of adversity.**

In considering the concept of transcendence a number of areas were considered where the notion of transcending had been utilised in examining human experience from various perspectives. This was an important step in the development of the current study as it allowed the concept of transcending to be examined from a number of different perspectives to determine its relevance in achieving the aims of the study. It also offered the advantage of allowing the researcher to clearly examine and consider the exploration of overcoming or
moving through and past burnout though the conceptual lens of transcending as a human experience. The decision to examine transcending and transcendence in relation to adversity generally came about through ‘stepping back’ from the concept of burnout and considering the fundamental nature of the experience. Concepts such as hardship, difficulty and stress were all considered however these did not capture the complexity of burnout and were all reflected in the broader notion of adversity.

**Transcending related to the concept of illness.**

The concept of transcending adversity in the form of illness was a concept that the researcher considered in the exploration of this concept. Whilst burnout is not considered to be an illness it does share a number of key characteristics with the concept of illness including the experience of hardship, discomfort and adversity, along with an associated intra-personal process of trying to make sense of and come to understand and accept the phenomenon being experienced. Transcending illness (and sickness) involved the intrapersonal journal that those suffering with a significant disease or disorder underwent in coming to terms with their illness and re-finding themselves through this experience.

In their 2005 article Coward and Khan explored the lived experience of Transcending Breast Cancer as described by 14 participants utilising phenomenological inquiry to guide the study. The study described the experience of being overwhelmed by the experience through being able to overcome and evolve past, whilst making some sense of what had happened such that the participants were able to face the future with some level of confidence. The findings of this study conceptualised transcending as a human process that occurs over a substantial period of time rather than being instantaneous or an immediate transition from one state of being to
another. Whilst relief could arguably be available in less complicated areas of life, the phenomenon being transcended was immersive and entangling and as such required time and persistent effort to overcome.

Coward and Khan’s (2005) study also described the concept of transcending through “reaching inwardly and outwardly” (p. 266). This reflected the notion that the experience of transcending was seen to encompass both the subjective and social self and occurred as a critical experience for the participants across their entire selves rather than being restricted to specific sub-parts. This illustrated another important aspect of transcending in its application to the researchers study. This concept suggested that transcending was not limited to solely an internal or intra-personal process; it was rather something that was lived in the individual’s interactions with their world around them as well. Interactions with others, sharing of information and ideas both directly and indirectly, observation, and reflection were all elements to the experience wherein individuals were able to transcend illness in this case.

By way of contrast an earlier study by Wainwright (1997) looked at transcending chronic liver disease in eight participants utilising a Grounded Theory approach and stated that the “trajectory of transcending chronic liver disease consists of the two stages: becoming ill, and not living” (p. 48). The participants faced an irreversible decline as a result of their illness however the study concluded that “patients often transcended many aspects of their illness as they wanted a normal life” (p. 49). This notion of wanting a ‘normal life’ reflected the idea that these individuals were trying to maintain a state of normalcy in which they were operating within the parameters of what was considered customary and conventional despite the nature of the illness they were experiencing. Wainwright’s (1997) study also suggested that transcending included the notion of being able to achieve the perception of some sense of control over the
experience of the illness through being able to hold onto being ‘normal’ in those areas of life where this was possible.

The concept of transcending illness was also the focus of a study conducted by Mellors, Erlen, Coontz and Lucke (2001) that explored the experience of transcending the suffering of AIDS. This study utilised a descriptive exploratory descriptive design to examine how patients (N=5) with AIDS transcending the emotional and physical suffering associated with the illness. The authors reported “creating a meaningful life pattern, connectedness, and self-care” (p. 239) as being the key findings. In the context of this study “Connectedness was expressed in the concepts of activities and relationships” (p. 241) whilst the theme of self-care was described as encompassing the notion of “beating the odds, and the need to survive” (p. 243). In terms of their contribution to the understanding of the notion of transcendence both of these ideas highlighted the importance of hanging in and enduring regardless of the degree of discomfort being experienced. The authors also discussed their findings in relation to the concept of self-transcendence as opposed to transcendence, a concept that will be examined in greater detail later in this chapter.

Transcending related to the concept of extreme human adversity.

The concept of transcending is often utilised in the exploration of human responses to the experience of extreme adversity with the literature containing some studies relevant to the development of this study. Transcending conceptualised as a distinct form of human experience associate with adversity originates with the work of Viktor Frankl, a psychiatrist and existential theorist who in 1963 described a number of transcendent states that he experienced whilst a prisoner in a concentration camp. According to Mellors et al., (2001), Frankl believed that “life
always has meaning for the individual; a person can always decide how to face adversity.

Therefore, self-transcendence provides meaning and enables the discovery of meaning for a person” (Frankl, 1963 cited in Mellors, Erlen, Coontz & Lucke. 2001, p. 236).

In her article examining the concept of transcending circumstance in those imprisoned in Nazi concentration Camps in World War II, Freeman (2002) states that “the human spirit strives to transcend the worst of times in the quest to be whole” (p. 33). In discussing the struggle to ‘transcend circumstance’ for prisoners in the Auschwitz camp the article describes “ways of coping” (p. 33) that included humour, the use of music and art as activities to distract or to remind the individual of the broader context of life as well as the importance of support from friends and family. It is impossible for most people to even begin to understand or appreciate the nature of such an experience; however the testimony of those who were there and did survive indicates that even “amid the degradation, death, and despair of the camps, there were some prisoners who could choose life” (Freeman, 2002, p. 35).

Further discussion and exploration of the concept of transcending suffering in the face of extreme adversity can be found in Hong Chen’s (2011) essay in which the author explores the concept of transcending suffering in the context of the 2008 Wenchuan earthquake in China. Hong Chen argues that “suffering … is in fact an interactive process of human transcendence—an action of exercising our moral reasoning toward one of the unavoidable human conditions” (p. 214). Hong Chen reports that the experience of transcending suffering is “intimately concerned with the way we view ourselves … and this provides us with unique avenues to personal exploration and self-realisation” (p. 214); furthermore this idea suggests that when faced with situations of adversity there exists the possibility for some individuals to transcend their situation and aspire to something greater than what already exists. Hong Chen considers
this to be a journey of intra-personal change that provides the individual with opportunities to
enhance and further develop their understanding if their world, albeit through a difficult and
challenging period of time.

Transcending related to the concept of transition.

Another concept in exploring and conceptualising the notion of transcendence was that
relating to the experience of transition. According to Bridges (2004, cited in Kralik, Visentin, &
van Loon, 2006, p. 322), “Transition is not an event, but rather the ‘inner reorientation and self-
redefinition’ that people go through in order to incorporate change into their life” (p. 323).
Implicit in this process is the notion that “Transition is clearly linked to the notion of self and
identity and how it is affected by disruption” (Kralik, Visentin, & van Loon, 2006, p. 326)
which is certainly reflected in the concept of transcending burnout, where burnout assumes the
role of the disruption that is affecting the individual’s notion of self. The difference between the
concepts of transcending and transition lies in the assumptions being made regarding the nature
of the change itself. With transition the movement is simply from one state of being to another;
or as defined on Wordnet, (the online lexical reference system developed by Princeton
University) the act of passing from one state to another; there is no expectation regarding the
quality or characteristics of the change, only that the change occurs. When considering the
concept of transcending Wordnet describes the meaning of this term to be to exceed or surpass
or to be greater in scope or size than some standard. For an individual to transcend an
experience (the focus of this study) they must do more than simply change. They need to evolve
and improve, and having done so emerge more capable than they were prior to the onset of the
initial obstacle.
Transcendence and Self-Transcendence

The concept of transcendence is a complex one that has many applications and uses depending on the area or field in which it is being applied. In examining potential ways in which to frame the research focus a number of notions were considered that had possible application. In the end the concept of transcending as an action or human process directed towards an external presence / influence / phenomenon rather than self-transcendence in response to an external phenomenon was chosen. That said it is worth commenting upon the notion of self-transcendence, if for no other reason than to ensure the difference between the two concepts is clear, particularly given that the latter notion is commonly utilised in health care research (Reed, 2009; Ellerman & Reed, 2001).

The notion of self-transcendence was also considered in the preliminary development of the study. Identified as “a developmental concept relevant to mental health, including depressive illness and emotional being” (Ellermann & Reed, 2001, p. 698). Nygren, Alex, Jonsen, Gustafson, Norberg and Lundman (2005), describe self-transcendence as being a phenomenon that “enables a person to extend personal boundaries” (p. 355), and in doing so “enhances one’s feeling of self-worth” (p. 355). This indicates that self-transcendence is a ‘lived’ process that allows a person to overcome a negative or stressful experience and in doing so develop as a human being. Self-transcendence is defined more thoroughly by Coward and Reed (1996) who described it as:

An expansion of personal boundaries inwardly, as though increased self-awareness and introspection; outwardly, in terms of investing oneself in relationships with
others and the surrounding environment; and temporally, by integrating perceptions of one’s past and future in a way that enhances the present life (p. 280).

This definition resonated for the researcher as these three distinct elements of self-transcendence provide a broad conceptual lens through which it is possible to examine the lived experience of the individual (self) in transcending a particular kind of experience, such as burnout. It is extremely important to the integrity and rigour of the study that in defining the notion of transcendence, the phenomenological researcher is able to construct a balance between the need to clearly define the key concepts, and the need to allow the participant’s lived experience to emerge and be seen as it is given, rather than demanding it fit into a pre-determined theory of understanding.

**Self-transcendence in nursing.**

Within the nursing profession the concept of self-transcendence is a significant concept that has evolved into a major nursing theory (Reed, 2009). Stemming from Rodgers theory of Self-transcendence, according to Hunnibell, Reed, Quinn-Griffin and Fitzpatrick (2008) is “the process of finding meaning in life and death … [sic] is characterised by awareness of the spiritual aspects of self, one’s relationship to others and the environment, and relationship to a higher being or purpose greater than the self” (p. 172). Reed (2003) also states that the aim of self-transcendence is to “enhance understanding about well-being in later adulthood. The theory is also applicable to any person whose life situation increases awareness of vulnerability and personal mortality” (p. 105).
Reed’s (1991) work was based on the earlier work of Frankl (1963) and built on connecting the concept of self-transcendence with the notion of the individual’s mental health. Reed argued that through the process of normal human developmental individuals develop a gradually expanding understanding of themselves that enables them to reach beyond their immediate selves to something greater regardless of the fact that they are experiencing some kind of adversity of difficulty (either physical or psychological). A combination of a number of factors including introspection, concern about others and their well-being, and integration of the past and future to strengthen one’s present life (Reed, 1991) enables this expansion beyond the immediate self and allows the individual to transcend their pre-existing self, emerging as a better developed more complete version of themselves.

The potential value of the concept of self-transcendence for this study lay in its potential use in situations where human beings were faced with adversity and hardship and in these times had the opportunity to the “persons capacity expand self-boundaries intrapersonally, interpersonally and transpersonally, to acquire a perspective that exceeds ordinary boundaries and limitations” (Ellermann & Reed, 2001, p. 699). As such it would provide a framework for understanding the experiences of the participants however it was ultimately rejected because it incorporated a number of significant issues that made it unsuitable for this research project.

The first of these involved the presence of an integral spiritual element in the experience of self-transcendence, as described by Pytell (2006) who argued that self-transcendence could be read “as a code word for religious conversion” (p. 498). The researcher was unable to reconcile with the study’s aims for two main reasons. Firstly there was absolutely no suggestion in the researchers mind whilst developing the study that there would necessarily be a spiritual element to the experience of transcending burnout. Self-transcendence evolved “as a resource for well-
being amongst those facing end-of-life issues” (Ellermann & Reed, 2001, p. 699), which sat at odds with phenomenon being explored as it did not really contain the ‘life or death’ characteristics common in situations where spirituality is understood to be especially significant. Participants were not struggling to find answers to existential questions; rather the study looked to explore their daily, lived experience in dealing with and overcoming an adverse experience specific to their working life and environment. Incorporating an expectation of spirituality also ran the risk of leading the participants away from focusing on the specific, individual experience of transcending burnout, which was the very goal of the study.

The second issue related specifically to the notion of self in self-transcendence. As with the issue of spirituality the researcher did not want to restrict the participants to transcendence within the self in recounting their experiences, nor restrict the researcher in a similar fashion during the data analysis process. The experience of transcending burnout whilst experienced intra-personally had the potential to involve any type of ideas or behaviours involving both the participant and others around them. It was felt by the researcher that the concept of self-transcendence may have the potential to have the participants feel obliged to discuss and value the internal experience of transcending rather than exploring the broader ‘lived experience’ of transcending with its potential for a combination of internal and external elements, of both feeling and doing included in their descriptions. It was also felt that self-transcendence contained a suggestion of inevitability such as that seen in persons facing an unavoidable fate such as seen in terminal illness and old age, where this concept has been widely applied (Ellermann & Reed, 2001). As has been discussed above the researcher was keen not to make any such assumption (albeit subtly), nor convey this to the participants in the study. This was in direct contrast to the idea of being able to move past or surpass the experience of burnout, a feat
that each of the participants had achieved (and which was the reason for their involvement in the study).

The third and arguably most significant issue faced (certainly from a methodological perspective) in considering the concept of self-transcendence was that it would impose expectations on the participants that were directly at odds with the type of inquiry the researcher was trying to undertake. In developing the description of the phenomenon it was important that the researcher not try to impose a pre-existing model for the experience, as this would be directly at odds with the fundamental assumptions of phenomenological research. In this regard a choice to apply the concept of self-transcendence would involve making a set of assumptions about what the participants were experiencing; it would in effect pre-describe the elements of the experience of overcoming burnout which in the researcher’s opinion was exactly the type of unfounded presumption that needed to be avoided.

**The Notion of Transcending Burnout**

Once the researcher had identified and explored the concepts of *Burnout* and *Transcending*, the next challenge was to bring these two ideas together in a fashion that allowed the research focus to fully develop. This process needed to facilitate a translation of the essential concepts fundamental to Burnout and Transcending from the theoretical to the practical to allow the phenomenon to be identified and explored in the real world of CAT Team nurses.

In attempting to bring a sense of unity to these varied and complex ideas the researcher critically examined the concepts already discussed and drew from them the key ideas, using these to inform the development of practical ‘signposts’ to structure the project. The
phenomenon under investigation cannot be specifically ‘pre-defined’ by the researcher, as it is the participant’s perspective that defines their experience. However, in order for the study to progress effectively and to fulfil the more pragmatic requirements inherent in achieving this goal the researcher developed the following list as a series of impressions drawn from the concepts presented previously to guide the process of bringing the notion of transcending into sharper focus:

- People may have an experience such as burnout.
- This experience may involve a range of experiential characteristics.
- The individual may become caught within the ‘grasp’ of the experience.
- Surpassing or moving beyond this situation is the act of transcending the experience.
- The individual must move forward or beyond the problematic experience; they cannot move backwards, or simply abandon the experiential situation entirely.
- The experience can potentially be a personally positive process.

Subsequent to this, the following guiding descriptive statement was evolved to concisely & clearly articulate the aim of the study and provide an operational definition for the concept of transcending burnout to guide the study:

To examine the mental health nurse’s experience (by their own definition) of consciously going beyond, surpassing, or rising above or through (transcending) the experience of burnout whilst working as a CAT (including ECAT) Team nurse.

It was intended that this statement or definition provided enough of a structure to ground the participants’ understanding of what the researcher was seeking to explore, as this was essential
to the practical progression of the study. That said, the researcher was careful not to make the statement excessively restrictive either as it was important not to passively influence the participant narratives through their understanding of the statement.

**Aims and Objectives of the Study**

In considering the aims and objectives of the study and the research focus that informed the study a number of issues were considered. The researcher desired to examine the individual mental health nurse’s lived experience (by their own definition) of going beyond, surpassing, or rising above or through (transcending) the experience of burnout that had occurred for them within the context of working on a Crisis, Assessment and Treatment Team.

In keeping with this intention the study would be guided by the following research aims to ensure that the necessary focus was maintained through the data collection and analysis process:

- To understand the lived experience of Transcending Burnout (by *going beyond, surpassing, or rising above or through*) as described by nurses working on a CAT Team.
- To explore the individual’s perception of the essential meaning associated with their lived experience of Transcending Burnout.

**The Research Question**

The research question needed to ensure that the aims and objectives of the study were authentically represented throughout the research process and reflected in the study findings. In order to achieve this, the following research question was developed to inform the study:
What is the lived experience of transcending burnout as experienced by community mental health nurses working within the Crisis, Assessment and Treatment (CAT) Team services?

**Significance of the Study**

Given the significance of burnout as a risk factor in broader mental health nursing practice (Sherring & Knight, 2009; Singh, 2011; Edwards, et al., 2006; Jenkins & Elliot, 2004; Edwards, et al., 2000) the study was driven by the potential value offered through achieving a better understanding of mental health nurses who had experienced and overcome the experience of burnout. The significance of this study therefore is:

- The impact of the phenomenon of burnout in the working environment is substantial not only because “of the detrimental influence it has on nurse-patient interaction, but also because of the negative effects on the affected nurse and their immediate colleagues … it has been associated with diminished work performance, [and] increased staff turnover” (Jackson & O’Brien, 2013, p. 10).

- In addition, burnout has been shown to have a clear link to serious personal problems (Majomi et al., 2003; Maslach, et al., 1996; Taylor & Barling, 2004) including physical and emotional exhaustion, increased poly-substance use, sleep difficulties and relationship problems, all of which make it a very serious issue, both in and out of the workplace.
The phenomenon of burnout in nursing is by no means a new concept however, there is a paucity of data available describing the lived experience of transcending burnout in the case of nurses working in the CAT Team setting.

Contemporary research undertaken in the field of mental health nursing, whilst important, lacks relevance to the experiences of the CAT Team nurse, given that a crisis Team working environment is entirely unique within the current public mental health system.

The autonomy and isolation of CAT Team nursing practice, constant high acuity of the consumer group, absence of 24 hour professional consumer supervision, unpredictability and diversity of the mental health care consumers, and the logistical difficulties inherent in providing an outreach service, all combine to create a workplace environment unlike any other. As such, it is reasonable to suggest that the factors that contribute to the lived experience of transcending burnout in CAT Team nurses will be diverse and unique to this specific working environment.

By developing a comprehensive understanding of the individual CAT Team nurses experience of transcending burnout in this setting, the researcher will have been able to uncover new and fresh insight into this phenomenon, including how it affects the individual mental health nurse, what are the perceived causes and contributing factors, that will enhance the present understanding of the phenomenon.

Through locating the study in the lived experience of the phenomenon, the insights uncovered have the potential to challenge the current understanding of the phenomenon of transcending burnout. This may provide guidance directly informed by those experiencing
the phenomenon itself in the development of more appropriate and effective support strategies. This has the intended goal of enabling better responses to burnout in CAT Team nurses, improving job satisfaction, team morale, and direct consumer care, whilst potentially reducing job turnover, absenteeism, and personal suffering as a direct consequence of professional burnout.

Overview of Thesis

This chapter has provided a conceptual background to the study, examining the preliminary ideas that lead to the development of the study. The evolution of the study has been described, beginning with the researcher’s initial curiosity stemming from his Masters research, right through to the introduction of the concept of transcending as the lens used to focus the inquiry. The chapter then provided an overview of the phenomenon of burnout as being a significant issue facing mental health nursing professionals. The complex notion of transcending has been discussed and its application to the study has been explored and defined in a manner that will provide the necessary parameters for the research to progress. The issue of transcending burnout has also been considered with particular relevance to the intended population, that being CAT Team nurses. Finally the structure and nature of this particular type of nursing has been examined and the significance of the proposed study has been summarised and laid out in a concise and explicit fashion.

Chapter Two provides a discussion regarding the initial literature review as utilised in phenomenological studies (Streubert-Speziale & Rinaldi Carpenter, 2011; Holloway & Wheeler, 2010). The complex issue of phenomenological reduction or bracketing (Streubert-Speziale & Rinaldi-Carpenter, 2011) as it applies to the literature review process is addressed.
The chapter then goes on to discuss the findings of the initial review of the literature undertaken in setting out and positioning the study.

**Chapter Three** provides an overview of the conceptualisation and development of CAT Teams to allow the reader a clear understanding to the situational context of the study. The chapter explores the evolution of CAT Teams (including ECAT Teams) from their inception in the early 1990’s through to their current practice structure and process. Literature from the Victorian Department of Human Services along with broader peer reviewed research will be presented and critiqued to allow a clearer understanding of the CAT Team environment as it relates to nursing practice.

**Chapter Four** provides a description of phenomenological thought with a particular focus on Husserlian phenomenology, the theoretical framework underpinning this study, and will discuss its relevance to the research being undertaken for this study.

**Chapter Five** provides an overview of the procedural steps in the phenomenological research process including an examination of each of the steps undertaken by this researcher in bringing the project to ‘life’, as well as a description of the ethical considerations that were deemed to be relevant to this study.

**Chapter Six** presents the findings of this study as revealed through the process of thematic analysis, utilising the procedural steps suggested by Colaizzi (1978). The Chapter presents the main findings of the dissertation in the form of the nine themes that emerged from data analysis. Each of the explicated themes will be presented and discussed in turn accompanied by
supporting excerpts from the participants' interview transcripts. The chapter concludes by presenting an exhaustive description of the phenomenon.

**Chapter Seven** discusses the emergent themes revealed by the study in relation to contemporary research literature. A summary of each theme is outlined, followed by a discussion of the literature relating to the respective theme.

**Chapter Eight** provides a detailed discussion of the strengths and weaknesses of the study followed by an exploration of the implications of the findings for both nursing practice and research. This is followed by specific recommendations for future nursing practice and research. The chapter concludes with the researcher’s reflections on the research process.
Chapter Two

Preliminary Literature Review

This chapter initially provides a discussion regarding the completion of a cursory literature review given its specific application within a Phenomenological study. The chapter outlines the purpose and limitations of the review along with the rationale underpinning this process. The literature considered is then presented with relevant discussion regarding its contribution to the development of the study. It should be noted that in keeping with phenomenological research practice a full review of the literature is presented as part of the discussion of the study’s findings in Chapter Eight.

Phenomenology and the Literature Review

Having developed the initial focus for the study the next stage in the development of most research studies would be to conduct a literature review in order to ascertain the details of research that had already been undertaken on this topic. However, as phenomenology was being strongly considered as the research methodology for the study (based upon the research goal of exploring the lived experience of transcending burnout), a full literature review was not conducted at this stage of the project (Munhall, 2012; Streubert-Speziale & Rinaldi Carpenter, 2011; Holloway & Wheeler, 2010). A full discussion of the methodological issues involved in undertaking the study is presented in Chapter Three, however the following section provides comment essential at this stage of the dissertation regarding the process undertaken by the researcher in examining the literature necessary for the development of the study.
The rationale for this variation in positioning in phenomenological inquiry within the literature is based on the researcher’s fundamental goal; that being to uncover the phenomenon under investigation in its purest form as described by the accounts of those human beings experiencing it. This process ensures that the researcher allows the phenomenon to be revealed through the interviews with the participants as “the fewer ideas or preconceived notions the researchers have about the phenomenon under investigation, the less likely their biases will influence the research” (Streubert-Speziale & Rinaldi Carpenter, 2011, p. 92). This approach also reflects the methodological requirements of the study, as it is in keeping with Husserl’s concept of Bracketing, described by Holloway and Wheeler (2010) as the “process of suspending beliefs and prior assumptions about a phenomenon” (p. 216). Bracketing is an essential step in establishing and achieving methodological rigour of the study as it constitutes the researcher’s practical application of this intra-personal process of consciously identifying and then deliberately setting aside pre-existing thoughts, ideas and expectations regarding the topic. Conducting a complete literature review at this stage of the study would run contrary to this key requirement. The researcher would find themselves in the difficult position of identifying and bracketing out pre-existing beliefs whilst simultaneously engaging in a thorough review of pre-existing literature leading to the development of new ideas which will in turn need to be identified and bracketed ‘out’. This was not a situation that would be conductive to the development of the study topic and so as a result an alternate approach needed to be adopted.

The full literature review is therefore postponed until after information analysis, as it allows the researcher to get closer “to the goal of achieving a pure description of the phenomenon under investigation” (Streubert-Speziale & Rinaldi Carpenter, 2011, p. 92). The importance of completing the literature review after the data collection and analysis is also reflected by
Munhall (2012), who expresses a very similar opinion about the timing of the literature review, stating “that it is “preferable to postpone the experiential description of the literature until after you have completed your interviews … It can assist you in staying as close to the participant’s narratives as possible, without the influence of the literature review” (p. 156). It is instead conducted after the data analysis is completed wherein it serves to place “the findings within the context of what is already known about the topic” (Streubert-Speziale & Rinaldi Carpenter, 2011, p. 93). Positioning it at this later stage of the research process would also allow the researcher to “experience things as fresh and new as they do not pre-judge” (Holloway & Wheeler, 2010, p. 221). For the researcher this was a requirement that demanded close practical attention in order to minimise the potential for these pre-existing concepts, notions, ideas or beliefs to unduly influence the data collection and analysis.

Having adhered to this methodological requirement, it was also essential at a practical level to conduct a preliminary review of the existing literature to inform the further development of the study. The information provided through a preliminary literature review was necessary in allowing the continued development of the experiential concepts used to conceptualise and ultimately define the experience to be explored (transcending). The researcher had been immersed in the area of CAT Team nursing and had witnessed the human experience of both burnout along with overcoming burnout. These experiences had provided the initial catalyst for the study, however it was also important to ensure they did not limit the scope of the study. A preliminary understanding of the literature was necessary to allow the researcher to consider broader associated areas of knowledge in positioning the study to ensure it would explore a topic that was both significant and relevant (Taylor, Kermode & Roberts, 2006).
Additionally, without this preliminary review of the literature the researcher faced the prospect of developing the parameters of the study in almost complete isolation, with no sense of whether the findings would later be able to be related to the existing literature on the topic. To ensure methodological rigour the researcher must actively aim to bring as few pre-existing ideas or notions to the research process as possible, hence the need to limit the extent of the literature review. However the researcher also has to ensure that the findings generated by the study can later be related to the wider context (defined as it is by the existing literature about the topic), as this is critical to the outcome of the overall research process. In order to achieve this requirement the researcher needs to possess enough awareness of the existing literature in developing and positioning the research to ensure the final results of the study are able to be related to the existing body of literature. If the results are unable to be related to what is already known (if only distantly) then the study will have produced knowledge of negligible value, thereby defeating the very purpose of undertaking the research in the first place.

Furthermore, it was important to examine the existing literature to determine what was already know about the topic of overcoming, or moving through and past burnout. At a theoretical level this preliminary literature review was a logical and necessary step as it allowed the researcher to ensure justification for the continuation of the proposed project. If research examining this topic had already been completed there would be little reason to repeat this study again. As an extension of this notion, examination of the existing literature was also necessary to ascertain if the phenomenon of transcending burnout in CAT Team nurses had already been researched utilising a phenomenological approach, and in doing so, verify the need for the proposed project to continue.
In reconciling these competing demands the researcher adopted the following strategy. A preliminary review of the literature related to the key concepts underpinning the study (as outlined below) was conducted in order to ensure that the study would be likely to produce new understandings that would be both relevant and useful within the area of inquiry. In order to minimise any potential issues related to the process of bracketing the researcher utilised reflective practice techniques such as journaling right through the literature review process. Literature uncovered in the development of the study was also regularly reviewed with the researcher’s supervisors as part of the supervisory process allowing for discussion regarding the impact of newly identified literature upon the researcher’s beliefs about the topic. The researcher was also mindful of the fact that the overall goal of bracketing is to achieve a “pure description of the phenomenon under investigation” (Streubert-Speziale & Rinaldi Carpenter, 2011, p. 92). As such the process of bracketing was most important during the data collection and analysis phase of the study, resulting in an additional focus on the practical application of this concept by the researcher during this period. This process is further outlined and discussed in Chapter Five.

The Preliminary Literature Review

Overall search strategy.

The preliminary literature review was completed through a detailed search of a number of databases. The preliminary review of the literature was conducted between 2004 and 2008 utilising the CINAHL, Proquest, PubMed and Scopus databases. It focused on an exploration of the twin concepts of burnout and transcending, as these were the two key ideas that underpinned the preliminary development of the study. The search initially targeted literature relating to
burnout and transcending in the broad sense, before being narrowed down to focus on literature relevant to the study topic. The specific literature strategy for both burnout (in community mental health teams) and the concept of transcending as human experience is outlined at the beginning of each section below.

**Preliminary Literature Review: Burnout in Community Mental Health Teams**

**Preliminary literature review strategy: burnout.**

The concept of burnout was initially explored using the term ‘Burnout’ which was then refined through the use of AND ‘Mental Health’, AND ‘Nursing’, before finally AND ‘Community’; the results of this search are summarised in the table below. The abstracts of all studies located were then reviewed by the researcher to determine their relevance to the current study. Studies that were not relevant to the context and focus of this study, or studies that were greater than ten years old (unless deemed to remain relevant despite their age) were also removed. Two studies could not be located leaving the researcher with 33 studies forming the basis of this preliminary literature review. This literature is presented in the table on the following page.
Table Two: Burnout in Community Mental Health Nursing Literature Search Summary (1995–2008)

<table>
<thead>
<tr>
<th>Database</th>
<th>Search Terms / Process</th>
<th>Result after Duplicates Removed</th>
<th>Result with articles not able to be located removed</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Burnout And Mental Health</td>
<td>And Nursing And Community Papers with Relevance to the Study</td>
<td></td>
</tr>
<tr>
<td>CINAHL</td>
<td>2911 204 90 31 27 23 22</td>
<td>23 22</td>
<td></td>
</tr>
<tr>
<td>SCOPUS</td>
<td>10680 1349 384 69 23 8 7</td>
<td>8 7</td>
<td></td>
</tr>
<tr>
<td>PUBMED</td>
<td>4796 560 214 51 29 3 3</td>
<td>3 3</td>
<td></td>
</tr>
<tr>
<td>PROQUEST</td>
<td>4335 762 127 32 16 1 1</td>
<td>1 1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Total 33</td>
<td></td>
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</tr>
</tbody>
</table>

For the purposes of the following discussion the literature relating to burnout in community mental health teams has been discussed under the headings: Initial investigations, Literature from the 1990’s, Stress and burnout in community mental health nursing, Stress and burnout in community mental health and other settings compared and Strategies in the Management of Burnout before a summary of the key concepts from the literature is presented.

**Initial investigations: literature from the 1990’s.**

The initial area of literature included within this review was grouped together from a number of studies completed in the 1990s. Although quite old by current standards, they
represent the initial body of research examining the issue of burnout in what were then the newly formed community mental health teams. As such they constitute a seminal contribution to the development of understanding regarding this topic as well as being the foundation for the research that has subsequently been undertaken on burnout in community mental health teams. For these reasons a brief summary of the key pieces of research is included below.

One of the first studies conducted in the exploration of community burnout was conducted by Fielding and Weaver (1994) who sought to compare the perceptions of work environments and psychological health of hospital and community mental health nurses (CMHNs). The study utilised a number of questionnaires including the Maslach Burnout Inventory, comparing the results provided by 67 hospital nurses and 55 community-based mental health nurses. The authors concluded that “hospital and community environments make different demands of nursing staff” (p. 1196), highlighting the inherently different circumstances and stressors faced by nurses working in each of these environments.

This was again the focus with the Claybury Community Psychiatric Nurse (CPN) stress study, undertaken by Fagin et al., in 1995, that focused upon a comparison of the stress in hospital verses community working environments. The study utilised six different survey tools on both the hospital and community psychiatric nurse groups and conducted interviews with the community psychiatric nurse group. The study involved a sample size of 250 CPNs and 323 ward-based psychiatric nurses (WBPN’s) and reported high rates of emotional exhaustion in both groups but higher rates of emotional detachment and poorer personal fulfilment in the WBPN group. Overall it concluded that burnout is a major issue in both environments and is a major contributing stressor to “higher absence rates, lower self-esteem and personal fulfilment” (p. 347). A subsequent article by Carson et al., (1995) presented a further comparison of the
findings of the Claybury Community Psychiatric Nurse (CPN) stress study with a subsequent study of burnout in 144 WBPN’s concluding that it whilst “appears to be more stressful to work in the community, CPN’s have better therapeutic relationships with their clients, and get more out of their jobs” (p. 580). The findings of these two articles reflect one of the key assumptions of this study, being that the experience of burnout (and subsequently of transcending burnout) in community mental health nurses (such as CAT Team nurses) is linked intrinsically to the unique nature of their working environment. These findings provide support to the rationale for the study mode and location.

Wykes, Stevens and Everitt (1997) undertook a study looking at the impact of stress and burnout upon sustainability of community mental health care delivery. The study utilised questionnaires to gather data on the experiences of 61 members of six multidisciplinary community mental health teams around Great Britain, with data being collected from psychiatrists, nurses, social workers, occupational therapists and psychologists. The teams themselves were involved in the delivery of assessment and treatment services across a variety of settings and as a result had a degree of similarity to contemporary CAT Teams in the nature of the work being conducted. The study concluded that “community mental health team workers do show evidence of high levels of burnout” (p. 405) with the following implications for the broader delivery of mental health care in the community: “community care depends for its success on high quality care from committed staff and these results clearly cast doubt on the sustainability of such care with such high levels of burnout” (p. 409). The study reported that the main cause of stress was “the levels of minor stressors experienced in the workplace” (p. 405), highlighting the notion that it is the nature of community mental health care specifically that contributes to increased stress and burnout. This again reiterates the fact that the experience
of burnout and subsequently of transcending burnout in CAT Team nurses is linked to the unique nature of their working environment.

A study by Ford, Middleton, Palmer and Farrington (1997) also undertook to understand the issues associated with the stressors associated with community health care practice. The study used a mixed method design initially surveying and then later interviewing 200 primary healthcare workers including mental health nurses about their perceived training needs. The authors concluded that additional training in the area of personal stress and burnout prevention was indicated. The study included primary healthcare workers from a variety of fields including GP’s, practice nurses, and midwives along with mental health nurses and as a result it is difficult to determine the relevance of these findings for CAT Team nurses though this study reiterated this area as being an issue in broader community mental health practice.

The topic of stress in community mental health nurses was also researched by McLeod in 1997 who conducted a three-way comparative study with sixty community mental health nurses divided into three sub-groups. The author compared the level of stress in community mental health nurses working with (Group 1) the long-term mentally ill (Group 2) a mixed caseload and (Group 3) neurosis or primary healthcare consumers, concluding that the level of stress increased with the severity of the consumer’s illness, with those in Group 1 reporting the highest level of stress. The study went on to identify the top ten stressors reported by the groups as a whole, with high workload, inadequate resources and working in a dysfunctional team topping the list (McLeod, 1997, p. 572). This study was unique within the review in that it examined stress across different types of community mental health teams though none of these were specific to a CAT Team context. These findings reinforce the fact that the experience of
burnout differs between different community settings depending on the characteristics of the consumers being treated.

A subsequent study, conducted by Hopkinson, et al., (1998) used a grounded theory based method (Hopkinson, et al., 1998) to examine community mental health nurses attitudes towards occupational stress. The study utilised a semi-structured interview schedule to examine the opinions of fifteen Community psychiatric nurses (CPNs) working in the London area, and found that issues such as ‘relationships’, ‘control’, and ‘resources’, played an important role in influencing the degree of stress CPNs were experiencing. The study exposed themes relating to the experience of occupational stress by community mental health nurses however it did not apply these findings to the phenomenon of burnout, nor was the participant population defined in terms of the type of community treatment they provided (e.g. CATT, Continuing Care, Mobile Support teams), an important issue when considering the contextual factors contributing to the experience of the stress.

**Stress and burnout in community mental health nursing.**

In 2000, a literature review by Edwards, Coyle and Hannigan examined the literature on stress and burnout in community mental health nursing. They reviewed seventeen papers, seven of which focused on stress and burnout in community mental health teams whilst the remaining ten were specifically focused upon community mental health nurses specifically. They concluded that healthcare professionals (in general) working in community mental health teams were “experiencing increasing levels of stress and burnout as a result of increasing workloads, increasing administration and lack of resources” (p. 7). Regarding stress and burnout in community mental health nurses specifically they concluded that stressors could be divided into
three main areas “stressors intrinsic to the job itself … role based stressors … stressors concerning relationships with others” (p. 11). In examining the limitations of the literature included in the review, the authors identified small sample sizes and inconsistent use of measurement tools as being the main issues in limiting the capacity to draw broader conclusions regarding burnout in community mental health nurses. In terms of its contribution to the development of this study the review by Edwards, Coyle and Hannigan (2000) reinforces the high levels of stress and burnout faced by clinicians working in the acute community setting due to the unique nature of the practice environment and relationships that occur there in. That said, the conclusions they drew were limited in their relevance to this study as they looked at multidisciplinary community clinicians across a broad range of community settings rather than focusing specifically on community mental health nurses working exclusively in an acute setting. The authors also noted the issues that existed with the existent body of literature and concluded that a large-scale study on the topic was warranted.

In 2000 the All-Wales Community Mental health Nurse (CMHN) Stress Study was conducted utilising a questionnaire booklet that contained a number of validated instruments used to measure the participant’s experiences of stress, burnout and coping along with three open ended questions on these topics. The questionnaire booklet was sent out to six hundred and fourteen Welsh CMHNs (constituting the entire Welsh CMHN workforce at the time) with responses being received from 301 Welsh CMHNs. This study was conducted with this sample in order to try to overcome the issues associated with the small samples sizes of many of the earlier studies undertaken on this topic of burnout in community mental health nurses. Significant efforts were made to ensure the anonymity of the participants in order to ensure the authenticity of the responses. The findings of this study were subsequently published in the five articles discussed below.
Hannigan et al., (2000) presented the overall findings of the all-Wales stress study based on the results of the Maslach Burnout Inventory, General Health Questionnaire, Rosenberg Self-Attitude Questionnaire and the Community Psychiatric Nursing (CPN) Stress Questionnaire. The authors reported fifty per cent of the participants described being emotionally overextended and exhausted by their work whilst twenty-five per cent held negative attitudes towards their clients and fourteen per cent gained little or no satisfaction from their work. CMHNs practicing in urban environments or those with an unsupportive manager were found to be at highest risk whilst those who had been practicing for longer in the community were likely to have more positive attitudes towards their clients. The authors concluded that these findings were a major issue of concern for the both the CMHN group as well as for the delivery of community mental health care in general. They noted the forty-nine per cent participation rate as a limitation on the study’s results and suggested the need for further longitudinal research though interestingly noted the fact that “high turnover of staff meant that few workers from the original phase of the research were still employed at the end” (Hannigan, et al., 2000, p. 133) highlighting the instability of the workforce which the authors linked to the high degrees of burnout reported.

Burnard et al., (2000) examined self-reported stressors and coping strategies in the study participants; in this particular paper the authors presented the results from the content analysis of the three open-ended questions included in the questionnaire. They concluded that workload, excessive paperwork and administration and broad client related issues were the main causes of stress whilst peer support, personal strategies such as relaxation along with a well-developed sense of self and supervision were found to be the most common coping strategies. The study’s sample size can certainly be considered a strength though it should be noted that this constituted 49% of CMHNs invited to respond which the authors themselves acknowledged as a limitation. The analysis itself was also noted as a limitation, being based upon a method of thematic
content analysis earlier outlined by one of the authors of this study with little information provided regarding the details of the process. In addition, in terms of the development of this study the population was drawn from the entire Welsh CMHN population and did not focus specifically on the type of working environment experienced by CAT Team nurses.

Fothergill et al., (2000) presented the third paper presenting findings from the all-Wales community mental health nurse (CMHN) stress study examining self-esteem in CMHNs. This article focused particularly on the results of the Rosenberg Self-Attitude Questionnaire included in the Questionnaire booklet sent out to all of the participants in the study. The authors reported that overall forty per cent of CMHNs were found to have low self-esteem with those on lower nursing grades and those who consumed alcohol being at highest risk whilst having higher levels of burnout. Conversely those with greater levels of experience working as CMHNs were found to have higher levels of self-esteem and generally lower levels of burnout. As with the previous studies the authors reported the response rate as being a significant limitation for the study findings. In terms of the development of this study the results highlight the complex relationship between the intra-personal self and increased or decreased levels of burnout, reinforcing the potential value of a detailed exploration of the individual CMHNs intrapersonal experience of burnout.

In 2001(a) Edwards et al., published the fourth paper, a study that examined the variety, frequency and severity of stressors experienced by the Welsh CMHNs in the study. This article focused particularly on the results of the Community Psychiatric Nursing (CPN) Stress Questionnaire included in the Questionnaire booklet sent out to all of the participants in the study. The authors reported the greatest sources of stress to be the challenge of maintaining high clinical standards for clients in the face an overwhelming volume of consumer demand and
limited resources along with difficulties in maintaining an uninterrupted working environment. Those with an unsupportive manager and those who worked continuously with a specific high acuity client group were found to be at greatest risk of burnout with the authors concluding that improved levels of support in CMHNs working environments would be an important step forward to addressing this issue. These findings were reflected in a study conducted by Haque et al., (2002) that examined the work and values of forty community mental health nurses noting issues associated with a lack of support as impacting upon practice. As with the previous studies the authors reported the response rate as being a significant limitation for the study findings as well as noting, “that there are a number of other undetermined factors that have an influence on community mental health nurses levels of stress” (Edwards et al., 2001a, p. 812). These factors would need consideration for future research in the area.

The final study from the All-Wales Community Mental health Nurse (CMHN) Stress Study was a second study by Edwards et al., also published in 2001(b) that examined stressors, moderators and stress outcomes experienced by the Welsh CMHNs in the study. This article focused particularly on the results of the General Health Questionnaire (GHQ) included in the Questionnaire booklet sent out to all of the participants in the study. The authors again reported high levels of stress in the participating CPN’s and described the most important coping strategies used by CPN’s as having a stable family life, good social supports an external activities (such as hobbies) that they enjoyed doing. This article was unique in this early literature in that it focused upon strategies used to manage stress rather than the causes of it in CPN’s. In terms of the development of this study the relevance of these findings is limited by the differences in location and clinical practice focus. Despite this, the Edwards et al., (2001) article highlights the capacity for CPN’s to develop strategies to cope with burnout, as well as acknowledging the need for further study in this area.
A study conducted by Pinikahana and Happell (2004) examined stress, burnout and job satisfaction in Victorian rural mental health nurses. The study utilised a questionnaire including the Maslach burnout Inventory, Nursing Stress Survey Scale and Job satisfaction scale to involved with a sample of one hundred and thirty-six rural mental health nurses working across a variety of settings with the authors concluding that rural mental health nursing, whilst moderately stressful did not entail higher levels of burnout than other areas of nursing. The size of the cohort and similar location were strengths to this study however the specific focus on rural mental health nursing and its inclusion of mental health nurses from across a variety of work settings meant that the results have limited applicability to the current study. However, they do serve to highlight the importance of the nurses working environment upon the nurses overall experience of burnout.

A Canadian study undertaken in 2003 by Robinson, et al., examined the incidence of vicarious trauma and burnout in mental health nurses (N=295) across a wide variety of clinical settings. The authors utilised a survey containing the Maslach Burnout inventory, Traumatic stress belief scale and a PTSD checklist to collect and analyse the data and reported high levels of emotional exhaustion (indicating high levels of burnout) whilst paradoxically also noting higher levels of personal accomplishment (indicating low levels of burnout). They also reported that the participants overall recorded average scores (compared to other mental health professionals) regarding vicarious trauma, though noted at the same time that significant numbers of participants struggled to maintain effective intra-personal boundaries regarding client trauma (21%) whilst 55% met at least one of the diagnostic criteria for PTSD. Of this group 59 reported these symptoms interfered in their life in some discernible manner. The findings of this study were limited in their relevance to the current study by their sample issues (only 29% of the original 1015 surveys originally sent out were returned), broad range of clinical settings along
with the different national setting. However these findings again reinforce the complex and significant threat posed by burnout to mental health nurses with significant implications for their clinical practice.

The review also identified four additional studies that examined the impact of various factors upon the development of burnout. Whittington (2002) explored the impact of a ‘zero tolerance’ attitude towards aggression in a community mental health setting in the UK. The study utilised a Tolerance Scale and Maslach Burnout Inventory to survey thirty-seven CMHN’s concluding that CMHNs who had been in the job for greater than fifteen years were more tolerant of aggression than less experienced colleagues whilst at the same time noting that more tolerant staff generally reported significantly lower levels of burnout. The author noted the small sample size as being a significant limitation limiting generalisability and also noted the inverse implications of the results, that being that those CMHNs who adhered more strictly to the ‘zero tolerance’ policy were likely to be at greater risk of burnout, acknowledging this as being an area of concern for CMHN practice in general. McGuiiness (2003) examined community mental health team skill mix in light of the impact of burnout on community mental health nurses. The project surveyed forty-two community mental health nurses concluding that an increased level of local support and clear career structure were important elements promoting a more positive working environment. Sturm (2004) conducted an Ethnographic study examining the influence of care on the practices of community psychiatric nurses (N=9) working in a suburban community mental health service. The author reported that the majority of the nurses in the study experienced significant levels of moral distress associated with a lack of resources available in the treatment of clients with severe mental illness that mirrored the findings of many of the studies discussed above. This was also reflected in the findings of a literature review by Walsh and Walsh (2001), who also reported that working intensively with severely
unwell clients was a significant contributor to increased clinician stress and risk of burnout. The findings of the study were limited by the specific location and small size of participant group and the fact that the study focused on a community mental health team that was dissimilar in its client focus to the CAT Team context central to this study. That said this was one of the few studies uncovered in this review that examined the experiences of the CMHNs from a qualitative perspective and highlighted the complexity of the day-to-day experiences faced by these nurses.

The literature review also identified two articles that looked specifically at the impact of client variables in the development of stress and burnout in community mental health clinicians. Gunstone (2003) examined the area of risk assessment in clients who self-neglect with seven community mental health workers using semi-structured interviews to collect data and analysing the data via a grounded theory model of data analysis. The authors concluded that a distinct lack of policy and procedural clarity led to significant difficulties in the assessment of clients who self-neglect. This resulted in increased levels of stress for mental health workers. Another study by Thompson, Powis and Carradice (2008) utilised an interpretative phenomenological approach in researching experiences of eight experienced community psychiatric nurses working with clients who engaged in deliberate self-harm. The findings explored a number of areas noting that desensitisation and burnout were specific risks associated with working with this group. For the purposes of this study these two articles clearly associate the risk of becoming burnt-out with two specific aspects of core contemporary CAT Team nursing practice, underlining the severity of the issue within the normal working life of CAT Team nurses.
An additional study by Majomi et al., (2003) utilised a grounded theory approach to examine the experiences of twenty community mental health nurses regarding the interaction between the stress they experienced both at work as well as at home. The authors noted the gap in the literature regarding the impact of home-based stressors on community mental health nurses with this study being the first to specifically examine this topic. The study concluded that home-based stressors were a significant contributing factor to the overall stress experienced by community mental health nurses and argued that all future research on the topic acknowledge the interlocking complexity of their roles both at work as well as at home. These findings were limited by the sample size and the non-specific nature of the client group looked at by their service, differing in this regard to the focused role undertaken by CAT Teams. However the major contribution of these results to the development of the current study lay in introducing the notion that the participants in this study, although all practicing as CAT Team nurses may experience transcending burnout across both personal and professional life domains. This reinforced the need for the researcher to explore all possible aspects of this experience, be they personal or professional in nature.

McAdam and Wright (2005) completed a literature review of 85 papers considering the role of mental health nurses in assertive outreach teams in the UK. The teams in question have a similar structure and clinical focus to CAT Teams in Victoria though from the author’s descriptions appeared more akin to Mobile Support & Treatment (MST) Team within the Victorian context. The focus of the study was to explore the role of mental health nurses in these teams and whilst many of the findings are not relevant to this study the authors did note that the contrasting roles “risk assessment verses engagement” (p. 648) had the potential to contribute to high levels of stress and burnout. The difficulty in managing these competing roles is similar to the challenges facing CAT Team nurses when working in the community. This
conclusion from the authors relates to CAT Team nursing practice and further supports the notion that the nature of CAT Team nursing practice is highly stressful.

**Stress and Burnout in Community Mental Health and Other Settings Compared**

A comparison of burnout in inpatient and community mental health nursing.

A 2001 review of the literature conducted by Barling examined the existing literature (as discussed above) on burnout across acute inpatient, community and long term inpatient settings, exploring them in the context of the Australian mental healthcare system. This article was the first to explore the issue of burnout from an Australian perspective linking the themes from the (primarily British) context to The National Mental Health Strategy (1992) along with other Australian studies examining the delivery of mental health care in Australian in the late 1990’s. Barling concluded that whilst there had been little specific research examining burnout in Australian mental health nurses there was no doubt that burnout was an issues for mental health nurses across all three clinical settings and constituted a significant barrier to achieving the quality of care required by the Evaluation of the National Mental Health Strategy: Final Report (1998). For the purposes of this study it connected the existing literature on mental health nursing burnout to an Australian context, proving the significance of burnout as an issue for Australian mental health nurses and reinforcing the importance of this study in better understanding how CAT Team nurses respond to burnout.

A 2007 study by Sorgaard, Ryan, Hill and Dawson explored the sources of burnout and stress in the delivery of acute psychiatric care, comparing the experiences of inpatient staff to those reported by community staff. A total of 204 inpatients staff and 209 community staff (including
nurses, doctors, psychologists, social workers and other professionals) across five European countries participated in the study that collected data via a number of surveys. The study found almost no differences in “burnout or aspects of burnout between acute ward and community staff” (p. 794) and with particular regards to the community teams study found that “community teams experienced more organisational problems, higher work demands, less contact with colleagues, but also better social relations and more control over their work” (p. 801). The study again highlights the unique nature of the stressors faced by clinicians working in the acute community setting, though its findings have some limitations in their relevance to this study as Sorgaard et al., (2007) looked at multidisciplinary community clinicians rather than focusing specifically on community mental health nurses.

Conversely, a 2007 study by Ward and Cowman examining job satisfaction in psychiatric nursing reported significantly higher levels of job satisfaction in community mental health nurses as compared to mental health nurses working in institutional settings. The study utilised a combination of a questionnaire adopted from the Occupational Stress Indicator along with focus groups to collect qualitative data from three hundred and forty-six Irish mental health nurses working across both community and inpatient settings. Whilst not specifically measuring burnout in these groups of mental health nurses the topic of job satisfaction examined in the study reflects the concept of personal accomplishment in the work context that is one of the three key symptoms of burnout (Maslach, Jackson & Leiter 1996). As such it has been included in this review to illustrate the complex and often conflicting nature of the results reported in this area.
A comparison of mental health and non-mental health areas of community nursing.

A 2004 study by Imai et al., sought to compare the prevalence of burnout in community mental health nurses as compared with other community health nurses practicing in a wide variety of services across Japan. The study surveyed 525 community mental health nurses along with 545 community nurses from a range of non-mental health settings (ranging from adult and aged to maternity to infectious diseases specialties) with the authors concluding that the prevalence of burnout was significantly higher for community mental health nurses due to factors such as “excessive work demands … and low job control” (Imai et al., 2004, p. 765). A subsequent article published by Imai et al., in 2006 explored the experience of burnout in community mental health nurses in greater detail, examining the impact of the working environment upon the development of burnout. The authors concluded the limited resources and out-of-hours nature of the work contributed directly to this phenomenon in these nurses. Whilst the findings of this study are limited by the differences in the Australian and Japanese contexts the relevance of these factors to local CAT Team practice settings underpins the specific contribution of this working environment to the development of burnout in these nurses.

Stress and forensic mental health nursing.

In 1999 Coffey conducted a study of 104 Forensic Community Mental Health Nurses (FCMHNs) to examine the rates of burnout in this group. The study utilised the Maslach Burnout Inventory, General Health Questionnaire and Community Psychiatric Nurse Stress Questionnaire in order to assess the levels of stress in FCMHNs and to identify the main contributing stressors. The study concluded that a large number of respondents (44.3%) were
experiencing high levels of burnout in relation to emotional exhaustion citing local, profession specific stressors as being the major contributing issues.

A subsequent study explored the relationship between support and stress in FCMHNs (N=80) working in the United Kingdom (Coffey & Coleman, 2001). The study utilised a demographic questionnaire and a range of validated measures and was able to identify statistically clear associations between higher caseloads and increased stress, and also the positive impact of support received from colleagues.

The findings of both of these studies exploring FCMHNs experiences, whilst valuable in their own right, are considered to have limited relevance to CAT Team nurses due to the significance differences between the two areas of community mental health nursing. They both reiterate the prevalence of burnout as an issue in community mental nursing (regardless of the area of specialty) and highlight the impact of local level stressors along with the value of collegial support. However the client population in each case is significantly different, with FCMHs having to deal with the issues associated with their client’s criminal offence and associated legal and mental health implications in addition to any unrelated mental health issues. This has the significant differences in local level working environments and associated stressors, with resultant limitations on the relevance of this research for the current study.

**Strategies in the Management of Burnout**

The literature review located four significant studies that had examined the impact of a number of specific factors on burnout in community mental health teams and nurses. These studies are now discussed with regards to their relevance to this study.
The review identified a research study conducted by Taormia and Law (2000) which examined the relationship between participant’s levels of burnout as measured via the Maslach Burnout Inventory (MBI). The Organizational Socialization Inventory (OSI) was also used to measures strategies used to measure personal stress management and the impact of organisational support. The study surveyed 154 nurses (a combination of professional and student nurses) from five different Hong Kong hospitals and concluded that more positive results in the areas of “job training, organizational understanding, co-worker support and future prospects” (Taormia & Law, 2000, p. 89) correlated with lower scores on the MBI. The study went onto discuss these findings in terms of their relevance to nursing administration, arguing that the development of training programs that included both an intra-personal and organisational dimension was essential in managing burnout in nurses.

A subsequent study by Funakoshi, Miyamoto and Kayama (2007) examined the supportive behaviours practiced by ten community mental health team managers managing community mental health teams in Japan in 2004. The study utilised a Grounded Theory approach to analyse the data identifying four main categories of managerial support: “(1) modifying client-nurse relationships; (2) ensuring community mental health nurse safety; (3) providing emotional support and (4) providing opportunities for skill development” (p. 232). The authors concluded these strategies were effective in supporting the community mental health nurses in assisting in the management of stress and potentially burnout. Both of these studies generated quite different findings relating to effective strategies in the management of burnout, further illustrating the complex and inconsistent nature of burnout and its implications for the development of strategies designed to manage it.
A 2005 phenomenological study undertaken by Edward examined the phenomenon of resilience in relation to the high risk of burnout faced by Crisis Care Mental Health Clinicians. Six crisis care mental health clinicians from nursing, allied health and medical backgrounds were interviewed regarding their experience of bouncing back from adversity and returning to a state of healthy being (Edward, 2005). The study generated five exhaustive descriptions including ‘the team as a protective veneer’, ‘faith and hope’ and ‘looking after yourself’. The study reinforced the risk of burnout associated with crisis work though the relevance of the findings for this study were limited by the small, multi-disciplinary nature of the sample and the focus on resilience as a process of ‘springing back’ from adversity such as burnout rather than transcending it.

A 2006 study by Edwards et al., (2006) examined the influence of clinical supervision on burnout in community mental health nurses. This study utilised the Maslach Burnout Inventory and the Manchester Clinical Supervision Scales with a population of community mental health nurses (N=260). The study identified high levels of emotion exhaustion in 36% of respondents along with high levels of depersonalisation in 12% of respondents, as well as low levels of personal accomplishment in 10% of respondents. This again confirmed the significance of burnout as an issue in community mental health nursing. The study compared the rates of these symptoms of burnout in nurses who had received at significant amounts of clinical supervision (as measured by the Manchester Clinical Supervision Scale) with those who had not and concluded that “if clinical supervision is effective then community mental health nurses are likely to experience lower levels of emotional exhaustion and depersonalisation” (p. 1008). That said the study noted that further research was required to explore the longer-term impact of supervision upon burnout.
Summary of the Literature on Burnout in Community Mental Health Teams / Nurses

The literature provides a complicated and inconsistent overview of the topic of burnout in community mental health teams and more specifically community mental health nurses. The literature examined in this review was published in the period from 1995 through to 2008, constituting the key initial period of research following the widespread Australian shift in mental health care from an exclusively institution based system to more of a community based care system. The research examined utilised a wide variety of quantitative and qualitative approaches across a wide range of team settings, differing disciplines and areas of clinical practice. The research contained numerous limitations as cited in the various studies, including small, inconsistent or biased sample sizes, poor response rates, the use of a broad range of different measures and methodologies along with a broad range of different practice contexts and team parameters making the establishment of strong evidence for practice change extremely difficult.

The measurement of burnout was undertaken utilising a wide variety of measurement scales, with the Maslach Burnout Inventory and the General Health Questionnaire being the most commonly utilised. Grounded theory and phenomenology were the main approaches used in the qualitative studies. The majority of the research identified significant levels of burnout in community mental health teams, with high levels of emotional exhaustion consistently reported in the literature, though the incidence of other key features of burnout (depersonalisation and reduced personal accomplishment) varied markedly from study to study. The studies identified a wide range of factors associated with the experience of burnout including the impact of the team environment, the type of clients being treated, the individual’s sense of role and life outside of work, along with the impact of team leadership and line management. The
consequences of burnout for the clinicians involved varied markedly from study to study, including absenteeism, difficulty in staff retention, variable job satisfaction and morale, role uncertainty along with personal dissatisfaction and dysfunction. Equally, there was very little consistency in the research overall regarding strategies or interventions to reduce the impact of stress upon community mental health clinicians. There was consensus in the majority of studies, which agreed that the seriousness of the problem necessitated the development and application of more effective support strategies for community mental health teams/nurses though there was little consistency in what this might specifically entail. Various factors were discussed including the potential value of increased education on burnout though the manner of delivering this was uncertain. Increased levels of support, more effective team design and leadership were all cited though the broad range of team settings and clinician disciplines meant that a conclusive outcome remained elusive.

It is also interesting to note that no literature was identified that examined burnout in CAT Teams in general, let alone any that specifically related to mental health nurses working in these teams. Given the significance of their role within the Victorian (and Australian) mental healthcare system as well as the unique nature of their work (see Chapter Three for a full discussion of same) this constitutes a significant gap in the literature regarding burnout in community mental health teams. For the purposes of this study the review identified not only a clear gap in the literature regarding burnout in CAT Team nurses, but more significantly no significant literature examining the experience of overcoming burnout through any type of human experience akin to transcending.
Literature Review: Transcending as Human Experience

Literature review strategy: transcending as human experience.

The complex and multi-faceted nature of transcending/transcendence as a theoretical concept meant that it required a significant exploration and consideration in the initial development of the study. This involved the researcher conducting an extremely broad exploration of the various uses and applications of the term before narrowing it down to literature that reflected the type of human experience that was the focus of this study. In considering each piece of literature the researcher utilised the following steps to guide the process of determining relevance:

1. Use of the words ‘transcend’ or ‘transcending’ purely as a simple verb or broader descriptive term that did not convey the same experiential quality utilised in this study were excluded.
2. Articles not considered relevant to the research study focus (transcending as human experience) were excluded.
3. Articles relating specifically to transcending used exclusively in the context of spiritual or religious research studies were excluded (not considered relevant to the aims of the study).
4. Studies published more than ten years ago (prior to 2003) were closely examined to determine contemporary relevance.

The concept of transcending was initially explored using the term ‘Transcending’ which was then refined through the use of AND ‘Human’, AND ‘Experience’. The results of this search
are summarised in Table Two below. The abstracts of all studies located were then reviewed by the researcher to determine their relevance to the current study. Studies that were not relevant to the context and focus of this study, or studies that were greater than ten years old (unless deemed to remain relevant despite their age) were also removed. Three studies could not be located leaving the researcher with 19 studies forming the basis of this preliminary literature review. This literature is presented below.

**Table Three: Transcending as Human Experience Literature Search Summary (1996-2008)**

<table>
<thead>
<tr>
<th>Data Base</th>
<th>Search Terms / Process</th>
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<th>Result with articles not able to be located removed</th>
</tr>
</thead>
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<td>Papers With Relevance to Study</td>
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<td>19</td>
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For the purposes of the following discussion, the literature relating to transcending as a human experience in the face of adversity has been discussed under the following headings: The Human Experience of Transcending, Literature related to the Lived Experience of Transcending Illness and Adversity and Literature related to the Lived Experience of Transcending Burnout in Nursing. Following this a summary of the literature and its relevance to the development of this study is presented to conclude the discussion on transcending as a human experience.
The Human Experience of Transcending

A literature review undertaken by Liberman and Trope (2008), examined the literature regarding the psychology of transcending the here and now in which they reported “abstract thinking is used to transcend the present and expand one’s mental horizon by thinking farther into time and space and considering remote social targets and unlikely possibilities” (p. 1204). The authors examined the way in which people relate to events in the near and recent past and future, objects in close and distant proximity, as well as likely and possible outcomes of events, concluding that transcending involved constructing mental models of possible outcomes to serve as a way to perceive beyond what is happening to them in the here and now. This outcome underlined the notion that transcending as human experience involved an individual’s capacity to engage in an interactive, intentional, process of constructing and being guided by potential outcomes for the future. The review underlined the validity of transcending as a conceptualisation of the human experience of moving beyond the real present to a potential though as-yet undetermined future.

Literature related to the Lived Experience of Transcending Illness and Adversity

Literature related to transcending illness.

The review of the research literature identified five pieces of literature that examined the concept of transcending various types of illness and sickness. In considering the relevance of transcending in this context the researcher concluded that whilst burnout is not considered to be an illness it does share a number of key characteristics with the concept of illness including the experience of hardship, discomfort and adversity, along with the associated intra-personal
process of trying to make sense of and come to understand and accept the phenomenon being experienced. For these reasons, the inclusion of literature that explored the experience of transcending illness was deemed to be important and therefore included in this discussion regarding relevant literature.

The earliest article applying the concept of transcending to breast cancer located in the review was an article by Kinney (1996) in which the author described her personal journey through her experience of breast cancer. In this autobiographical article the author described her diagnosis, treatment and recovery from breast cancer. She described the holistic process of transcending as “a sense of exceeding one’s usual limits, having surpassed or gone beyond the material existence” (p. 201), drawing on the work of Abraham Maslow (1972) in developing this idea. The author describes her experience of transcending in great detail, including the sense of reconstructing and re-integrating her sense of her whole self in response to each of the stressors and challenges she faced. Equally important was the importance of being able to listen to her inner voice in “an evolving and integrating process that is ongoing and ever-building” (Kinney, 1996, p. 202). In terms of its relevance to the study, this article raised a number of the key parameters (that would be built on in the discussion below) that would define the concept of transcending for the study.

The topic of transcending in the context of breast cancer was next the focus of an article by Chiu (2000). This study explored the experiences of fifteen Taiwanese women utilising a van Manen’s (1990) phenomenological approach to guide the study. Four key themes emerged: describing the essential structure of transcendence as “the capacity of a person to give meaning to suffering, liberate self from a clinging nature, open self to life and death and heal self with compassion” (p. 64). The author examined the concept of transcending in some detail in the
study, concluding that it manifests in the “capacity to reflect, reach out beyond one’s self, exert oneself beyond personal concerns and take on broader life perspectives and purposes” (Chiu, 2000, p. 65). In terms of relevance to this study, Chiu’s conceptualisation of transcending (as human experience) contributed to the understanding of the intra-personal process of increasing personal awareness leading to reaching out beyond the immediate day-to-day experience to find something broader beyond the individuals immediate personal concerns; this notion would later contribute to the working parametres of transcending as human experience utilised in the study.

Transcending breast cancer was also the subject of a 2005 study by Coward and Khan that explored the lived experience of transcending breast cancer utilising phenomenological inquiry (including Colaizzi’s model of data analysis) to guide the study. Focusing on the lived experiences of fourteen women newly diagnoses with breast cancer the study conceptualised the process of transcending as occurring over a period of time (in this case many months) wherein the women moved from describing being overwhelmed by the experience through to being able to overcome and evolve past it. They also reported making some sense of what had happened such that they were able to face the future with an increased level of self-confidence. In describing the findings the authors reported that in transcending the participants experienced reaching both inside and outside of themselves for support and understanding whilst interactions with others were important in the expansion of self-boundaries, comfort, and a desire to change their life priorities (Coward & Khan, 2005).

The review uncovered a fourth article that described the concept of transcending in the context of a diagnosis of breast cancer. This study by Mitchell et al., (2007) utilised a constructivist qualitative approach to examine the experience of survivor dragon boating (as a recovery related activity) in ten women engaging in the activity for the first time. The study identified
five key themes in its findings, with the fifth of these being transcendence which the authors described as “not trying to go back to a pre-cancer reality …the sense of becoming more than they were before, of becoming physically, mentally, emotionally stronger…enabled participants to shift cancer from the foreground to the background of their lives” (p. 134). This theme provided a practical manifestation of the key characteristics unique to transcending as human experience; in transcending illness the participants were not seeking to return to the way they had been prior to becoming unwell. They accepted that this was not possible and instead evolved and grew through the experience in such a fashion as to allow them to alter the way in which the illness affected them. It remained an unwanted aspect of their life however in transcending they were able to reassert the power of their lived life over the spectre of the illness.

The experience of transcending in the face of HIV / AIDS was the focus of articles by Newshan (1998) and Mellors, Erlen, Coontz and Lucke (2001) both identified in the literature review. The article by Newshan (1998) utilised the concept of transcending in relation to physical pain with patients with HIV and/or cancer. This study examined the spiritual aspect of the experience of pain, arguing that this manifests through the experience of love and relatedness, meaning and hope. The author argued that in order to effectively look after these patients nurses need to be aware of and possess this perspective and this is achieved through their own experience of transcending to this higher level of awareness. Although focused very much on the spiritual perspective associated with the concept of transcending the results of this article were included as they reflected the importance of being able to move beyond the superficial and mundane and engage at a deeper intrapersonal level in overcoming the experience of adversity.
A subsequent study exploring the experience of transcending the suffering of AIDS was undertaken by Mellors, Erlen, Coontz and Lucke in 2001. This study utilised a descriptive exploratory descriptive design to examine how five patients with AIDS transcending the emotional and physical suffering associated with the illness reporting, “creating a meaningful life pattern, connectedness, and self-care” (p. 239) as the key findings. The participants in this study were striving to function and find meaning in their existence in the face of an irreversible medical condition, with their description of transcending reflecting the human need and capacity to regain and maintain a meaningful life in the face of a serious illness. The authors noted the limitation of the small sample size, however reported that the findings of the study fitted well with the concept of self-transcendence as outlined by Frankl (1963) and Reed (1991). The concept of self-transcendence as it relates to this study is discussed separately later in this chapter.

The review identified five studies that examined the concept of transcending as human experience in the face of other forms of serious chronic illness. The first of these, by Lindsay (1996), explored the notion of health within illness, utilising an interpretive phenomenological study with eight participants suffering with various types of chronic illness. The author described six key themes, one of which was the concept of “transcending the self … expanding beyond the physical realm” (p. 470). Although participant sample size and context were a limitation for this study, this finding illuminated the capacity for the individual to reach beyond the limitations of their reality based distress, seeking at an intrapersonal level to construct ways to find meaning and hope in their lives. This tendency when faced with adversity reflected the human experiential quality that this study was aiming to explore, albeit in the face of a different form of adversity.
The literature review identified a further piece of research by Wainwright (1997) that looked at transcending chronic liver disease utilising a Grounded Theory approach in a sample population of eight patients receiving treatment at a hospital in the southeast of England. The author stated that the “trajectory of transcending chronic liver disease consists of the two stages: becoming ill, and not living” (p. 48). This article related to participants in a very different context, usually facing an irreversible decline as a result of their illness however the study concluded “patients often transcended many aspects of their illness as they wanted a normal life” (p. 49).

Additionally, the study reported that “being positive, wanting independence, and having a sense of humour” (p. 48) were important qualities in the experience of transcending; these qualities reinforced the intra-personal human nature of transcending as well as the notion that it was an approach that came about through the choice of the participants in not allowing themselves to be defined or controlled by the illness.

A 2003 study by King et al., utilised a grounded theory approach to examine the experiences of fifteen participants with a variety of chronic disabilities, including “attention deficit disorder … cerebral palsy … and spina bifida” (p. 188). The study focused on the factors and outcomes associated with major turning points in their lives wherein they were faced with acquiring new meaning about their world. The authors introduced the concept of transcending as a protective process in which the individual replaces a loss with a gain” (p. 184). The authors described a process wherein the individual was able to experience a negative event however through this emerged an opportunity for a new gain that had not been there before. It constituted more than just a return to the pre-existing state of affairs; it was an opportunity for further gain and development that resulted in the participants transcending their earlier state of being, rather than simply returning to it. This notion was reflected in a study by Egnew (2005) in which the author utilised a grounded theory approach to explore the notion of transcending suffering in seven
physicians, concluding that “transcending suffering is surely personal growth” (p. 260).

Although this participant group was very different to the participants in King et al.,’s (2003) study the notion of transcending was described by both researchers to involve the same intrinsic quality; transcending involved moving beyond or rising above the adversity being experienced with the opportunity to grow or evolve as an individual.

The notion of transcending illness was also utilised in Leite’s (2007) exploration of the experience of transcending De Quervain’s disease, a condition that primarily involves “tenosynovitis of the radial styloid” (p.254). This study utilised a case study approach from an existential phonological approach to explore the experiences a forty-year-old female nurse struggling to overcome De Quervain’s disease in the context of her working life. The authors explored the losses and anguish associated with the disease, before exploring her experience of transcending, concluding that “transcendence occurs when the worker acknowledges her [sic] situation, and nevertheless sets goals and finds a meaning in her existence” (p. 257). The study was limited by its specific and focused context along with small sample size, however it again provided further support for the relevance of transcending as a conceptual lens for the exploration of overcoming human adversity.

By way of contrast the review also located a literature review by Kleiber, Hutchinson and Williams (2002) that examined the role of leisure in the process of transcending negative events in life. The authors concluded that leisure contributed to transcending in four different ways; they provided a buffer for the individual from the impact of negative life events, through [1] distraction, [2] generating optimism, [3] assisting in reconstructing a consistent life story. However it was the fourth area, “leisure activities are used in the wake of negative events as vehicles for personal transformation” (p. 229) that was most significant. This proposed that
leisure could provide a vehicle for personal transformation in which the activity itself became one of the first areas where the affected individual could actually experience ‘transcending’, as they were able to enjoy themselves free from the effects of the negative event. This concept underlined the importance of viewing transcending as an experience that can occur potentially across multiple domains of a person’s life.

The concept of transcending barriers associated with illness in order to enjoy leisure experiences was the subject of a study by Gosselink and Myllykangas (2007) in which they explored the experiences of four older women diagnosed and living with HIV /AIDS. The study utilised a thematic, constant comparative method to analyse the data, concluding that the participants experienced transcending through increased spiritual awareness, as well as moving beyond other practical barriers to being able to access leisure experiences. The authors reported that the participant’s experience of transcendence appeared “to mature …formed a continuum” (p. 16), suggesting that the experience of transcending was a gradual and ongoing one. Within the experience of transcending the individual was able to become more capable and effective the longer they spent in the context of the experience.

**Literature relating to transcending in the context of human adversity.**

The concept of transcending is often utilised in the exploration of human responses to the experience of extreme adversity and in this literature contains some concepts relevant to the findings of this study. Transcending conceptualised as a distinct form of human experience associate with adversity originates with the work of Viktor Frankl, a psychiatrist and existential theorist who in 1963 described a number of transcendent states that he experienced whilst a prisoner in a concentration camp. According to Mellors et al., (2001), Frankl believed that “life
always has meaning for the individual; a person can always decide how to face adversity. Therefore, self-transcendence provides meaning and enables the discovery of meaning for a person” (Frankl, 1963 cited in Mellors, Erlen, Coontz & Lucke. 2001, p. 236). In her article examining the concept of transcending circumstance in those imprisoned in concentration Camps in World War II, Freeman (2002) states that “the human spirit strives to transcend the worst of times in the quest to be whole” (p. 33). In discussing the struggle to ‘transcend circumstance’ for prisoners in the Auschwitz camp the article describes “ways of coping” (p. 33) that reflect the real-world lived expression of transcending as it applied to the individuals imprisoned in this camp.

Another example of the concept of transcending suffering can be found in a study by DeFrain et al., (2003), in which the authors explored the experience of surviving and transcending a traumatic childhood. The authors utilised a 92 item questionnaire that was analysed both quantitatively as well as qualitatively with the article focusing primarily on presenting the themes that emerged from the thematic analysis of the participants responses. The authors ultimately described the process in two parts with children simply surviving or enduring as they lacked the means to do more, whilst the experience of transcending, described as “going beyond or rising above” (p. 144) occurred when they reached adulthood, though it was an ongoing process. The study by DeFrain et al., (2003) was important in the development of this study in that it involved the application of transcending as a human experience to an external adverse or negative event. The authors provided a sophisticated yet practical and accessible description of transcending, describing transcending as a gradual day-by-day, step-by-step process that fit very much with the aims of this study in exploring the experiences of CAT team nurses in transcending burnout.
The issue of transcending trauma in childhood was also the focus of an article by Skogrand et al., (2005) describing a qualitative study undertaken with 84 participants examining the role of their spouses in transcending their childhood trauma. The authors collected stories from childhood trauma survivors via a survey and then conducted a thematic analysis on the written responses in order to generate their findings. The authors reported that the spouses of the 49% of the participants in the study played a significant role in their transcending in a variety of ways, from providing a listening ear, role modelling supportive behaviour and providing unconditional love. It is worth noting that 51% of the participants did not see a happy marriage as being an important element in transcending the past, however for those in the former group having a supportive partner who was ‘there for them’ in a practical and emotional sense was an important part of the experience of transcending.

The final article identified in the review regarding transcending adversity was a study completed by Dahlqvist, Soderberg and Norberg (2008), examining the experiences of healthcare students in overcoming stress. The study utilised qualitative content analysis to explore the experiences of one hundred and sixty-eight healthcare students (nursing, occupational therapy, physiotherapy and medicine), describing transcending as being a key theme. Transcending was divided into the subsections ‘opening up’, described as “being present, contemplating and feeling connected to life” (p. 481) and ‘finding new perspectives’ which the authors stated “was about shifting perspectives from oneself to others, arriving at an understanding and sense of meaningfulness” (p. 481). This expression of transcending reinforced the complex and multi-faceted nature of transcending as human experience whilst maintaining many of the key features identified in the previous discussion, namely as an intra and inter-personal process of becoming open to understanding the nature of their experience and finding a revised sense of meaning and connection.
Literature related to the Lived Experience of Transcending Burnout in Nursing

The search for literature specific to Transcending Burnout in Nursing was also undertaken utilising the CINAHL, Proquest, PubMed and Scopus databases and uncovered only a single piece of literature, though this is to be expected given that this was a very precise concept where it was anticipated that there had been very little research undertaken. The one article identified by Edward and Hercelinskyj (2005) was a literature review that focused primarily on the use of resilient behaviours as a resource for coping with burnout, paying particular attention to the use of “professional development processes … supervision, reflective practice, in-service education” (p. 240) in enabling nurses to transcend burnout and workplace stress. The findings of the study, focus specifically on the notion of resilience and its potential contribution to managing burnout, and offer little in terms of a discussion or description around the meaning contained within the phrase transcending burnout. The research does not include any significant exploration of what transcending burnout specifically involves from an experiential perspective either, utilising the term more as a euphemism for recovering from burnout and as such is not particularly relevant to the development of this study.

Summary of the Literature on Transcending as Human Experience

The literature presented on transcending as human experience is both broad and highly varied in its nature. Transcending has been discussed in relation to overcoming adversity generally, wherein it involved moving through or beyond hardship in a way that has involved the individual not simply returning to their previous state of functioning, but rather growing and evolving through the process. Transcending has also been the focus of studies that have sought to explore the experiences of those diagnosed with a diverse variety of illnesses such as breast
cancer, liver disease and HIV/AIDS as well dealing with stress and reconnecting with leisure activities. The research presented all employed the concept of transcending as being a response in relation to adversity or illness as a way of overcoming or moving past the initial source of adversity or hardship. In this regard it is important to note the essential relationship between the episode of adversity and the experience of transcending which would not occur outside of it. Transcending was not a stand-alone human experience that occurred independently of other factors; transcending was transcending of some form of adversity or hardship and as such needed to be seen and understood within the context of this relationship.

From the review of this range of different studies a picture of the notion of transcending has emerged that is both complex and multifaceted. Transcending has been described within the literature as incorporating a range of experiences: at a practical psychological level it involves the individual being able to engage in an flexible creative process wherein known characteristics of the situation they were in are tempered with sophisticated hypothetical possibilities to consider and then move towards possibilities beyond what is immediately available in the original instance. This concept of transcendence as being an aware and intentionally conscious process was reflected consistently across the literature with the important implication that as such it would be accessible by the participants in exploring the topic making it a suitable concept for exploration.

In describing the key features of transcending as a human experience the literature consistently identified three key themes. Central to the idea of transcending was the notion that people are driven past their existing characteristics, qualities and conceptualisations towards something more than what had originally been present or available. Transcending was not a return to the way things were. Rather it involved the individual seeking to become more than they were
before, of becoming psychologically, emotionally and at times even physically stronger than they had been. In this regard, it differed quite significantly from the concept of resilience, which focused more on enduring the source of the adversity with the intention of being able to bounce back from adversity and return to a state of healthy being. This characteristic was also linked to the importance of being able to overcome the negative effects of the adversity being faced, reclaiming lost capacity or activities, asserting control or at the least be able to re-structure the responses to the source of adversity in order to minimise its negative effect on the individual involved.

Finally, it is interesting to note that despite the detail contained in this review, transcending as a theoretical concept remains difficult to describe completely or define absolutely. However, whilst these studies discussed have identified various different characteristics encompassed in transcending they have also identified the core qualities of transcending (overcoming adversity though growing and evolving through increased self-awareness and a revised relationship with the external world). The use of transcending as a conceptual lens to describe the human experience of overcoming or moving past various forms of adversity has certainly been applied in a wide variety of settings. As a result it is clearly a valid and legitimate theoretical approach to exploring the lived experience of overcoming burnout.

**Summary of the Chapter**

This chapter outlined the findings of a preliminary literature review undertaken by this researcher in order to verify the value of the proposed research proposal. In keeping with the phenomenological method of research, the literature review was neither comprehensive, nor was it definitive as this would have placed the researcher at risk of clouding the study with his
own opinions and bias, and therefore compromised the integrity of the whole project. This said, the preliminary review of the literature that was conducted presented two interesting ideas that support the potential value of this study; (1) there does not appear to have been any studies undertaken which have examined the phenomenon of transcending burnout, as experienced by mental health nurses working specifically within the CAT (or ECAT) Team working environment, and (2) that there has not been any detailed investigations undertaken into this phenomenon utilising a phenomenological method of inquiry. The preliminary literature review was therefore, important in highlighting the dearth of current understanding regarding transcending burnout as experienced by mental health nurses working in the CAT Team setting, as well as adding weight to the need for such an investigation to be undertaken.
Chapter Three

An Overview of Crisis Assessment and Treatment (CAT) Teams

This chapter defines Crisis Assessment and Treatment (CAT) Teams and discusses the development of the CAT Team nurse role. As previously stated, the term CAT Team encompasses the Enhanced Crisis Assessment or ECAT Team role as a sub-set of CAT Team practice. For most nurses both roles are commonly undertaken by CAT Team nurses on a shift by shift basis and involve the same type of clinical practice: the main difference is the environment in which they are operating. In order to explore the concept of transcending burnout in CAT Team nurses it is necessary to first understand the nature of these teams including what it is to practice as a mental health nurse in this unique setting. To provide this insight, this chapter will examine the evolution, function, role and nature of CAT Teams. Finally the key areas of contemporary CAT Team practice (including practice specific to the ECAT setting) along with consideration of what this involves for the individual CAT Team nurse in their daily clinical practice will be discussed.

Mental Illness and Health Care Delivery in Victoria, Australia

Mental Illness is a serious health issue within the contemporary Australian [and Victorian] setting that involves significant challenges in the delivery of effective healthcare for those who live with one of the many forms of mental illness. It is not a new issue for the Australian population [nor for Victoria’s health care providers], as the “origins of mental health care in Victoria date back to 1837, when people with mental illness were incarcerated with the prisoners of Port Phillip Goal (Bostock, 1952; Murphy & Hodges, 1993 cited in Sands, 2009, p. 364). Earlier beliefs that the “fresh air, space, and the climate of the country
would preclude madness” (Evans, 2013, p. 50) had proved to be ill founded and the care of those with mental illness through much of the period from settlement to the 1950’s was provided through stand-alone ‘Lunatic Asylums’ that provided little more than the most basic level of care (Sands, 2009).

Over the last twenty years the delivery of care has been guided by a series of National Mental Health Plans, beginning with the First National Mental Health Plan delivered in 1993 through to The Fourth National Mental Health Plan (2009) that covers the over-arching model for the delivery of care through to 2014 (Commonwealth of Australia, 2009). In setting the context for the framework of care delivery, the Fourth National Mental Health Plan (2009) provides an overview of the incidence and impact of mental illness as a background to highlighting the magnitude of the problem. According to the 2007 Survey of Mental Health and Wellbeing conducted by the Australian Bureau of Statistics “one in five people aged 16 to 85 years’ experience one of the common forms of mental illness… in any one year” (Commonwealth of Australia, 2009, p. 16) these being Anxiety Disorders (14%) and Affective Disorders (6%). This alone equals approximately 420,000 Australians in any one year, but to this is added the incidence of ‘low prevalence’ conditions such as Schizophrenia that affects 1-2% of the population with the result that “Mental illnesses are the largest single cause of disability in Australia, accounting for 24% of the burden of non-fatal disease” (Commonwealth of Australia, 2009).

The redevelopment of the delivery of mental health care in Victoria through the period covered by the National Mental Health Plans (One through Four) was formalised with the release by the Victorian State Government in April 1994 of Victoria’s Mental Health Service:
The Framework for Service Delivery, which outlined the shift from a hospital based service delivery model to community oriented service delivery, wherein:

Community-based service networks will become the nucleus of the services system, with hospital inpatient services providing appropriate support and back-up…Hospital admissions will be minimised and will only occur in the context of a community-based treatment and service strategy where community based alternatives are either inappropriate or unavailable (Victorian Government Mental Health Branch, 1994, p. 15)

The Framework (1994) outlined the delivery of care through regional service systems and set out the basic parameters of the various service elements within the regions, including Psychiatric Crisis Assessment and Treatment (CAT) Services, Mobile Support and Treatment (MST) services, Continuing Care, clinical and consultancy services as well as Acute, Residential and Secure Extended Care inpatient services.

In line with this new model of service provision large stand-alone specialist psychiatric hospitals that had previously been the main building blocks of the Mental Health System were gradually closed down. Treatment was re-envisioned based upon the philosophical tenet of ‘least restrictive environment’, and in keeping with this concept the focal point of mental health treatment would be in the person’s own environment: “community and home-based service networks [have] become the nucleus of the service system, with hospital inpatient services providing appropriate support and back-up” (Victorian Government, 1994, p. 15). Care provision was re-structured to be provided to the mental health care consumer in their own home environment, in the least intrusive manner, with the aim of causing as little
additional disruption and intrusion (from the process of service delivery) into their lives as was possible. Essential to the success of this shift in the delivery of care was the need to develop teams of clinicians able to provide the practical requirements of this community-based mental health care. The new teams would need to be able to respond to everything from the assessment of consumers experiencing the very first symptoms of illness through to those with chronic conditions in need of long-term care as well as being able to triage and treat a broad range of mental health crisis in the community. It was in this environment that CAT Teams first came into being and they have since gone on to become one of the key elements of the Public Mental Health system over the last two and a half decades (Sawyer, 2005).

**Overview of the Evolution of Crisis Assessment and Treatment (CAT) Teams**

Emerging as a result of the de-institutionalisation of the public mental health care system in the late 1980s, CAT Teams constituted a practical manifestation of the shift in the focus of Mental Health treatment provision from a hospital-based system to a more community-based system. Drawing from previously successful treatment delivery models, these teams were designed with a strong emphasis on community treatment and the minimisation of inpatient treatment on the delivery of consumer care.

In their earliest iterations, Victorian CAT Teams were developed utilising the psychiatric crisis team structure earlier developed in the 1979 Hoult Project that ran in New South Wales in the late 1970s and had “demonstrated that providing intensive community treatment available on a 24 hour outreach basis was superior in a number of measures to standard care involving hospital admission and outpatient follow-up” (Gerrand, 2005, p. 262). The CAT Team model also drew inspiration from similar services that originally ran in Wisconsin, USA
(Gerrand, 2005; Sawyer, 2005) that provided outreach care 24 hours a day across a full seven day week. The key rationale underpinning the use of this team model was that fact that both of these services were seen as having been able to reduce both frequency and duration of inpatient admissions where a suitable community treatment option could be provided (Sawyer, 2005). The team itself was designed to incorporate all of the key elements of the multi-disciplinary team in order to deliver holistic care and as such, was usually comprised of a Consultant Psychiatrist, Psychiatric Registrar, specialist Mental Health Nurses and Allied Health Staff such as Psychologists, Occupational Therapists and Social Workers. The highly complex nature of the consumers often seen by the CAT Team along with the out-reach based nature of the practice has meant that “the nursing staff, as well as other staff, are generally clinicians with extensive psychiatric/mental health nursing experience and are consequently employed at a senior level” (Wortans & Happell, 2006, p. 80).

The expansion of CAT Teams to provide a presence within the Emergency Departments of major Melbourne Hospitals (as ECAT Teams) also became commonplace in the late 1990’s to ensure that effective community oriented mental health assessment was available to any person who might require it whether they were in their own home or attended their local hospital. Since that time CAT Teams have become an integral part of all Victorian Area Mental Health Services. The initiative underpinning this far-reaching shift in the delivery of treatment by the Victorian Mental Health Service was encapsulated in the ‘Framework for Service Delivery’ (1994) document. This clearly outlined the philosophical direction in which service delivery was to develop:

The key change in Victoria must be the match in practice of the long held aim of shifting the focus from a reliance on separate psychiatric hospitals as the preferred
place of treatment … the development of treatment and other services from community-based settings (Human Services, 1994, p. 1).

CAT Teams were initially designed to provide community-based, outreach driven mental health treatment and have remained at the forefront of this role since their inception. They were responsible for conducting all initial assessments of any person referred to the Mental Health service 24 hours a day, 7 days a week (be this in the community or in an Accident and Emergency Department), along with providing intensive community (home based) treatment for persons with an acute episode of mental illness as an alternative to hospitalisation, under the philosophy of providing treatment in the least restrictive environment. In examining the way in which CAT Teams were designed to function (which is essentially the way they continue to operate currently), the two core aspects to CAT Team practice are evident: (i) assessment and (ii) community treatment. As these two roles involve quite different parameters for practice they will be discussed in turn.

The first of these; the assessment (or screening) of all new referrals was considered to be a key function of the CAT Team, and required that the CAT Team conducted a comprehensive assessment of any person in the acute phase of mental illness. This assessment represented the entry point into CAT service and was initiated by two CAT Team clinicians (Victorian Government, 1994), (generally nurses or social workers), with the intent to evaluate the client’s (i) mental state, (ii) level of support available, (iii) need for additional community supports to enable community treatment, and (iv) degree of risk to themselves and others (Victorian Government, 1994). This assessment involved an examination of the following areas:
• Presenting problem
• Suicide risk.
• Risk to others.
• Psychiatric history.
• Physical state and medical history.
• Mental state.
• Personal and social history.
• Family details.
• Needs for service.
• Specialised needs assessment.

(Victorian Government, 1994, p. 51)

This assessment was usually conducted via either a clinic-based intake service, outreach home-based assessment, or at the Accident and Emergency Department of Hospitals (ECAT Team) within the catchment area (though the prevalence of service type could vary from service to service). In addition CAT Teams were required to work with psychiatric inpatient units to “minimise the length of stay” (Victorian Government, 1994, p. 11), and to oversee the accessing of inpatient facilities. The CAT Team services therefore “facilitate public psychiatric inpatient admissions and divert people from public psychiatric inpatient admissions, where appropriate” (Victorian Government, 1994, p. 11), ensuring the most effective, and least restrictive use of inpatient facilities.

The second area of responsibility entrusted to CAT Team services was the provision of “short term, intensive, outreach treatment and support to clients in the community on a planned basis during the acute phase of the client’s mental illness” (Victorian Government, 1994, p. 11). The
commencement of this treatment was initiated where indicated by the outcome of the assessment. Community treatment ranged from brief involvement for a day or two aimed at linking the person with other identified community-based services, such as providing secondary consultation to the consumer’s GP, to the total management of an acute episode of mental illness, including organic screens, medical review and commencement of appropriate medication, regular monitoring of the consumer’s mental state (to assess progress and risk) and provision of support to the family. In all cases, regardless of duration, CAT Team clinicians were expected to be actively involved in the discharge planning for each mental health consumer to ensure that an optimal level of care continued in a seamless fashion once the CAT Team withdrew from actively treating an individual. In addition, CAT Team clinicians played a “range of supportive roles including negotiating access to services such as income support, or accommodation, assisting the client to communicate their wishes to others, providing personal encouragement and positive reinforcement, providing direct practical assistance such as transport and negotiating with family members, [and] employers” (Victorian Government, 1994, p. 59).

Central to the process of effective community treatment was the consumer’s case co-ordinator, usually a registered mental health nurse, who assumed responsibility for co-ordinating the delivery of the consumer’s care. Where possible, “client contact [is] structured so that the CAT Team service case co-ordinator has priority for contact with the client, particularly in relation to the more significant contacts” (Victorian Government, 1994, p. 59). Such arrangements had (and continue to have) the effect of requiring each registered mental health nurse working in a CAT Team to assume the primary responsibility for the delivery of intensive mental health care to several (usually between two and six) acutely unwell mental health consumers at any given time (in addition to regularly conducting mental health
assessments). This has had the effect of adding to the immediate level of stress faced by the individual mental health nurse on a day-to-day basis, placing them at increased risk of burnout over time.

In 2007 the Victorian State Government undertook a large-scale review of the CAT Team services in response to broader concerns and need for reform regarding access to mental health services. This review is discussed in detail in the following section of the chapter with an emphasis on examining the contemporary role of the CAT Team and the consequences for CAT Team clinician practice. It is however important to note that in considering possible future directions for services the report concluded that CAT Team services “are an important part of ‘front-end’ services” (Victorian Government, 2007, p. 32) but at the same time acknowledged that “CAT Teams need to concentrate on the original intention of the service” (p. 50). This clearly suggests that whilst CAT Team practice had shifted from the role originally envisioned by the Victorian Government due to changes in clinical demand (particularly for assessment services), the original model remained the preferred one as is evident when looking at the contemporary role of the CAT Team.

Literature on the overall effectiveness of CAT Team type services is limited despite their ubiquitous nature in mental health services across the developed world. A systematic review of the effectiveness of Crisis teams undertaken by Carpenter, Falkenburg, White and Tracy (2013) examined 37 articles and concluded that “Crisis resolution teams are cheaper than in-patient care and, overall, patients are satisfied with CRT care … High-quality evidence for CRTs is scarce, although they appear to contribute to reducing admissions” (p. 232) which is certainly in keeping with the intentions for Victorian CAT Teams as laid out in the Victorian State Government guidelines.
The Contemporary Role of the CAT Team

As of the beginning of 2013, a quarter of a century since their creation within the Victorian Mental Health system, CAT Teams remain at the forefront of community-based, outreach driven mental health treatment service. That said, their evolution has been a complex journey as the various roles undertaken by CAT Teams have both expanded and diminished from their original vision to meet the multi-dimensional needs of the modern Victorian community. According to the Victorian Department of Health web page as of 2013, CAT Teams are defined thus:

A component of an Adult Area Mental health Service which is available 24 hours a day to provide community based assessment and treatment for people experiencing psychiatric crisis. CAT services aim to prevent unnecessary hospitalisation, by providing treatment in the person’s own environment such as in their home but may also work within emergency departments of hospitals. CAT services provide urgent assessment and will arrange inpatient admission if this is the most suitable treatment option. (Department of Human Services, 2006, p. 39)

This definition locates CAT Teams within the broader framework of the Victorian healthcare system, identifies its key roles around assessment and treatment of persons suffering with mental illness. The definition also emphasises the strong community focus to CAT Team practice in keeping with the least restrictive care philosophy underpinning all care delivery under the legislative framework (Mental Health Act, Victoria, 1986). This is further expanded in the Department of Health document describing Victoria’s Mental Health Services that
reinforces the above whilst broadening the role of the team in making decisions around the most appropriate type of care for each mental health consumer as outlined below:

Crisis Assessment and Treatment Teams

These services operate 24 hours a day and provide urgent community-based assessment and short-term treatment interventions to people in psychiatric crisis. CAT services have a key role in deciding the most appropriate treatment option and in screening all potential inpatient admissions. CAT services provide intensive community treatment and support, often in the person’s own home, during the acute phase of illness as an alternative to hospitalisation. CAT services also provide a service to designated hospital emergency departments through an onsite presence.

(State Government of Victoria, Department of Health, 2013, Victoria’s Mental Health Services, para. 3)

To better understand contemporary CAT Team practice the use of the key roles outlined above provides an appropriate structure to guide this exploration. Therefore the following discussion will focus on the CAT Teams core roles of [i] providing 24 hour a day urgent community based assessment, [ii] undertaking a key role in deciding the most appropriate treatment option, including undertaking the role of ‘gatekeeper’ for hospital admissions, [iii] the provision of intensive community treatment and support as an alternative to hospitalisation, and finally [iv] the provision of an onsite presence in hospital emergency departments.
The provision of 24 hour a day urgent community based assessment.

As one of the key roles undertaken by the CAT Team this area constitutes a core aspect of CAT Team practice. Referrals are generally received through the Psychiatric Triage element of each Area Mental Health Service (AMHS). The Triage service can be contacted by any member of the general public (twenty-four hours a day / three hundred and sixty five days a year) via a 1300 phone number that can be located on the Victorian Department of Human Services (DHS) website, with the services being aligned to certain Suburbs or Shires of the city or regional areas of the state. The Triage services are “primarily a telephone screening and advice service” (Victorian Government, 2007, p. 1) and are generally staffed by experienced mental health clinicians [generally mental health nurses]. Triage services are usually located in a ‘back of house’ office within one of the hospitals or clinics in the area they service, as they don’t have a direct consumer contact. They are also often located geographically some distance from the offices of the CAT Team or Teams (in some areas a single Triage service may service three different CAT Teams) that they refer the consumer to depending on the consumer or their carer’s home address.

The main role of each Triage service involves taking calls, conducting a phone assessment of the situation and determining the most appropriate response to the caller’s needs. This may range from the provision of information and resources at one end of the spectrum through to the mobilisation of the CAT Team for an assessment or emergency services for a more urgent response if the need arises. Referrals for a CAT Team assessment are generally graded utilising a standard triage tool based upon their level of urgency as assessed by the Triage Service clinician taking the call, requiring a response anywhere from ‘immediately’ through to within the subsequent twenty-four hours. The urgency is based on a wide variety of factors,
though ultimately it is the perceived degree of risk the (potential) mental health consumer poses to themselves or others that is the over-riding factor in making this decision. Where the mental healthcare consumer is able to remain in the community for the assessment the referral will be sent to the CAT Team to follow up. Where the referral requires an immediate medical assessment or response (such as in the case of a person who has taken an overdose) or requires immediate containment (such as a person with active suicidal behaviour who has been referred to the Police) the referral is instead forwarded to the relevant ECAT Team, depending on which hospital emergency department the person is being transported to (this role will be discussed further in the section below regarding the role of ECAT Teams).

The decision to refer to a CAT Team for an assessment is based upon a wide range of factors but ultimately the decision to refer to the CAT Team is predicated upon the (potential) consumer’s situation being a crisis of some type. If it were not, most consumers would be able to attend a mainstream healthcare provider such as their General Practitioner who would be able to refer them onto the appropriate type of longer term specialist, be that a Psychiatrist, Psychologist, Community Health Centre or other type of service. This pathway to accessing service, whilst certainly very effective generally takes some time to come to fruition, making it ineffective for a consumer who is unable to tolerate their situation or symptoms for the days to weeks to months usually required. It is in situations where “mental health crisis or emergencies occur when individual’s mental or emotional states deteriorate quickly, resulting in breakdown of coping mechanisms” (Wright & McGlen, 2012, p. 48), that an urgent response is required and where the assessment services offered by CAT Teams become most relevant.
In order to understand the process of a referral becoming an actual assessment some comment on the broader CAT Team environment is necessary to effectively set the context. As previously stated CAT Teams operate seven days a week with three community staff on the ‘early shift’ (generally running from 08:30-17:00) and two community based staff on the ‘evening shift’ (generally running from 14:00-22:30) in addition to the clinicians in ECAT Teams and Triage Services. These numbers also usually reduce to two staff on the early shift on weekends. Shift teams usually meet at the start of each shift (in both the morning and early afternoon) to assess the workload for the shift associated with existing consumers being treated in the community as an alternative to hospitalisation as well as to look at the new referrals for assessment that have been received over the last twelve to twenty-four hours. Each shift has an identified shift leader (usually a senior member of the team operating at senior clinician or Grade Four registered nurse) who in conjunction with the other members of the shift will sort through the competing demands on the teams available resources, in an attempt to ensure all existing and newly referred consumer needs are met. This process involves consideration of the current consumers that need to be seen in their homes, including how long these visits are likely to take and any liaison or consultation (with other service providers or families/carers) that needs to be undertaken for these consumers.

Once received new referrals need to be examined and triaged in terms of their urgency (as determined via the Triage Service). This process can also involve a review of any existing medical records the person may have from earlier contacts with the service (particularly relevant in the case of consumers with long-term disorders such as Schizophrenia or various Mood disorders) and liaison with relevant third parties such as existing service providers (GP / Psychologist / Psychiatrist) and family members or carers. In terms of prioritising resources “acute assessment takes priority” (Victorian Government, 2007, p. 46), and as they are
expected to be completed by clinicians operating in pairs, often travelling significant distances between assessments, (Victorian Government, 2007, p. 31) this role can often absorb the bulk of the time available in each shift, especially where the team has two to three assessments to complete as is often the case. Ultimately, “when CAT services have more than one request for urgent assessment at the same time, they prioritise on the basis of clinical need” (Victorian Government, 2007, p. 1). This approach appears logical and clear-cut in theory however it can often be much more of a challenge for CAT Team clinicians in reality. Given that most of the cases referred to CAT Team have been so in the first place due to their high level of ‘clinical need’, prioritisation based on this criterion can often be very difficult to accomplish. A full CAT Team assessment, completed to the necessary detail and allowing for time with the consumer and input from carers where possible will generally take an hour to complete though the time taken can extend out in more complex cases. This means that three assessments will take up a full shift for two of the three clinicians on the team. Finally, an urgent referral received mid-shift can disrupt the best laid plans of the team, requiring an immediate reorganisation of both clinicians and the work planned for the shift as two of the team members are immediately sent to undertake the new assessment as required.

Once the workload has been organised and allocated for any given shift, the CAT Team nurses involved will need to organise the practicalities necessary to conduct the assessment, namely a time and safe location to carry it out. Where the consumer is willing to see the CAT Team nurses and there are no concerns for the safety of either the consumer or the CAT Team nurses this usually involves the simple task of setting up a time for the visit and confirming the consumer’s address. The nurses subsequently attend the consumer’s home as planned and conduct the assessment as organised. In situations where the consumer is less willing to meet with the CAT Team nurses (ranging from a mild level of hesitation through to flat refusal) the
process becomes much more difficult and time consuming. When family are supportive of the assessment they are often able to act to facilitate this occurring though often (particularly in the cases of paranoid or insightless consumers) this is not possible. In these cases a CAT Team may often have to visit unannounced in the hope of being able to engage with the consumer and conduct enough of an assessment to enable decision making around the need for and possible delivery of treatment as required. In the most extreme cases CAT Team nurses endeavouring to assess a person will be required to engage the assistance of the Police (particularly where there is an increased level of potential risk reported) in order to gain access to property or to assist in allowing the CAT Team nurse to engage in an assessment with a person who might otherwise refuse to do so. Conversely requests for a CAT Team assessment can often come from the Police (or Ambulance) who are at a person’s home and have concerns for the mental wellbeing or concerns for their safety.

In most of these cases undertaking this core area of CAT Team practice involves a significant level of uncertainty on a day-to-day basis, especially considering that much of the work is undertaken in “unpredictable environments such the clients home of public places, and in time pressured situations” (Sands, Elsom, Gertz & Khaw, 2012, p. 698). From the number of assessments that need to be organised and managed in each shift through to the potential for hostility and aggression when conducting the actual assessment CAT Team nurses operate in an environment characterised by a high level of unpredictability on a daily basis.

**Undertaking the role of ‘gatekeeper’ for hospital admission triage.**

The importance of CAT Team triage practice (as it relates to the experience of being a CAT Team clinician) cannot be understated, as it is one of the practice areas that makes the
role most challenging. CAT Team clinicians are key contributors to effective decision making around treatment planning, and “care planning has become a fundamental and essential component for all nurses in community mental health teams” (Walsh, Cleary & Dowling, 2012, p. 272). Following on from the assessment as discussed above, CAT Team nurses assume a high level of responsibility for decision making in determining the most appropriate level and type of care necessary for the consumers they are providing care for. This involves a complex process of identifying the most appropriate treatment interventions required to effectively treat the consumer whilst also factoring the outcome of the risk assessment regarding the consumer’s potential risk to themselves and/or to others. Furthermore, the broader psychosocial context surrounding the consumer must be considered, with particular consideration being given to how the consumer’s psychosocial situation may act to assist in or hinder their recovery. Finally, in their role as gatekeeper (Victorian Government, 2007) for the service’s inpatient beds the CAT Team nurse needs to consider the resources that are actually available at any given time for the effective delivery of the most appropriate treatment option.

In undertaking this key role consideration must again be paid to the practical nature of the CAT Team working environment. CAT Teams are multi-disciplinary teams largely consisting of specialist mental health nurses and social workers. This structure along with the limited medical resources available out in the community and the outreach nature of CAT Team practice means that the majority of assessments are conducted by two CAT Team nurses, operating autonomously in the community. This has the resultant effect that the responsibility for the initial decision making falls very much to the clinical judgement (Elsom, Happell & Manias, 2007) of the nurses at the time of the assessment and whilst they are generally able to access additional input from other members of the team via phone this provides support at a distance only.
The ‘accuracy’ of the assessment conducted by the CAT Team nurses and translation of the information gathered to correctly formulate the initial diagnosis is critical in the initial phase of the engagement. The initial assessment will have a significant impact upon the consumer’s progress over the days following. Inaccurate assessment has the potential to commence the consumer on the wrong treatment path, whilst a lack of clarity may lead to hesitation in the provision of treatment which can again delay recovery whilst extending the period during which the consumer is experiencing high levels of distress and emotional discomfort.

Furthermore, where the outcome of the assessment necessitates referral to an external specialty service for specialist input, this may also be delayed or misdirected if the CAT Team nurses assessment or decision-making process does not accurately reflect the consumer’s needs. In this regard, an accurate and up to date knowledge of the various services available at both the local and broader levels is also necessary to enable referrals as required. Without this knowledge the triage of consumers to relevant follow-up, especially where the CAT team does not remain involved with the consumer treating them in the community, may not occur, with potentially sub-optimal outcomes for the person in the longer term.

In determining the most appropriate treatment option the CAT Team nurse must also identify and consider the broader psychosocial factors that are both contributing to and resulting from the consumer’s mental health issues. Factors such as the type and practical availability of family support, financial situation, job security and accommodation (Elder, Sharrock, Maude & Olasoji, 2013) all need to be considered in deciding the optimal course in delivering treatment. For a service that practices primarily in the community unstable or non-existent accommodation is a particularly important factor as “mental illness is associated with homelessness” (Lee, et al., 2010, p. 506).
The final element in this area of core responsibility involves the role of the CAT Team nurse contributing to the management of the broader resources available within the service and in particular the availability of inpatient beds for consumers that need them. This “gatekeeping function” (Victorian Government, 2007, p. 1) involves the CAT Team nurse liaising between the available resources on the inpatient units, planning around intended discharges and identifying consumers who might be suitable for ‘early’ discharge with CAT Team follow-up in the community. The role also involved triaging and managing the external demand for inpatient beds whether this be due to need arising from the CAT Team’s own assessments, referrals from other parts of the services (such as Mobile Support or Continuing Care Teams) or the demand from consumers with mental health problems presenting to Emergency Departments (Victorian Government, 2007). Juggling these competing demands (on top of the actual clinical work being done) in a health care system with often limited resources (Walsh, Cleary & Dowling, 2012) is often a complex and difficult administrative task that can cause significant stress for CAT team nurses.

The provision of intensive community treatment and support as an alternative to hospitalisation.

One of the least visible, though arguably most important elements of CAT Team practice involves the provision of intensive community treatment and support as an alternative to hospitalisation. This core area of practice harks back to the original conceptualisation and creation of CAT Teams, and reflects the key philosophical principle of de-institutionalisation, that being that the best outcomes for people with mental illness could be achieved treating them in their own homes and communities.
Originally conceived in the 1994 Victorian Government blueprint outlining CAT Team practice, community treatment as an alternative to hospitalisation remains one of the core roles for these services. Community treatment is described as being “short term, generally spanning a period comprising a number of weeks where frequent and intensive contact is provided on an outreach basis during the period of psychiatric crisis” (Victorian Government, 1994, p. 59) before responsibility for the consumer’s care was handed back to a longer-term service provider such as a case-manager, GP or Private Psychiatrist. The importance of this role was re-affirmed in the 2007 Victorian government review of CAT Team services and functions which reported in its findings that:

When CAT services engage in short-term, intensive treatment in the community, it seems that the people who are able to utilise that service, fare as well as those in acute units. This is consistent with the positive findings in the research for treatment of mental illness in the community (p. 23).

The decision to treat a consumer in the community involves a comprehensive assessment of the consumer’s potential risk though it is important to note that the presence of risk does not exclude a consumer from community treatment; “an individual may have a high level of risk but also a level of support that allows them to remain at home” (Brooker, Ricketts, Bennet & Lemme, 2007, p. 1320). Ultimately the decision to treat at home is the preferred option for the overwhelming majority of people assessed by CAT Teams and taken on for assessment, as it’s in keeping with the core philosophy of CAT Team practice. The decision itself is made through a reflective and practical weigh-up of the ‘risk factors’ against the ‘protective factors’ (Elder, Sharrock, Maude & Olasoji, 2013) present in the case. At a situational level these protective factors include but are not limited to the willingness of the family to provide
support for treatment at home, as well as an appraisal of the family’s actual ability to provide
effective support in the given circumstances. At a personal level protective factors such as
well-developed family and friendship support groups, a good level of insight, a willingness to
accept treatment along with a sense of hope for the future are all indicators for intensive
community based treatment. From anecdotal experience working as a CAT Team nurse the
provision of this intensive community treatment is typically considered to be one of the most
positive aspects of CAT Team nursing practice as it comprises the essential features of nursing
practice; namely working closely with people and helping them recover from whatever mental
health issue they may be experiencing.

One of the main challenges to this core area of practice is the previously discussed notion that
assessment takes priority in the day-to-day CAT Team operation. This led to the 2007
Victorian Government Review of CAT Team services and functions which reported that:

A desire for immediate access to CAT service from groups as diverse as consumers
and carers, police, GP’s and other teams in the mental health system has led to the
perception that the demand for urgent community assessment has overwhelmed the
capacity of CAT to perform short-term community based intensive treatment (p. 11).

This was further reflected by feedback from CAT Team managers who contributed to the data
collected in this report, stating: “more assessments and support of ED has eroded the ability to
perform other functions, particularly intensive treatment in the community. This activity often
has to be re-scheduled in the face of other demand” (p. 26) as well as feedback from
consumers who reported that “insufficient availability of intensive treatment in the community
was an issue” (p. 26). This shift in the dual role of assessment and treatment has resulted in a
narrowing of the scope of CAT Team practice, moving from a broader ‘treatment focused’ service to more of a ‘risk management service’, with an increased “emphasis on risk management and protocols to assess and contain risk … and masks a decline in service to the client” (Sawyer, 2005, p. 293). For CAT Team nurses this has had significant implications as it represents a shift from a philosophy of care “centred on the provision of home treatment, to a risk consciousness, underscored by the development of protocols to evaluate a client’s level of risk to self and others” (Sawyer, 2005, p. 283). An increased focus on risk assessment and management as the primary determinant of CAT Team practice has the potential to expose clinicians to constant high-stress situations. This change in practice focus has resulted in clinicians experiencing high levels of personal anxiety. It has also reduced their experience of the more positive outcomes associated with the successful treatment of an episode of mental illness via intensive community treatment.

**The provision of an onsite presence in hospital emergency departments.**

The evolution of the ‘Enhanced’ CAT Teams referred to as ECAT Teams role occurred initially in the late 1990s and underwent a significant state-wide period of expansion through the period from 2004 – 2007 (Victorian Government, 2007, p. 26) in response to the increasing demand for specialty mental health services in the Emergency Departments (ED’s) of major Victorian hospitals. A recent study by Gerdz, Weiland, Jelinek, Mackinley and Hill (2012) reported that “in Australia mental health problems are estimated to account for 3-5% of all public hospital ED attendances” (p. 493), whilst Morphet et al., (2012) report that “people with MH presentations … make up 5-10% of all ED presentations” (p. 149), with this increase in demand being attributed to the “integration of psychiatric services with mainstream generalist health services, resulting in ED’s becoming the primary treatment centre for many
psychiatric patients” (Nicholls, Gaynor, Shafiei, Bosanac & Farrell, 2011, p. 531). There is no doubt that most ED’s possess a number of qualities that make them highly favourable as points for accessing care for people with acute mental health needs. Twenty-four hour-a-day availability (without the need to book an appointment months in advance), along with the fact that attendance is free (another major benefit given the financial hardship that goes hand-in-hand with many forms of mental illness), and (typically) close proximity to public transport make ED’s an obvious choice for many people accessing mental health services.

The experience of nursing practice as an ECAT Team nurse is quite different to that of community CAT Team nursing due to the significant differences in the working environment along with the differences in the characteristics of the people seen by ECAT Team nurses. The ECAT Team nursing environment involves a shift from the community back into a hospital setting characterised by high levels of stress associated with the high levels of acuity and unpredictability evident in people that typically present to ED’s. Often the basic layout of the environment and design of the ED “does not take into account the behaviourally disturbed person” (Meadows et al., 2012, p. 273) leading to significant problems in the practical management of the person whilst in the ED. This, along with various environmental factors including limited time available to see consumers and the high stimulus nature of the environment (Gerdtz et al., 2012, p. 494) negates any attempt to create a supportive, therapeutic environment in which to undertake an assessment and provide care.

In addition to this ECAT Team nurses are faced with the care of persons suffering with mental health issues in what is primarily a general health setting. In this particular environment ECAT Team nurses are often faced with high levels of stigma (Meadows, et al., 2012) which is often associated with the consumer presenting with mental health issues along with the ECAT nurse
themselves as they are often seen as being an outsider in this particular clinical environment (Heyman, 2012). Expectations regarding what makes for a ‘successful’ episode of care vary wildly with the 2007 Victorian Government review of crisis assessment and treatment (CAT) services and functions stating that “ECAT staff are expected to provide a ‘holding strategy’ if the consumer needs specialist mental health service until the client is assured of being taken by the relevant team” (p. 14). In direct contrast to this is the generalist focus on minimising time spent in the emergency department through the provision of quick-acting interventions designed to alleviate the immediate issue allowing for discharge onto other service providers such as GP’s. In this situation ECAT Team nurses often find themselves caught between opposing expectations making for a difficult and challenging working environment. To provide the required ‘mental health appropriate’ care can often mean a longer period spent in the ED, which can result in the ECAT Team nurse being challenged and criticised for not meeting the ED’s expectations for a rapid outcome.

ECAT Team practice also involves a significant difference in the characteristics of the consumers being seen as compared to CAT Teams. Presenting mental healthcare consumers often comprise a “broader group than those who require specialist mental health service and often includes people with physical or drug and alcohol comorbidities as well as those in situational crises” (Victorian Government, 2007, p. 14). As previously discussed the preference is to assess and treat people in the community where ever possible. However in many cases this is not possible due to a variety of reasons such as a lack of stable accommodation, family support, or a level of risk too high or unpredictable to be managed in the community, and it is these people that require immediate containment that either choose to present, or are brought into ED most commonly via the Emergency Services (Victorian Government, 2007) for assessment and containment. Mental health consumers seen in this
context typically present with heightened levels of emotional distress, particularly intense or acute symptoms, and high levels of risk either in the form of thoughts or threats to harm themselves. In many cases these individuals will have acted upon these thoughts having already harmed themselves in some way and now find themselves needing rapid medical attention for the harm done. Presentations are often complicated by substance use wherein the person’s clinical presentation is clouded by their use of substances, increasing their risk of impulsive, irrational or poorly considered behaviour whilst making an accurate assessment much more difficult.

**CAT Teams and the ‘Crisis’ Misnomer**

One the greatest areas of contention around the role of CAT Teams and the way in which they are perceived by the broader public stems from a level of confusion around what CAT Teams are actually designed to do. The use of the word ‘crisis’ as one of the two key concepts contained in the team title has led to a level of misunderstanding from not only the general public but also other health care and emergency services providers regarding the core function of CAT Teams. The term ‘crisis’ evokes images of highly difficult and complex situations often associated with an element of risk that in other fields of health care or general public life invokes an emergency response from one of the main emergency services with a response time counted in minutes and characterised by flashing lights and blaring sirens on arrival. By contrast, this is rarely the case with a CAT Team response, equipped as they usually are with little more than a pen and notepad.

This disparity between the expectation and the reality was experienced anecdotally by the researcher on numerous occasions during his 12 years of practice as a CAT Team nurse. The
level of negative response in this regard ranged from mild frustration through to open hostility and at a practical level often added another complicating factor to an already complex clinical situation, especially where there were concerns for the consumer’s safety. This issue is certainly not new as reflected in the findings of the Suicide Prevention Task Force Report (1997), which reported “the most passionate criticism of mental health services heard by the task force at the public consultations was in respect to the limitations of services provided by CAT teams” (p. 106). In these situations concerned consumers and their families felt let down by the service being provided by CAT Teams as they felt it fell short of what they expected. For the CAT Team nurses involved it contributed to their level of frustration and stress as they were being criticised for providing a theoretically appropriate response that did not meet consumer expectations as the two were not compatible in the first place.

In addressing this issue the 2007 Victorian Governments review of CAT Team services and functions acknowledged the issue of the disparity between CAT Team’s intended role (reaffirmed in the report) and the communities misconception of this role but in response stated quite clearly that “CAT are not funded or staffed to provide an emergency response. Community expectations and the role of non-mental health emergency services need further clarification” (p. 15). Indeed the report even went as far as to state that “the name ‘CAT’ be changed as it places undue emphasis on the crisis assessment aspect of the CAT role while underplaying the intensive community treatment aspect” (p. 31) It is however worth noting that as of mid-2013 this name change has not progressed, whilst the ongoing misconceptions held by many community stakeholders and non-acute service providers about the role of CAT remain as problematic as ever.
The Contemporary Role of the CAT Team Nurse

It is important to consider the roles and responsibilities of the individual CAT Team nurse practicing within this environment. CAT Teams continue to recruit nurses with substantial clinical experience due to the complex nature of the practice. For example, Wortans and Happell (2006) suggest that “CATT clinicians have been working as autonomous practitioners from their inception, using advanced practice skills” (p. 80). This has the advantage that CAT Teams are usually comprised of nurses who have several years of clinical experience behind them. With this comes a well-developed understanding of the treatment and care of persons presenting with a variety of forms of mental illness along with an understanding of the corporate culture of the public health care system.

Nurses working in CAT Team roles need to be able to work with a high level of autonomy, coupled with an ability to tolerate ambiguity, uncertainty and risk, as these are often the hallmarks of crisis as the defining space in which these clinicians practice. Well-developed competence in clinical assessment skills and the capacity to trust their clinical judgement in determining treatment planning and delivery is critical as is a keen understanding of the mental health ‘system’, in order to ensure astute and effective management of consumers. Finally the capacity to practice constantly within the crisis stage of the mental health care continuum seems fundamental to practicing effectively in this role, as this remains the core business of CAT Team practice. The demands placed upon CAT Teams by the continuous influx of new referrals, combined with their very specific focus on, and expertise in acute crisis work ultimately result in this being a constantly high intensity working environment (Wortans & Happell, 2006). For the contemporary CAT Team nurse this means practicing in an environment where most consumers are only beginning their recovery when CAT team
involvement ends, leaving CAT Team nurses unlikely to witness the longer term progress associated with their interventions. Indeed, it is only those who have either not recovered sufficiently, or who have had a subsequent relapse in their illness that are seen again, leading the CAT Team nurse without clear, visible evidence to illustrate the value of their practice in many cases (Meadows, et al., 2012).

**Summary of the Chapter**

This chapter has provided an overview of the creation and emergence of CAT and ECAT Teams in the state of Victoria, from their original inception as a key part of the deinstitutionalisation of mental health care movement in the mid-1990s through to their current role and practice. Their founding practice principles have been examined and linked to the key elements of contemporary CAT Team practice. This chapter has undertaken this review with the aim of providing a detailed context for CAT Team nursing practice considered necessary as a precursor to the research study examining the experience of transcending burnout.
Chapter Four

Overview of the Selected Methodology: Phenomenology

When considering the approach to be adopted in conducting any research study it is important that the researcher consider the overall goal of the investigation, the motivation behind it, and whether it will generate understanding that will be of value in explicating the phenomenon under investigation. This chapter begins by outlining the rationale for the methodology (Descriptive Phenomenology) utilised for this study. Building from this discussion the chapter then explores the key concepts of Edmund Husserl’s (1859-1938) Descriptive Phenomenology. This will follow with an exploration of the way in which these concepts have been applied to research practice through the methods developed by the Duquesne School (Holloway & Wheeler, 2010) of phenomenology. The chapter concludes by considering the evolution and relevance of phenomenological research to contemporary nursing practice in keeping with the notion that “it is important to understand and acknowledge the methodology of a study to ensure that the methods are harmonious with the theory behind it” (Taylor, Kermode & Wilson, 2006, p. 321).

Philosophical Underpinnings of the Study

Given the inherent complexity of phenomenological philosophy and the often confusing nature of its relationship to research practice (Mapp, 2008) it is important that the researcher clearly describe the philosophical underpinnings of the methodology as they apply to the study (Stubblefield & Murray, 2002). For the purposes of this study a descriptive phenomenological approach in the Husserlian tradition (Lopez & Willis, 2004) was chosen. This decision was made, as it would guide the study in exploring and describing the lived experience of
Transcending Burnout as described by mental health nurses working on CAT Teams.
Furthermore, in keeping with the application of Descriptive Phenomenology in guiding practical research the researcher chose to utilise Colaizzi’s (1978) method of data analysis, situated as it is within the Duquesne School (Holloway & Wheeler, 2008) of phenomenology.

**Phenomenology**

In order to understand phenomenological research methodology it is important to examine the philosophical underpinnings of phenomenological thought, as it is as “much a way of thinking or perceiving as it is a method” (Streubert-Speziale & Rinaldi Carpenter, 2011, p. 74). The term itself “derives from the Greek word *phainomenon* meaning ‘appearance’” (Holloway & Wheeler, 2010, p. 214). As the origin of the word suggests the primary focus is seeing things as they appear in the subjective lived experience of everyday life. The philosophy itself is underpinned by existentialist thought that stresses the “personal ‘here and now’ experience and responsibility and the demands they place on the individual as a free agent in a deterministic and meaningless universe” (Stephenson & Corben, 1999, p. 117). Essentially phenomenological philosophy is anchored in lived experience, the purpose of which is to understand the essential nature of phenomena as experienced by human beings (Stephenson & Corben, 1999).

The development of phenomenological philosophy can be divided into three main phases: the (i) Preparatory, (ii) German, and (iii) French phases” (Streubert-Speziale & Rinaldi Carpenter, 2011, p. 75) each of which has its key contributors to the development of the movement. For the purposes of this study the period of greatest significance is the German phase and in particular the works of Edmund Husserl (1859-1938) which will be discussed in detail below. It is also important to examine the first of these phases, the Preparatory phase, which was
dominated by the works of the philosopher Franz Brentano (1838-1917), and his student Carl Stumpf (1848-1936).

The central focus of their work during this period was the development of the notion of *intentionality*. The term intentionality “refers to the human capacity for awareness of objects as well as their contextual features and it is what allows humans to reason about objects in their world and communicate with others” (Earle, 2010, p. 287). The notion of intentionality also posits that human experience always points to something beyond itself, to whichever external phenomenon the individual is mindful of in a given moment as being “the object of the experience” (Crotty, 1996, p. 40). The importance of this concept to the development of phenomenological thought lies in the relationship between the individual (consciousness) and that which the person is conscious of: “consciousness is always consciousness of something” (Streubert-Speziale & Rinaldi-Carpenter, 2011, p. 75). Therefore, an individual and his/her experiences, although separate in their own right, constantly effect and interact with one another and cannot therefore be examined by themselves; the individual and their experiences must be considered in the context of the ever-present relationship between the experience and the individual experiencing it.

For Husserl, “intentionality is the key to understanding human experience” (Earle, 2010, p. 287) as this concept reflects the individuals “inseparable connection to the world” (van Manen, 1997, p. 5). Intentionality is ‘the essential feature of consciousness’ which is directed towards an object (Holloway & Wheeler, 2010 p. 214). The object itself is a generic term, which refers to “things in the external world, facts, consciousness, dream images, essences … anything” (Paley, 1997 p. 190). Langridge (2007) suggests that the object of an individual’s consciousness is the (their) everyday world. For the researcher of this study the concept of intentionality was
considered a fundamental building block for the process by which the data was collected and analysed.

**Descriptive Phenomenological in the Husserlian Tradition**

Broadly credited as the founder of Phenomenology (Maggs-Rapport, 2001), Edmund Husserl (1859-1938) was active during what has come to be known as the second or German phase of the movement (Stephenson & Corben, 1999). Husserl’s work was undertaken from a desire “to seek an alternative to positivism that would integrate the world of science alongside the real ‘life-world’ (lebenswelt) of people” (Schneider, Whitehead, Elliot, Lobiondo-Wood & Haber, 2007, p. 109). Husserl was responsible for the development of the central phenomenological concepts that will be examined below including: [1] the notion of universal essences/ [2] phenomenological intuiting (Anschauung) and [3] phenomenological reduction (also referred to as bracketing) under the now famous battle cry of “*back to the things themselves*” (Streubert-Speziale & Rinaldi-Carpenter, 2011, p. 76). This phrase encapsulated Husserl’s (1857-1938) belief that people should be “guided by experience and not by taken-for-granted concepts or inherited principles” (Crotty, 1996, p. 51). In doing so Husserl demanded that the individual’s experience of their world be attributed an appropriate degree of meaning and value, rather than be forfeited in favour of more widespread and socially acceptable notions usually taught by one generation to the next. These three concepts (universal essences, phenomenological intuiting and phenomenological reduction) will be discussed in detail in the following section.
Husserl’s notion of universal essences.

Described by Giorgi (2000) as “higher level … invariant meanings” (p. 6) Husserl’s concept of essences is one of the critical notions in his phenomenological philosophy. “Husserl concluded that ‘essences’, as the things that define experience, exist within the conscious experiences of people and this consciousness (and its intention) is presented by people to the world” (Schneider et al., 2007, p. 109). As such the goal of phenomenological inquiry is the explication of “new knowledge and new understanding in the search for the essence of things through the identification of essential themes” (Hamill & Sinclair, 2010, p. 17). Cohen and Omery (1994) provide the following overview of the concept of essences within the broader context of phenomenological thought:

Eidetic phenomenology as a research method rests on the thesis that there are essential structures to any human experience. These structures are what constitute any experience. Each unique experience is made up of distinctive structures that pattern the specific experience uniquely. When these structures are apprehended in consciousness, they take on a meaning (or truth) of that experience for the participants (Cohen & Omery, 1994, p. 137).

For the purposes of this study the researcher acted in the belief that in exploring the phenomenon of transcending burnout there would be clear experiential essences drawn from the descriptions of the participants. Furthermore, that when explicated, these essences would provide light to the “ideal or true meaning” (Streubert-Speziale & Rinaldi-Carpenter, 2011, p. 75) of the phenomenon under investigation and would ultimately identify those essential
structures that make this phenomenon “what it is (and without which it would not be what it is)” (Dowling, 2005, p. 133).

**Phenomenological reduction.**

The concept of phenomenological reduction was also pioneered by Husserl who argued that in order for the researcher to be able to reveal new understandings it was first necessary for the researcher to put aside any presuppositions that he/she might have in relation to the question. He termed this *epoché* or bracketing (McConnell-Henry, Chapman & Francis, 2009, p. 9). The term ‘bracketing’ was used by Husserl to describe the “process of suspending beliefs and prior assumptions about a phenomenon” (Holloway & Wheeler, 2010, p. 216) as a key feature of phenomenological inquiry. This process requires the researcher to closely consider, explicate and examine their own feelings, ideas and beliefs about the phenomenon under consideration and having done so put aside any preconceptions he or she may have about the topic to allow the data to emerge in it’s given form, untainted by the researchers own bias. In doing this, “the researcher does not influence the participants understanding of the phenomenon. Thus it is the participant’s reality” (Hamill & Sinclair, 2010, p. 17). Additional strategies such as using field notes or a diary and seeking critique on analysis from experts in the methodology or field of study ( Wojnar & Swanson, 2007) also act as valuable tools to increase the effectiveness of researcher bracketing during the research process.

Phenomenological reduction forms the essential precursor to phenomenological intuiting (as discussed below) which relies upon the researcher having created an area of ‘blank canvas’ within their consciousness. This area is essential as a ‘space’ for the process of intuiting to occur in order to prevent the researcher from overtly or covertly layering his or her own pre-existing
ideas in with the concepts emerging through the intuiting process. Therefore reduction
(conducted prior to and during the data collection and analysis process) acts as a conscious
cognitive process in clearing out the researcher’s presumptions, hunches, and beliefs that pose a
threat to the integrity of the data that emerges. It is a challenging and energy consuming process,
as the “dance between intuiting and bracketing can prove to be an all-consuming cognitive task
for the descriptive phenomenologist” (Wojnar & Swanson, 2007, p. 177), however it is critical
to the overall success of the phenomenological research process.

The notion of bracketing is one that has received significant attention and caused much debate
amongst qualitative researchers as well as in the broader research community (Holloway &
Wheeler, 2010). Questions ranging from whether it is even possible to bracket something from
an individual’s consciousness, to what or how much related to the topic under investigation
should be bracketed [out] have caused great debate (Crotty, 1996; Paley, 1997), and continues to
pose a challenge for phenomenological researchers. Giorgi (2000) in summarising the
phenomenological process states that the “Husserlian method involves description from within
the reduction” (p. 6), and argues that the key notion in this is that “the analysis and descriptive
results of the researcher take place within the phenomenological reduction” (p. 9). In applying
this concept the researcher is asked to ‘clear their canvas’, carefully erasing or putting aside any
previous strokes or scribbles that may have already applied, before preparing to take a fresh
brush and paint an entirely new picture guided only by the participants descriptions of their
experiences.

For this researcher this concept required particular consideration given his own experience
working as a CAT Team clinician as well as his previous research in completing his Masters
study on the phenomenon of burnout. The methods and strategies utilised by this researcher in undertaking this study is discussed in greater detail in Chapters Two and Five Four of the thesis.

Phenomenological intuiting.

Described by Husserl as ‘Anschauung’, phenomenological intuiting describes “an eidetic comprehension, or accurate interpretation of what is meant in the description of the phenomenon under investigation” (Streubert-Speziale & Rinaldi-Carpenter, 2007, p. 79). At a practical level phenomenological intuiting involves a process of “imaginative variation, researchers begin to wonder about the phenomenon under investigation in relationship to the various descriptions generated” (Streubert-Speziale & Rinaldi-Carpenter, 2011, p. 76). In order to accomplish this, the researcher reflects upon what has been said by the participant and considers the possible ideas, understandings, perspectives and meanings contained therein whilst also considering how these might apply to other contexts in order to understand what it must be like to live these experiences. This is expanded on by Wojnar and Swanson (2007) who state that phenomenological intuiting “ultimately leads to an innate sense of what it might be like to ‘live in another’s skin … the intuitive process leads to the investigator owning a sense as if he or she had personally lived the participants’ experience” (p. 176). Intuiting involves the researcher immersing themselves in the participant’s experiences, in order to open a bridge to the lived experiences of another. This allows the researcher to develop a description of the phenomenon under investigation that is informed from within the experience itself rather than through the researcher’s external perspective.
The importance of phenomenological intuiting within the data analysis process is reflected by Colaizzi (1978) who states “meanings are given with the protocol, but are not in it” (p. 59). Colaizzi argues that in order to develop an accurate interpretation of what is meant in the description the researcher must employ the technique of ‘creative insight’ to make this ‘precarious leap’ in generating an understanding of what the participants mean (Colaizzi 1978). These two essential concepts in Colaizzi’s data analysis are both based upon the principle of phenomenological intuiting. ‘Creative insight’ constitutes a form of imaginative variation whilst the ‘precarious leap’ is formed from wondering about the phenomenon being investigated. However phenomenological intuiting also demands that the researcher must also be vigilant in not generating any presumed meaning’s that were not representative of the original data, and must remain faithful to the participant’s experience, or as Colaizzi (1978) states, “the researcher must go beyond what is given in the original data, and at the same time, stay with it” (p. 59).

This notion is also clearly reflective of Husserl’s work around the idea of phenomenological reduction as this is essential in creating an untainted environment (both subjectively and in the relationship between the researcher and the participant) to allow the process of phenomenological intuiting to be undertaken by the researcher.

**Phenomenology as a Research Method: The Duquesne School of Phenomenology**

The evolution of phenomenology as a research method, whereby it has “become a dominant means in the pursuit of knowledge development in nursing” (Dowling, 2005, p. 131) owes a great deal in its genesis to the work of the “scientific phenomenology community from the field of psychology, particularly those from the Duquesne school (Pittsburgh University)” (Dowling, 2005, p. 135). Comprised of members of the Duquesne School (Pittsburgh University) of psychology (Amedeo Giorgi, Paul Colaizzi and Adrian Van Kaam being the best
known members) the Duquesne School was primarily “guided by Husserl’s ideas about eidetic structure … focuses mostly on the notion of description” (Holloway & Wheeler, 2010, p. 219).

Their work in developing a series of steps, deeply rooted in the fundamental Husserlian notions of descriptive phenomenology, was critical in the emergence of phenomenology as a research method. “Their proposed method involving description, reduction and the search for essential structures has been credited with the quest to establish reliable methods for conducting existential-phenomenological research, arising from their dissatisfaction with the limitations of empiricism” (Dowling, 2005, p. 135).

As a philosophy, phenomenology had emerged and evolved for the best part of a century however, despite the incredible depth and variation in this body of work “none of the phenomenological philosophers developed research methods” (Dowling, 2005, p. 134).

Reflecting upon the origins of Husserl’s work in developing the philosophical underpinnings of phenomenology there can be no doubt that the original purpose of the movement was to provide insight and understanding into essential human truths. “Husserl strived to develop a means for studying human experience, his phenomenology nevertheless arose from the natural sciences, whereby objectification of the findings remained the gold standard” (McConnell-Henry, et al., 2009, p. 11). This led to the emergence of a gap between the traditional or ‘European’ phenomenology that “stretches from transcendental phenomenology … to existential phenomenology” (Crotty, 1996, p. 1) and the ‘American’ school of phenomenology which was increasingly focused on the development of methods for conducting scientifically valid phenomenological research.

The interface between these two ‘manifestations’ of phenomenology is clearly described by Amedeo Giorgi (2000) [a prominent member of the Duquesne School of Phenomenology] who
described the articulation as follows; “phenomenological philosophy is a foundation for scientific work; it is not the model for scientific practice. The insights of the philosophy have to be mediated so that scientific practices can be performed” (Giorgi, 2000, p. 4). For phenomenology to have a place in the paradigms of ‘legitimate’ health care research it needed to possess a practical applicability, to allow the performance of these ‘scientific practices’ in the form of rigorous research. Munhall (2012) notes the importance of this influence when she states “the closer a method could look like a ‘scientific method’ the more acceptable it was to the academy” (p. 126). This highlights the need for scientific validity faced by proponents of phenomenology; without this any results produced would not have any credibility or relevance in the eyes of the broader scientific community. It is this key notion that has subsequently led to the development of a significant number of different methods for ‘doing’ research that have their philosophical foundations firmly rooted in the traditions of phenomenological philosophy:

If you ask a quantitative question, which relates either to frequencies or magnitude, then you should use a quantitative method. However, if you ask a qualitative question, which relates basically to the question: *what is it like to experience a particular phenomenon?* then you use a qualitative method. Such logic is impeccable. (Giorgi, 2005, p. 80)

The value of such an approach within the healthcare profession comes from the intrinsically ‘human’ nature of the profession and the associated need for a research approach that is designed to encompass the requirements of researching the subjective nature of the human condition.
Descriptive Phenomenology: Paul F. Colaizzi’s Model of Data Analysis

The decision was made to use the approach to phenomenological data analysis outlined by Colaizzi (1978) to examine the phenomenon of burnout in CAT Team community mental health nurses. Although over a quarter of a century has passed since it was first published, this particular approach has continued to be utilised across a wide range of healthcare focused studies as it has maintained its relevance, primarily due to the fact that “this particular process of analysis for the eidetic approach of (sic) phenomenology is both logical and credible” (Holloway & Wheeler, 2010, p. 222). Its strength as a method for data analysis lies in its strong adherence to the underpinning principles of Husserlian descriptive phenomenology combined with its ‘usability’. This usability comes from the fact that the methodology design is simple enough to be easily accessible whilst being capable of guiding the analysis in a fashion that is deep, sophisticated and highly complex ensuring its commitment to undertaking a “discovery of the genuine experience of participants” (Li et al., 2013, p. 341).

Described by Swanson-Kauffman and Schonwald (1988) as a “universal skeleton that can be filled in with the rich story of each informant” (p. 104), Colaizzi’s method provides sufficient structure in the seven steps articulated in the method to maintain focus and rigour, though encourages flexibility where warranted on the part of the researcher (Holloway & Wheeler, 2010; Sanders 2003) to ensure it is not limited by dogmatic procedural requirements. This flexibility in the application of the model has resulted in it having great utility in its application. A search of the term Colaizzi in the CINAHL Database (chosen due to its relevance for Nursing literature) identified 120 articles on topics as diverse as barriers in the pain management of Iranian children through to physical activity among the aged in China, exemplifying the diversity of topics relating to its use.
Colaizzi’s beliefs as outlined in his original article regarding the essential value of human experience were instrumental in this researcher’s choice; “to believe that my experience doesn’t count, amounts to believing that my existence doesn’t count” (Colaizzi, 1978, p. 52). This seemingly simple statement stands as the very cornerstone of the approach and reflects Husserl’s original goal, being to restore the value ascribed to the reality and meaning within human life-experience (Munhall, 2012). Colaizzi’s approach was also adopted because it primarily intended to describe human experience as it is, acknowledging the significance of this: “It must be, in short, a method that remains with human experience as it is experienced, one which tries to sustain contact with experience as it is given” (Colaizzi, 1978, p. 53). As the principle aim of the project is to uncover understanding and insight into a phenomenon not previously studied, Colaizzi’s approach allowed the researcher to remain free to allow the data generated by the participants to guide the process of discovery; “as a phenomenologist, I must begin by contacting that phenomenon as people experience it” (Colaizzi, 1978, p. 57), without needing to fit the data into any pre-existing theoretical framework. This researcher also shared a belief in the unconditional value of human experience, and a desire to investigate it as it is, and as such found Colaizzi’s (1978) ideas to fit well not only with his own core beliefs but also those of the mental health nursing profession more generally. Colaizzi’s statement that the “phenomenologist is satisfied with his descriptive method which provides him with the identification of psychological phenomena because, at the core of his approach towards himself, the world and others, he is content to understandingly dwell” (Colaizzi, 1978, p. 68).

Colaizzi’s method of data analysis differs from others within the field of descriptive phenomenology “in that final validation of the study is provided by the participants who are given the description of the experience to verify” (Mapp, 2008, p. 311). This step is considered to be an optional “final validating step” (Colaizzi, p. 61) that may be undertaken by the
researcher in order to “validate the findings” (Wojnar & Swanson, 2007, p. 177). In this way the participants themselves become the find filter for the data analysis process, ensuring that the description generated resonates for them as being an accurate reflection of their experience of the phenomenon.

**Phenomenology and Nursing**

The use of phenomenological investigation as an accepted research methodology within the nursing profession has been gradually on the increase over the last thirty years. A review of published literature by Beck (1994) indicated that “there were few published phenomenological studies in the 1970s, with a large increase in the latter 1980s, and this continued into the 1990s” (Holloway & Wheeler, 2002, p. 123), whilst Earle (2010) states that phenomenology has become a “dominant means in the pursuit if nursing knowledge” (p. 291). The development of clear and definitive approaches to conducting phenomenological research by authors such as van Kaam (1959), Giorgi (1985), and Colaizzi (1978) (Leininger, 1985) has added a clear degree of structure to the methodology and in doing so has made it more accessible to would-be researchers, with Colaizzi’s method commonly utilised in nursing research (Langdridge, 2008). In particular, it has enjoyed growing popularity amongst nursing researchers, becoming increasingly prevalent as an accepted and valued method of nursing research. The congruence of this methodology to the nursing profession is clearly identified by Streubert-Speziale & Rinaldi-Carpenter who state “This rigorous, critical, systematic method of investigation is a recognised qualitative research approach applicable to the study of phenomena important to the discipline of nursing” (2011, p. 72).
Phenomenology is an inductive approach that serves the “caring goal of understanding the lived experience of every individual and the world these individuals live in” (Stephenson & Corben, 1999, p. 117), a characteristic that makes it particularly relevant and applicable to nursing research. Within the nursing profession “phenomenology has primarily been concerned with apprehending experiences of illness … health research is often [undertaken] to gain insights into the lived experience of having a particular condition” (Dew, 2007, p. 435). Motivation for investigation and inquiry will invariably be influenced by the prospective researcher’s disciplinary background, including their philosophical attitudes. Nurses operate under an holistic model of care, respecting each person as an individual, a fact that is incorporated into their basic competencies: “accepts individuals/groups regardless of race, culture, religion, age, gender, sexual preference, physical or mental state… ensures that personal values and attitudes are not imposed on others” (Australian Nursing & Midwifery Council, 2006, p. 1). For nursing professionals, the individual experience has an intrinsic value that must be acknowledged and respected; indeed this is in many ways the very cornerstone of modern nursing practice:

Nursing encourages detailed attention to the care of persons as human beings and grounds its practice in a holistic belief system that cares for mind, body and spirit. Holistic care and the avoidance of reductionism is at the centre of professional nursing practice. The holistic approach to nursing is rooted in the nursing experience and is not imposed artificially from without. Just as caring for only part of the patient is inconsistent with nursing practice, so too is the study of human beings by breaking them down into parts (Streubert-Speziale & Rinaldi-Carpenter, 2011, p. 87).

That said, nursing is also a modern health care profession and as such operates under the scientific model where “a prerequisite to acceptance as a discipline in the academy or university
is to have bona fide research or a ‘science’ for research” (Munhall, 2007, p. 145).

Phenomenology as a mode of inquiry allows the nurse researcher the mechanism to investigate and better understand the unique lived experiences of individuals, giving insight into “layers of our experience un-probed in our everyday living, thus providing deeper foundations for both science and life” (Munhall & Oiler Boyd, 1993, p. 113) As a qualitative research methodology phenomenology facilitates the understanding of individual lived experience, a commodity in itself that is much valued by the nursing profession as it strives to develop a body of professional knowledge. In the case of this particular study the aim is to better understand the lived experience of transcending burnout as it is perceived by individual CAT Team nurses. Value and worth is ascribed to the thoughts and feelings of the participants due to their potential for revealing the true nature of the phenomenon; therefore the rationale for the use of this methodology is that “phenomenological method investigates subjective phenomena in the belief that essential truths about reality are grounded in the lived experience” (Streubert-Speziele & Rinaldi-Carpenter, 1995, p. 35). This is particularly true in situations involving the broad field of mental health where the understanding about a person’s illness, (or other life problem) is obtained principally through the process of verbal and non-verbal communication (i.e. an interview), rather than via some kind of test, scan, or procedure. As Edward (2006) states the philosophical principles of phenomenology are in keeping with the practices underpinning the nursing care practiced by mental health nurses sharing a belief in the value of “the uniqueness of the person, the importance of personal discovery and acceptance of life situations, the need for the exploration of the meaning of experience, interpersonal relating potential for personal growth and use of self as a therapeutic tool” (p. 238). In this situation the healthcare providers are almost entirely reliant upon the interview process to generate an understanding of a consumer’s illness. And there may be no other way to access the understanding that is essential for the generation of diagnosis and therefore treatment. Once the nurse engages in an interview,
they engage in a reciprocal process of sharing information about thoughts and feelings that are usually of a very personal nature to the consumer. For the nurse to organise and conduct the interview in a direction that is both effective (in meeting the goals of the interview) but also mindful of the consumer’s needs the nurse must possess a genuine, and essential respect for the value of that persons lived experience, otherwise there is little value in conducting the interview at all. If there are no essential truths contained within each person’s lived experience then why conduct the interview at all? The answer is of course that for the profession of nursing every individual must be understood and valued for the complexity and uniqueness their lived experience brings.

**Summary of the Chapter**

This chapter has provided an outline of the philosophical underpinnings of Husserl’s descriptive phenomenological philosophy, from its original roots in 19th century existential philosophy through to its application from the late 20th century as a method for guiding research. The key elements of Husserlian descriptive phenomenology were explored followed by an exploration of the evolution of phenomenology as a research method, with a particular focus on the descriptive research methods developed by the Duquesne School. The concept of phenomenological thought and research as it applies to contemporary nursing research has been examined, in particular highlighting the value that both phenomenological philosophy and the nursing profession place upon both human existence, and individual experience.
Chapter Five

The Research Method and Process

This chapter describes the research process involved in conducting the phenomenological investigation undertaken in this study. The translation of the research inquiry (as outlined in Chapter One) from a theoretical notion through to specific questions used to guide the data collection process is considered and clearly defined. Participant identification and recruitment is discussed and the procedure for data collection is outlined. The data analysis process is discussed in detail, with particular attention being paid to the steps of Colaizzi’s (1978) method of data analysis along with discussion regarding their practical application to this study. The ethical issues relevant to the study are then examined and discussed by the researcher before the notion of rigour is introduced and explored in the last section of the chapter.

Focus of the Research

In considering the translation of the research focus (as outlined in Chapter One) from a theoretical notion into a practical research process that would faithfully achieve the research goal the researcher considered a number of issues. Critical to this was the idea that the research focus was authentically carried through during the research process and was reflected in the study findings. Underpinning this study was the fact that the researcher desired to examine the individual mental health nurse’s experience (by their own definition) of going beyond, surpassing, or rising above or through (transcending) the experience of burnout that had occurred for them within the context of working on a Crisis, Assessment and Treatment Team (CATT) including as part of an ECAT Team. To this end the researcher had developed the following focus for the study:
To examine and describe the ‘lived experience of transcending burnout as described by community mental health nurses working within the Crisis, Assessment and Treatment Team (CAT Team) services’.

**Selection of Methodology**

Phenomenology argues the key notion that essential meaning concerning our existence can be gleaned from an understanding of our personal experience as it is lived, rather than as it is interpreted, contextualised or categorised (Taylor, Kermode & Roberts, 2006). The researcher therefore drew from this concept in the expectation that a phenomenological study aiming to uncover an understanding of the phenomenon of transcending burnout may generate insights about what it is to transcend (go beyond, surpass, or rise above / through) the experience of burnout.

The decision to utilise phenomenology as the methodology to guide the study was driven by the belief that it would allow the researcher to achieve the broader goal of the inquiry, that being to explore a specific area of human experience. Dowling and Cooney (2012) argue that “phenomenology should be the method of choice when aiming to understand the meaning of the lived experience of a phenomenon” (p. 25). In the case of this study the researcher wished to better understand what it meant for individual nurses working in the CAT Team environment to experience transcending burnout. This is supported by Converse (2012) who in discussing phenomenology as a research methodology stated that “this experiential way of coming to know and understand phenomena and the experience of these phenomena can help nurses understand particular circumstances” (p. 32). This was very much in keeping with the intent of the study, being the desire to gain an
understanding of a very specific and particular area of experience in a unique group of nurses. The relevance of Phenomenology as the chosen methodology is further supported by Mapp (2008) who suggests that this methodology is most relevant when the aim is to understand an experience as it is understood by those who are experiencing it. As the aim of the study was to explore and explicate the experience of transcending burnout specifically from the perspective of those nurses who actually experienced this phenomenon this again led the researcher to identify phenomenology as the method that would best allow the study to achieve this goal.

It is also worth noting that the paucity of existing research in the area of transcending burnout (in general), and more specifically transcending burnout in CAT Team nurses, was another factor in the choice of methodology. One of the great strengths of phenomenological research is that it allows the participant to guide the path that the researcher follows; “each participant has a unique meaning of the lived experience of the phenomenon which the researcher gathers in order to come to understand the phenomenon” (Converse, 2012, p. 31). In a situation such as this, where there was very little existing literature or established knowledge to act as ‘landmarks’ in guiding the development of the study’s structure, adopting a phenomenological perspective (and process) provided the researcher with a valid and rigorously sound path by which the study could proceed.

**Selection of the Participants**

The selection of participants is critical to the success of the study in phenomenological research, as the researcher must access participants not only with
experience of the phenomenon under study, but also with the ability to communicate effectively with the researcher regarding the phenomenon (Taylor, Kermode & Roberts, 2006). The researcher must consider whom, what and where to select participants as well as ensuring the sample is both appropriate and adequate; “Appropriateness means that the method of sampling fits the aim of the study and helps the understanding of the research problem. A sampling strategy is adequate if it generates adequate and relevant information and sufficient quality data” (Holloway & Wheeler, 2010, p. 144). In considering the participant cohort for this study it quickly became evident that a homogenous cohort would be required and that purposive sampling would be the most appropriate method in selecting participants given that the “logic and power of purposeful sampling lies in selecting information-rich cases for in depth study …those from which one can learn a great deal about issues of central importance to the purpose of the research” (Patton, 2002, p. 169). Purposive or purposeful sampling involves the selection of participants based upon a specific, desired criteria, in this case possession of a certain type of experience, and was chosen primarily because it is very well suited to the “collection of descriptive data as in qualitative studies that seek to describe the lived experience of a particular phenomenon” (Lobiondo-Wood & Haber, 2010, p. 295). This would ensure that the sample population would comprise of a group of participants who had first-hand experience of the phenomenon under investigation and would therefore be able to explore and describe it in the necessary level of complexity, depth and detail (Burns & Grove, 2007).

In choosing participants Colaizzi’s (1978) belief that experience (as outlined in Chapter Four) “with the investigated topic and articulateness suffice as a criteria for selecting subjects” (Colaizzi, 1978, p. 56) was used to guide the selection process. Individuals invited to participate in the study were registered mental health nurses who had by their own account experienced the phenomenon of transcending burnout as it related to their
professional practice and experience in the workplace whilst working as CAT Team or ECAT Team nurses. At a practical level suitability was explored and established through discussion at the initial point of contact. Potential participants were asked to discuss briefly their experiences to see if they were relevant to the researchers notion of describing the lived experience of going beyond, surpassing, or rising above or through [thereby transcending] burnout. Where required essential elaboration or clarification about the topic was provided, though in doing so the researcher remained very aware of focusing on the immediate goal of determining suitability, rather than unintentionally ‘pre-empting’ any discussion about transcending burnout that might restrict or influence their own description of their experience of the phenomena.

Furthermore, the participant’s willingness to reflect upon and discuss their experiences was considered by the researcher as an important factor in determining the inclusion of each individual participant; “Good informants must be willing and able to critically examine the experience and their response to the situation … must be willing to share the experience with the interviewer” (Morse, 2012, p. 132). Experience in the phenomenon alone would not be sufficient; the participants also needed to possess the ability to reflect on their personal experience as well as have a willingness to explore these experiences more deeply than they that might normally have done.

The specific inclusion and exclusion criteria associated with participation in this research project are outlined below:
Inclusion Criteria:

- Currently practicing as a mental health nurse working on a CAT Team / ECAT Team in Melbourne, Victoria.
- An experience of a period of burnout in their CAT Team practice leading to the associated / subsequent experience of coming to terms with this and overcoming, or moving through and past feeling burnt-out whilst continuing to practice in a CAT Team nursing role.
- Be able to communicate articulately in English and be willing to share their experiences with the researcher.
- Be available to meet for two (2) separate meetings as required.

Exclusion Criteria:

- The presence of any associated problems of issues that might be more likely to be the cause of the burnout.
- An inability to meet the requirements of the research process (i.e. unable to make the required meetings or an inability to articulate their experiences).
- Exhibiting significant psychological or emotional distress related to other issues that may significantly impede their ability to describe clearly their experience of transcending burnout.
- Nurses working on the same team as the researcher were excluded due to the potential for bias / passive coercion.
Accessing the Participants

The first step in gaining access to potential participants was for the researcher to engage in the technique of professional networking. Professional networking is a form of convenience sampling whereby “people are selected because they are conveniently (and opportunistically) available with regard to access, location, time, and willingness … also all meet the predetermined criteria for inclusion in a study” (Schneider, Whitehead, Elliot, Lobiondo-Wood, & Haber. 2007, p. 124). As a practising mental health nurse currently working in the field of crisis assessment and treatment a number of potential participants were already known to the researcher. Once approval to proceed with the study had been obtained from the RMIT Ethics Committee (See Appendix A) these individuals were approached in person by the researcher and invited to consider being involved in the study.

All participants recruited into the study were asked to suggest other potential participants known to them through their practice as CAT Team nurses. This involved identifying any other mental health nurses working on CAT or ECAT Teams whom they believed might be willing to share their experiences, and, with that person’s consent, providing their contact details to the researcher. This technique, known as ‘snowballing’ or network sampling (Patton, 2002) is one in which “a previously chosen informant is asked to suggest other individuals with knowledge of a particular area of topic, who participate and in turn nominate other individuals” (Holloway & Wheeler, 2010, p. 141). This is an “effective strategy for identifying participants who can provide the greatest insight and essential information about an experience of [an] event that is being studied” (Burns & Grove, 2007, p. 346). Each potential participant was then contacted by phone by the researcher to determine whether or not they met the inclusion criteria and whether they were interested
in being involved in the study. At the time of this initial contact a brief outline of the purpose of the study and the level of participant involvement was discussed. For those individuals who expressed interest in participating in the study, a mutually agreed time and place was negotiated to meet and discuss the study in more detail. Those who continued to express interest in being involved in the study were subsequently invited to participate.

The issue of population size was also considered, as it is an important issue in a phenomenological study such as this and can impact significantly upon the quality of the data generated. In conducting the interviews, the researcher’s goal was to achieve data saturation, wherein “additional sampling provides no new data, only redundancy of previous collected data” (Burns & Grove, 2007, p. 348) and therefore “data collection must continue until the researcher is assured saturation has been achieved” (Streubert-Spezziale & Rinaldi-Carpenter, 2007, p. 95). However it is also important that the number of participants was not too large for fear of losing the intricate details provided by each participant during the interviews; “a large sample … is unnecessary and might result in less depth and richness … An overlarge sample might not capture the meanings participants ascribe to their experience, and it could result in the loss of the unique and the specific” (Todres, Galvin & Richardson, 2005 as cited in Holloway and Wheeler, 2010, p. 146). In order to achieve this in practice, data collection and data analysis are done concurrently to ensure that the researcher is able to accurately identify the point where no new data emerges and saturation has occurred. In the case of this study, data saturation (Patton, 2002) was achieved after the completion of the 12th interview / analysis. For a more detailed overview of the participant group please refer to Appendix B.
Insider Outsider Considerations

One of the issues that the researcher also considered in accessing the participants was the notion of his insider/outside status. As an active member of a CAT Team the researcher certainly considered himself in some ways an insider, having had direct experience in working as a CAT Team nurse, with an intimate knowledge of the day-to-day experiences that make up this particular job. The value of being thus situated as a clinician and researcher is well recognised; "researchers without any clinical experience or any direct exposure to the clinical phenomena or service systems they study miss many of the real-world issues that can inspire innovative and relevant research" (Yanos & Ziedonis, 2006, p. 250). Additionally, Colaizzi (1978) considered the position of ‘insider’ as an essential advantage in ensuring accurate sampling for phenomenological studies; “Experience with the investigated topic and articulateness suffice as criteria for selecting subjects” (Colaizzi, 1978, p. 58), further emphasising the value of the researchers ‘location’ in conducting this phenomenological study. For the purposes of this study the researcher’s experience as an experienced CAT Team nurse came with the benefit of having numerous contacts within the CAT Team service that could be an initial starting point for the professional networking used to begin participant recruitment.

In considering the potential challenges associated with the researcher’s insider status the notion of ‘internal role confusion’ wherein “internal role confusion results primarily from the fact that research and clinical work consist of fundamentally different tasks and ways of being” (Yanos & Ziedonis, 2006, p. 252) was given particular consideration as will be discussed in detail below. In considering how best to manage this potential pitfall the researcher was obliged to reflect upon his own ideas as to the similarities and differences
between the two roles and how these might manifest in a primary data collection process such as an interview. The researcher needed to possess and maintain a clear understanding of the key differences in the point of his being there, both as the insider (fellow CAT Team clinician possessing an intimate understanding of the range of experiences and situations common in this professional domain) and the outsider (as another human being with a different set of experiences and understandings). Such consideration was required to ensure that the necessary sense of perspective was maintained. Indeed, though the researchers ‘insider’ status had substantial value in allowing access to participants and was in keeping with Colaizzi’s (1978) requirements it also posed a significant threat to the phenomenological integrity of the study should the researcher begin to ‘presume’ too much of his own ‘insider’ knowledge and experience at the expense of allowing the participants own experiences to emerge unimpeded.

In order to ensure that this did not occur, the researcher adopted reflexivity in exploring the insider / outsider considerations. The advantage of this was primarily that “reflexivity provides transparent information about the position and personal values of the researcher that could affect data collection and analysis” (Walker, Read & Priest, 2013, p. 38). In this regard reflexivity was viewed as a lens utilised to examine and explore the relationship between the researcher and the object of the research (Brannick & Coghlan, 2006). At a practical level this reflexivity involved significant reflection, journaling and mind-mapping on the part of the researcher to explicate his own notions about: [i] being a CAT Team nurse, [ii] the experience of burnout in CAT Team nurses and [iii] his ideas regarding transcending burnout as a CAT Team nurse. In undertaking this reflection the researcher focused his thinking particularly on his experiences as a practicing CAT Team nurse as these were the elements that he felt most needed to be identified. The outcomes of this
reflective process was ultimately incorporated into all of the subsequent elements of the research process in order to ensure that the researcher operated from the position of ‘researcher’ rather than that of a ‘CAT Team Nurse’.

**Preparation for the Interviews**

In preparing to conduct the participant interviews the researcher considered Colaizzi’s (1978) notion that the participant is:

…exquisitely a person, and the full richness of a person and his (sic) verbalised experiences can be contacted only when the researcher listens to him with more than just his ears; he must listen with the totality of his being and with the entirety of his personality. One can be present to the totality of a person only by being totally present to him; one must be present in every imaginable way; the researcher must assume the stance of imaginative listening.

(Colaizzi, 1978, p. 64)

In endeavouring to achieve this stage of total, imaginative listening, the researcher developed a number of strategies in preparing for conducting the interviews with the participants. The purpose of these was twofold: firstly they allowed the researcher to identify his own presuppositions and therefore minimise the impact they may have upon the data collection process, to ensure that he not “assess the answers as being right or wrong” but rather “have an honest interest in getting the subject to express themselves” (Sjostrom & Dahlgren, 2002, p. 341). The second reason was that they assisted the researcher’s level of self-awareness (with regards to his interview appearance and
behaviours) in order to enhance his level of ‘being present’ (Colaizzi, 1978) during the interview. Reflection at this point also enhanced the researchers capacity for “reflection-within-the-moment” (Kofoed, 2011, p. 133), which would be of significant value during the interview process in allowing the researcher to remain entirely focused on the participants story as it was unfolding, in the belief that it would improve the quality and authenticity of the information collected.

The researcher had previously utilised strategies such as self-reflection and journaling to identify and set aside “certain beliefs, hypotheses, attitudes and hunches held” (Colaizzi, 1978, p. 58) about the phenomenon under investigation. The process of bracketing (Giorgi, 1997) [as discussed in the previous chapter] involves the researcher attempting to put to the side his own thoughts, beliefs and ideas about the phenomenon under investigation. Given the innate complexity of subjective experience it is acknowledged that “to forget one’s pre-understanding is impossible” (Dahlberg, Drew & Nystrom, 2001 cited in Ekstedt & Fagerberg, 2005, p. 61). This was a dilemma that required the researcher to try to reconcile the theoretical tenants of the methodology with the pragmatic context in which the study was being conducted. Ultimately the process of self-reflection (enhanced by the exercise described below) as well as journaling and mind-mapping (as mentioned above) provided the researcher with the opportunity to become more aware and insightful of his own beliefs, notions and bias’s so as to allow him to be vigilant against them infiltrating the interview process (Ekstedt & Fagerberg, 2005). This was also in keeping with the notion that “you begin your phenomenological study with self-reflection” (Munhall, 2007, p. 182). The challenge is then to ensure that this increased self-awareness is carried through into the researchers behaviour, demeanour and communicating during the data collection interviews.
Prior to commencing the data collection process the researcher conducted a single mock interview with the goal of improving the researcher’s self-awareness and reflexivity (Streubert-Speziale & Rinaldi-Carpenter, 2011). The intention of this was to improve the researchers awareness of his own behaviours and mannerisms (non-verbal communication), as well as to observe the researchers verbal delivery of the questions used to guide the interview along with the use of prompting behaviours (Stein-Parbury, 2009) that the researcher used when carrying out the interviews. The mock interview involved interviewing an uninvolved party about a “lived” aspect of their life (in this case career dissatisfaction). In conducting it the researcher assumed the same stance as would be utilised for the study interviews, with the main goal being to encourage the ‘mock participant’ to explore his own lived experience.

The exercise was based on research that found that “self-assessment of counselling sessions on video has been found to be an effective strategy for nurses to enhance their learning” (Poskiparta, Liimatainen & Kettunen, 1999, p. 4), whilst Long, Angera and Hakoyama (2006) argue that “the use of videotaped feedback may actually help increase individual’s self-awareness” (p. 429). The interview was conducted simulating authentically the process that the researcher was intending to utilise in the study interviews with the exception that the camera was pointed at the researcher rather than the participant as this allowed the researcher to “imagine yourself (sic) in the interviewee’s place” (Munhall, 2007, p. 185). This enabled the researcher to evaluate his own participation in the research process, as a potential participant would perceive it, which served to give the researcher a more accurate and genuine understanding of his place during the data collection process. Furthermore it allowed the researcher to identify any aspects of his behaviour, demeanour and communication that did not support the goals of the research
process, and that may present a hurdle for the collection of a rich, expansive description of
the phenomenon under investigation.

In carrying out this exercise the researcher had considered Colaizzi’s key requirement that
“we describe what we see and not what we think we see” (Colaizzi, 1978, p. 65) which
demands that we focus on behaviour as it actually is, rather than how it is recalled, or
believed to be. In preparing for the interviews the researcher applied this notion to himself
with the intention of ensuring that when he conducted the study interviews, it would be
with a strong, authentic understanding of how he actually appears, rather than how he
thinks he appears to the participants. It was also undertaken by the researcher as a practical
strategy to meet the requirement of effective reflexivity, that being “the responsibility of
researchers to examine their influence in all aspects of qualitative inquiry” (Streubert-
Speziale & Rinaldi-Carpenter, 2011, p. 324). The researcher reviewed the videotape of this
interview and concluded that the verbal and non-verbal communication behaviours
exhibited were consistent with the consistent attentive and interested demeanour that he
was intending to display. The result of this was to confirm the researcher’s confidence in
his role in the interview process.

**Information Collection**

Phenomenological inquiry prescribes that the researcher aims to uncover the lived
experience of the phenomenon under investigation, as it is experienced by the participants
in the study. This requirement generally involves the use of an in-depth interview (Polit &
Beck, 2004; Sjostrom & Dahlgren, 2002) to facilitate information collection, though in
keeping with Colaizzi’s (1978) recommendation, each participant in the study was asked to
participate in two separate interviews. The first interview was for information gathering. The second interview was to provide an opportunity for both the researcher and the participant to review and consider the transcripts from the first interview along with the researchers accompanying analysis. The process of such a review, undertaken as a collaborative process between the researcher and participant, is to ensure that the analysis has faithfully and accurately captured the essence of the participant’s experience (Colaizzi, 1978).

The data collection for the project was conducted through the use of in-depth focussed interviews (Eskert & Fagerberg, 2005; Sjostrom & Dahlgren, 2002; Walker, Hall & Thomas, 1995). This format was chosen as these interviews allowed the researcher the opportunity to join with the participant in exploring their experience of the phenomenon. This notion of a shared experience was considered vital by the researcher, as it was imperative that the participants were allowed the opportunity to reflect upon their experiences in a manner that also allowed the researcher to accompany them on their journey; “interviewing is not an interpersonal exchange controlled by the interviewer but rather a transaction that is reciprocal in nature” (Benoliel, 1988, p. 211). The choice of this particular method of information collection is also deemed to be the most appropriate as described by Streubert-Speziale and Rinaldi-Carpenter (2011) who state:

The interview allows entrance into another person’s world and is an excellent source of data. Complete concentration and rigorous participation in the interview process improve the accuracy, trustworthiness, and authenticity of the data … the researcher must remember to remain centred on the data, listen attentively, avoid interrogating
the participant, and treat the participant with respect and sincere interest in the shared experience. (Streubert-Speziale & Rinaldi-Carpenter, 2011, p. 90)

For the purposes of this study the interviews were conducted in a setting that was quiet, relaxed, and free from disruption that provided an environment that was highly conductive to open and free dialogue, thus contributing to the emergence of information-rich data. The actual time and location set for each interview were determined by the researcher and the respective participant together, paying particular heed to the participant’s preference in making a decision. This ensured that the participant felt relaxed, comfortable and secure enough to be able to speak in an un-restrained and ‘free’ fashion about their thoughts, experiences and feelings. The researcher was willing to travel to any location that the participant selected, be this an ‘out of the way’ office at work, the participants own home or an office at the University.

The researcher also paid attention to the time requirements demanded by the interview process as it was important that sufficient time be made available for the interview by both the researcher and the participant (Taylor, Kermode & Roberts, 2006). It was anticipated by the researcher that the interview would take approximately 60 minutes to complete. Therefore the participant was advised of how much time they would need to allow for the interview, and interviews were scheduled at times when the participants did not have a pressing deadline to attend if the interviews were to run longer than anticipated. The researcher also ensured that the interviews were unlikely to be disturbed by external interruptions by selecting a location that was quiet, and by turning off anything such as mobile phones, or electronic devices that might interrupt the interview.
Prior to the first interview each participant was provided with a full verbal description of the study as well as receiving a copy of the Plain Language Statement (Refer Appendix C). All of the participants were given an opportunity to ask any questions they may have had about the purpose, process and value of the study, which were thoroughly responded to by the researcher. All participants agreed to take part in the study and so after each gave informed consent in writing (See Appendix D), the interviews commenced.

All of the participants agreed to their interviews being audio and videotaped, with the audiotape subsequently being transcribed in preparation for the data analysis process. The videotapes were utilised as an additional information source for clarification of emphasis made by participants during the interviews allowing the researcher to revisit what he had witnessed during the data collection process. At the end of the interview all of the participants were thanked for their involvement and after the first interview the researcher also took the opportunity to remind them that he would re-contact them once the analysis was completed to organise a further interview. This was to elicit their views on the findings and to validate them (Holloway & Wheeler, 2010) as per Colaizzi’s (1978) guidelines.

**Guiding and Following: The Interview Questions and Dialogue**

When considering the actual questions to utilise during the interviews the phenomenological researcher has to strike a fine balance. On one hand the researcher needs to be able to focus the interview to ensure that the content is relevant to the topic under scrutiny. Accurate selection of participants with the necessary experience of the phenomenon under examination will go a long way to ensuring this however, within the
parameters of the interview the researcher needs to be able to refine this further. The researcher also needs to ensure that the participant’s reflections and thoughts spring from their experience of the phenomena, and the participant must also be allowed the freedom to follow the various paths that emerge through their dialogue as the interview unfolds.

Sjostrom and Dahlberg (2002) argue that in order to meet these conflicting demands, and to gather as complete and comprehensive an account as possible of the phenomena under investigation the interview “comprises a few entry questions, while the subsequent dialogue proceeds according to the answers obtained” (p. 341). In keeping with the expectations of phenomenological research (Lobiondo Wood & Haber, 2010) these questions would need to be succinct enough to ensure that the data collected was relevant to the phenomenon under investigation whilst at the same time not being overly restrictive so as to ensure that the participants experience would be able to emerge unrestrained by any pre-conceived expectations on the part of the researcher. In keeping with these requirements all of the participants were asked the following two key questions during the interview in order to give the data collection focus. The first of these was framed in an invitational format to engage the participant in talking about their experiences whilst the second aimed to facilitate deeper exploration. The two questions were:

- Please describe your experience of transcending burnout whilst working on a CAT or ECAT Team.

- How have you come to understand the feeling of transcending burnout that you have experienced?
The researcher also gave significant consideration to the presence of non-verbal communication elements within the interview process in order to ensure that the dialogue within the interview would incorporate all elements of communication. In communicating ideas, thoughts or in general conversation human beings utilise a number of elements, namely the verbal, para-verbal and nonverbal (Stein-Parbury, 2009). Each of these elements are interwoven during the process of communication, however the relative contribution of each element is quite uneven though there is no doubt that “non-verbal communication forms the greater part of any communication process” (Knight, 2005, p. 31). Mehrabian’s (1971) seminal work in the area examined the impact of each element within a communicated message, concluding that the verbal component contributed only 7% to the receipt of the message, the para-verbal component 38% and the nonverbal 55%. Over the ensuing three decades the importance of the non-verbal and para-verbal components in communication has been increasingly reinforced (Anderson & Tredway, 1999; Knapp & Hall, 2010, Mehrabian, 1971; Mehrabian & Epstein, 1972; Richmond & McCroskey, 2000) for counsellors, researchers and nurses alike. Considering the ratio’s suggested by Mehrabian (1971) it is clear that nonverbal behaviours contribute a large proportion of the message. Highlen and Hill (1984) suggest that our non-verbal behaviours “regulate conversations, communicate emotions, modify verbal messages … give insights into self-perceptions, and provide clues that clients are not saying what they are thinking”, a notion echoed by Munhall (2007) who wrote; “language with all its intonation and inflection is the most revealing. Facial expressions and body language are also forms of language meaning” (p.181).

Due to the importance of these communication elements the researcher undertook to both listen to and observe the participants communication of their experiences during the
interviews. This ensured that the researcher was much more perceptive of the messages being communicated by the participants through verbal, non-verbal and para-verbal means. The following para-verbal elements were closely considered during the interviews:

- Tone of voice.
- Volume.
- Pitch.
- Tonal Inflection.
- Clear and precise language use.
- Speed of speech.

(Poskiparta, Liimatainen & Kettunen, 1999, p. 5)

The following nonverbal elements were closely considered during the interviews:

- Eye contact
- General appearance
- Facial expressions
- Body orientation
- Touch
- Gestures
- Body posture
- Personal space or distance
- Speed of movement

(Poskiparta, Liimatainen & Kettunen, 1999, p. 5)
Effective identification of these communication elements with the interview was also combined with communication techniques intended to encourage reflection, exploration and expression of the participant’s experiences. Communication skills such as paraphrasing and clarification (Elstedt & Fagerberg, 2005) along with broader prompting and probing skills (Stein-Parbury, 2009) were employed by the researcher in order to remain centred on the data as it emerged.

**Information Analysis: Colaizzi’s Method**

The researcher opted to utilise the guidelines developed by Colaizzi (1978) to guide the manner in which information was gathered and analysed for this research project. The rationale for this choice has been discussed previously in Chapter Four, with the following section to outline the practical application of Colaizzi’s (1978) method of data analysis to this study. The basic principles of Colaizzi’s (1978) method for data analysis are as follows:

1. Read all of the subjects [sic] descriptions (conveniently termed *protocols*) in order to acquire a feeling for them, and to make sense out of them.

2. Return to each description and extract from them phrases or sentences which directly pertain to the investigated phenomenon: this is known as *extracting significant statements*.

3. Try to spell out the meaning of each significant statement; these are known as *formulated meanings*.
4. Repeat the above for each description and organise the aggregate formulated meanings into *clusters of themes*.

a. Refer these clusters of themes back to the original protocols in order to *validate* them.

b. At this point, discrepancies may be noted among and/or between the various clusters: some themes may flatly contradict others, or may appear to be totally unrelated to others. (The researcher is advised by Colaizzi to refuse the temptation to ignore data or themes that do not fit.)

5. The results of everything so far are integrated into an *exhaustive* description of the investigated topic.

6. An effort is made to formulate the exhaustive description of the investigated phenomenon in as unequivocal a statement of *identification of its fundamental structure* as possible. This has often been termed as an essential structure of the phenomenon.

7. A final validating step can be achieved by returning to each subject [sic], and, in either a single interview session or a series of interviews, asking the subject about the findings thus far.

(Holloway & Wheeler 2010, pp. 223-224)
The pre-analysis preparation.

Although not specifically required by Colaizzi this step was undertaken in order to apply the principles of phenomenological reduction (bracketing) in a practical, lived-world sense. The researcher also used this opportunity to become more aware and insightful of his own beliefs, notions and bias’s so as to allow him to be vigilant against them unintentionally influencing the interview process. Self-reflection and active questioning of the researchers own perspective and beliefs was revisited prior to and then during the data analysis process. In addition the ideas previously raised through journaling were again revisited to ensure the researcher maintained a high level of self-awareness allowing effective bracketing to occur during the data analysis process. As data collection and data analysis were done concurrently in order to meet saturation principles (as discussed earlier in the chapter) this process continued right throughout the data collection and analysis period.

Step one: Acquiring a feeling for / making sense of the descriptions.

On completion of the interview the researcher transcribed each interview in full. The transcription was completed using the audio recording of the interview, with the researcher meticulously working through the interview transcribing every word said by both parties. In doing this the process of completing Colaizzi’s first step of data analysis began. Every sentence was listened to numerous times to ensure the transcription was accurate. Whilst typing each word was considered for its meaning, both within the norms of contemporary communication as well as within the specific context of the interview. Broader patterns of communication were noted and thought about, whilst the meaning behind specific turns of
phrase or the use of jargon was reflected upon. The significance of para-verbal communication such as pauses or repetition was wondered about within the context of the message being communicated. In completing this first step, the researcher engaged in the initial use of phenomenological intuiting, employing “imaginative variation” (Streubert-Speziale & Rinaldi-Carpenter, 2011, p. 76) through intentionally pondering various different possibilities when considering the meaning in making sense of the descriptions.

To augment this process of acquiring a feeling for /making sense of the descriptions the video recording of the interview was re-watched several times: This allowed the researcher to return to the moment when the researcher and participant sat face to face in the actual interview rather than relying on an inherently flawed recollection of the event. This approach also allowed the researcher to remain faithful to Colaizzi’s (1978) expectation that “we describe what we see and not what we think we see” (Colaizzi, 1978, p. 65) by doing literally that in making sense of the descriptions.

**Step two: Extracting significant statements.**

Once the researcher had acquired a feeling for and made sense of the transcripts, the process of extracting significant statements was conducted. This process involved the researcher again working his way meticulously through the transcript to identify and extract significant statements that related to transcending burnout. Paragraphs containing multiple (often over-lapping) significant statements were examined and broken down in multiple different ways to ensure that the message they conveyed was accurately captured in the final statement selected. These statements were then collected in a new document and labelled numerically with the participant’s identifying letter (participant A-L) attached
as a prefix (i.e. A1, A2, A3 etc.) in the order they occurred chronologically within the interview. This process initially involved the extraction of statements that related to the participants experience of burnout as well as those more specific to transcending burnout. These were separated out and removed through the following analysis step in which meanings were formulated for the statements allowing the researcher to differentiate accurately between the two different groups. This process was repeated with each new participant interview, resulting in the identification of 521 significant statements across the 12 participants involved in the study (see Appendix E).

**Step three: Spelling out the formulated meaning from each significant statement.**

Once the researcher had identified and extracted each of the significant statements the next step was to formulate a meaning for each of them. This was a complex and time-intensive cognitive task for the researcher that involved the application of a number of the key elements of phenomenological research. These have been discussed previously in Chapter Four however their practical application is the focus of the discussion here. The first of these involved the ongoing critical application of phenomenological reduction or bracketing. Whilst this had been occurring throughout much of the research process it was revisited regularly through this stage of the analysis due to the importance of ensuring that the researchers pre-existing beliefs, ideas, and assumptions did not pollute the analysis process. Reflection in the form of a journal and time set aside for reflective cognitive exercises were utilised to identify, examine and then consciously place the researchers pre-existing beliefs, ideas, and assumptions to one side. This ensured that the researcher remained fully aware of these, and was therefore able to remain vigilant for assumptions
potentially encroaching upon the analysis process, and to be able to detect their influence should they emerge at all in the researchers thinking. In this way the researcher was able to ensure an environment conductive to allowing the effective application of the other key elements in the analysis process, phenomenological intuiting and reflexivity.

Phenomenological intuiting lies at the heart of the phenomenological process, being used here to incorporate the process of identifying, explicating and forming the meanings contained within each statement. The meanings of individual words, phrases and sentences were considered with the researcher endeavouring to look ‘within’ their linguistic structure to identify the meaning that they were trying to convey. In doing this the researcher was enacting Colaizzi’s (1978) notion that “meanings are given with the protocol, but are not in it” (p. 59). Potential meanings for each statement were considered and then creatively varied to consider more than the initial interpretation of what the researcher thought was meant. This creative variation required that the researcher contemplate a wide range of likely and unlikely possibilities in striving to consider the widest possible range of meanings. At the same time the researcher needed to ensure that the process of intuiting remained faithful to the original statement; the researchers creative variation needed to consider all possible meanings whilst remaining congruent with the participants original protocol. In doing this the researcher was honouring Colaizzi’s (1978) expectation that “the researcher must go beyond what is given in the original data, and at the same time, stay with it” (p. 59) and in this regard being able to re-watch the videotapes of the recordings allowed the researcher to remain present with the participants in their expression of their ideas.
Reflexivity (introduced earlier in this chapter) was also utilised during this stage of the analysis as the researcher adopted “a self-critical stance” (Holloway & Wheeler, 2010, p. 311) in formulating the meanings from the significant statements. In applying this concept the researcher moved back and forth between the participant’s statements and their formulated meanings, oscillating between the bracketing and intuiting elements in the data analysis process to ensure that the formulated meanings were a genuine and acute representation of the participants lived experience. This was applied to each statement in turn and then as more statements were examined was expanded to include the broadening body of meaning the intuiting process. Finally, the results of the researchers formulation of meanings was regularly reviewed by the researchers supervisors, with feedback provided being considered and integrated into the analysis process.

During this stage of the analysis those statements whose formulated meaning pertained specifically to burnout alone (rather than transcending burnout) were removed from the analysis process after thorough consideration, as the experience of burnout was not the focus of the study. This resulted in the removal of 148 statements across the 12 participants involved in the study leaving 373 significant statements whose formulated meanings related specifically to transcending burnout.

**Step four: Aggregating formulated meanings into clusters of themes.**

The fourth step of the Colaizzi’s (1978) data analysis process involved grouping the formulated meanings into clusters, organised by similarities in theme. This required the researcher once again to consider the similarities and differences in the formulated meanings to detect broader ideas and concepts that would allow this process to unfold.
Initially the researcher allowed the formulated meanings to directly establish the foundations of the different themes regardless of their consistency with each other, with the resultant generation of 17 different draft themes at the height of the analysis process. This was in keeping with Colaizzi’s (1978) notion that there may be significant differences between the different theme clusters to the point where they may seem entirely unrelated however it was important to not exclude or ignore any data or themes that did not readily fit into the existing themes.

As more formulated meanings were added into this process the characteristics of each theme gradually evolved and became more clearly delineated from the others. Ensuring congruence between the meanings contained within the participants protocols and the theme clusters was of paramount importance (Colaizzi, 1978). Achieving this required that the researcher regularly return to the original protocols and participant significant statements to ensure that the themes generated remained valid and in keeping with the content contained within the original protocols. Additionally, as with the earlier steps in the analysis, the aggregation of formulated meanings into clusters of themes was regularly reviewed by the researcher’s supervisors, with feedback incorporated into the analysis process.

**Step five: Integration of all analysis into an exhaustive description of the phenomenon.**

The fifth step of Colaizzi’s (1978) data analysis process involved synthesising all of the analysed data undertaken up until this point into a comprehensive and exhaustive description of the phenomenon of transcending burnout. In keeping with the principles of
the method, this was commenced by revisiting the formulated meanings and theme clusters already developed through the analysis process, with the researcher immersing himself in this material by reading and re-reading the material. From here the researcher developed the exhaustive description beginning with the theme clusters and writing and re-writing the description until it accurately and authentically captured the essence of the experience as described by the participants. As with all of the preceding steps in the analysis process, the researcher continued to re-visit the results of the earlier steps in writing the exhaustive description to ensure accurate representation, whilst obtaining and integrating feedback from his supervisors.

Table Four: Significant Statements, Formulated Meanings and Theme Clusters

<table>
<thead>
<tr>
<th>Emergent Themes</th>
<th>Theme Clusters</th>
<th>Participant significant statements</th>
</tr>
</thead>
<tbody>
<tr>
<td>[1] Transcending Burnout through Personal Strength: Grim Determination, Pragmatism and Optimism, involved participants being able to know and tap into their own strengths and capacity to endure and evolve through hardship. Whether it was clinging on through tenacious grim determination or by being able to laugh at the situation each had allowed themselves to be guided by their own pragmatic needs or even by deeper lifelong values. The participants drew heavily upon their intrapersonal qualities in rising above and beyond the hardship of burnout.</td>
<td>Transcending burnout required drawing on personal strengths such as grim determination, pragmatism and optimism.</td>
<td>A: 4, 12, 19, 22, 23, 25. D: 14. E: 3, 24. F: 3, 32. G: 5. I: 6, 7, 8, 16. J: 9, 11. K: 20.</td>
</tr>
<tr>
<td>Transcending burnout meant refusing to be beaten or give in.</td>
<td></td>
<td>A: 9, 53, 58. C: 37, 39. I: 19, 20.</td>
</tr>
</tbody>
</table>
Transcending burnout meant staying faithful to core beliefs and principles.  
A: 7, 8.  
E: 22.  
H: 29, 33, 39, 41.  
J: 8, 10.  
K: 2, 22.  
L: 25.

Transcending burnout meant drawing on broader life achievements.  
A: 32, 33.  
E: 18.  
I: 23, 26, 27.

[2] Transcending Burnout through Reaching for Support, involved participants being able to interact and converse with others [primarily colleagues] within the mental health profession, particularly other CAT Team nurses. It required being able to communicate with others in a manner where the participant could feel both safe and able to reveal their feelings of uncertainty, vulnerability and loss of confidence. Participants describing reaching for support from CAT Team colleagues within the work environment, through supervision with other MH nurses in the services or informally through their social networks of MH nurses, though in all cases it was the sense of being understood and of not being alone that was the essential element.

Transcending burnout meant looking to others and knowing they were there to provide emotional and practical support and assistance.  
A: 5, 26.  
B: 28.  
D: 37.  
E: 8.  
G: 8, 11.  
J: 6, 12.

Conversing and interacting with CAT Team colleagues to re-find a sense of connection was a vehicle for transcending burnout.  
A: 16.  
C: 21.  
D: 7.  
E: 7.  
G: 31, 33.

External supervision from someone who ‘understood’ CAT Team nursing practice was a useful strategy in transcending.  
F: 4, 5, 6, 17, 18, 19.  
G: 32, 34, 35, 37.  
H: 9, 10.  
J: 5, 17.  
K: 14, 19.  
L: 6, 7, 8, 13, 18, 29, 31, 34, 35.

Gestures of support and acknowledgement from colleagues were important in providing validation.  
A: 17.  
B: 28.  
C: 11.
[3] Transcending Burnout through Weathering the Storm involved participants persisting and pushing on through difficulty and adversity with the sense that this was the way forward. It involved not only the willingness to carry on and stick with it, but also the capacity to accept this as being an integral element in transcending burnout that would ultimately have some value for the participant despite the personal and emotional discomfort this involved. In many cases participants described the importance of constructing and maintaining an escape hatch that served to inform a feeling of choice that was so important in weathering the storm; they remained because they wanted to, not because they had to. Finally, some participants spoke of burnout as being an unavoidable hazard of the CAT Team working environment, describing their experience of moving past and beyond it as being an ongoing journey that would ebb and flow, but which ultimately had no end in sight.

<table>
<thead>
<tr>
<th>Transcending Burnout through Weathering the Storm</th>
<th>Hanging in there and enduring through a slow and difficult road of gradual improvement.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Remaining patient and learning to accept what they were experiencing as part of wider CAT team practice.</td>
<td>Keeping an escape hatch available if needed to the world outside provided strength in hanging in there.</td>
</tr>
</tbody>
</table>

[4] Transcending Burnout through Making Sense of the Personal Non-Sense and Re-Finding Clinical Meaning involved participants developing an increasing sense of intrapersonal understanding of the nature and characteristics of the situation they found themselves in. This involved examining and making sense of their greater intrapersonal understanding included an increased sense of awareness, better emotional tolerance and self-checking.

<table>
<thead>
<tr>
<th>Transcending Burnout through Making Sense of the Personal Non-Sense and Re-Finding Clinical Meaning</th>
<th>Greater intrapersonal understanding included an increased sense of awareness, better emotional tolerance and self-checking.</th>
</tr>
</thead>
</table>
abilities and limitations as clinicians in light of
the impact that feeling burnt-out had had upon
them. By reflecting upon the changes they had
experienced in their various roles, responsibilities
and expectations (coming both from within and
without) of their working environment and
‘reconstructing’ these elements in a way that
make sense for the individual they were able to
again find a way to understand their experiences.
In accomplishing this difficult and at times
uncomfortable process the participants described
being able to reconnect with their sense of
clinical meaning and again make sense for
themselves of the value of their clinical practice.

| A: 41, 42. |
| B: 38. |
| E: 13. |
| F: 22, 23, 30, 41. |
| G: 52. |
| J: 20. |
| K: 17, 18. |
| L: 24. |

Accepting their capacity and limitations
as clinicians and as individuals was
necessary.

| G: 48. |
| H: 31, 38, 40. |
| I: 5, 14, 15. |
| J: 18, 25. |
| L: 17, 20, 21, 37. |

It was important to ‘reconstruct’
experiences and roles as CAT Team
nurses in a way that made greater sense
for them.

| B: 31, 37, 41, 44, 45. |
| C: 34. |
| D: 8, 9. |
| E: 9. |
| F: 30. |
| G: 51. |
| H: 5. |
| I: 5, 17, 18. |
| L: 32. |

Re-making sense of the non-sense meant
feeling interested and reconnecting with
clinical meaning over a sense of clinical
pointlessness.

| A: 18, 36, 38. |
| B: 13, 14, 17, 19, 20, 21, 22, 23, 24, 25, 35, 46, 47, 48. |
| D: 11, 42. |
| E: 2. |
| H: 7, 27, 30. |
| I: 23. |
| J: 16. |
| K: 3. |
| L: 10, 14, 15, 16, 28. |
**Transcending Burnout through Regaining Balance and Lost Control**

Regaining control involved participants firstly being able to recognise and understand when they felt that they had a poor sense of control and balance. It involved being able to rationalise and organise their interpretation of their surroundings in order to allow the participants to start to make decisions about the scope and limitations of their practice. Once accomplished, this new sense of intrapersonal clarity and awareness lead to the individual being able to assume this newly regained control in practical behaviours that had the resultant effect of returning their life to a more balanced state where they no longer feel burnt out.

Regaining control included disengaging from feeling stressed and overwhelmed to feeling more organised, structured and positive in their practice.

Regaining control required acknowledging the things that couldn’t be controlled.

Sometimes assistance from others was necessary in regaining a sense of control.

Regaining control in reality required making specific, pragmatic changes in the real world of their practice.

Regaining lost control in a broader sense involved a better sense of balance between their professional and personal lives.
### Transcending Burnout through Connection with the World Outside

In this category, participants were able to understand and appreciate the role that their life outside of work played as a counter-weight to the hardship of burnout. The presence of a strong social network to provide opportunities for simple enjoyment whilst time spent with close trusted family members allowed participants to unload their negative emotions with the support of an understanding listener. At other times the participant’s world outside offered opportunities for activities that provided simple distraction and the chance to think about something else. Finally, for many of the participants self-caring and self-soothing activities allowed them to engage in feeling happy and relaxed in their experience.

- Increased consciousness of the importance of using their life outside work was a catalyst in transcending burnout.
- Effective use of external family and social networks was important in challenging the negative aspects of burnout in enabling transcendence.
- An active life outside of work served as a welcome distraction or a source of simple pleasure and self-care.

### Transcending Burnout through Rebuilding the Boundaries / Setting and Affirming Realistic Expectations

This category involved participants being able to repair and rebuild their intrapersonal and interpersonal boundaries based upon a foundation of realistic self-expectation. It required that they were able to consider and accept the limits of their own practice within the broader working environment, separating the idea from the actual and accepting the

- It was important to rebuild a sense of the psychological interpersonal boundary between nurse and consumer expectation.
- Accepting the limits of their own practice setting and separating the idea from the actual informed better practice.
practical limitations that this entailed. This also involved setting limits on themselves, not taking on more than they could handle and being willing to disseminate the responsibility for consumer care outcomes with colleagues. Transcending burnout in this way also meant ensuring the boundary between work life and home / personal life was kept in good repair to ensure that the division between the two domains was maintained.

Revisiting and re-establishing an effective work life / personal life boundary required active attention and effort.

Transcending burnout was seen as being a temporary state of affairs on a backdrop of an ongoing struggle against burnout.

Transcending burnout could be a positive experience that had provided an opportunity to evolve and grow as a person.

Moving on meant being able to re-find and appreciate their own full emotional range as their ‘normal’ state of being rather than having mostly negative expectations and boundaries.

[8] Transcending Burnout as the Road Goes Ever On involved the participant’s idea that whilst they been able to move beyond their recent experience of burnout further episodes may emerge for them in the future. This reflected an acknowledgement of the highly challenging nature of working in the CAT Team environment, though this was accompanied with a clear sense of calm acceptance rather than the resistance that had accompanied the earlier episode. Participants described a clear sense of growth and broader understanding of themselves and their feelings related to transcending. Out of the discomfort and suffering of burnout they had been able to re-find aspects of themselves previously thought lost as well as developing new strengths and resources that they could identify as being important for their working lives in the future. This was the rainbow at the end of the storm.
Step six: Formulation and description of the essential structure of the phenomenon.

The sixth and penultimate step of the analysis process (Colaizzi, 1978) involved the researcher developing a concise, detailed description of the essential structure of the phenomenon of transcending burnout. Whereas the exhaustive description was quite expansive and unrestrained in its formulation the essential structure constituted a focused, critical description of the ‘bare bones’ of the phenomenon, limited to only those elements and characteristics that were absolutely crucial in describing it. In doing this the researcher considered the fundamental nature and meaning of the participant’s experience of
transcending burnout order to capture their description within the description of essential structure of the phenomenon. This was developed initially as a written description and then was later extended to include a diagrammatic representation of the essential structure of the phenomenon.

**Step seven: Returning to the participants to validate the findings.**

The seventh and final step of the analysis process (Colaizzi, 1978) involved the researcher organising a follow-up contact with the participants to review the essential structure (in both written and diagrammatical form) of the phenomenon developed in the sixth stage of the analysis. This step was essential in validating the fundamental structure of the phenomenon, ensuring that the essence of their intended meaning in describing the phenomenon was encapsulated in the description. Overall the participants reported that the essential structure was an accurate and faithful representation of their experiences, with feedback received being noted and utilised to refine the final revisions to this document.

**Ethical Issues and Considerations**

The importance of ethical practice in any form of research is acknowledged without question, as the safety and well-being of the participants must never be threatened or jeopardized in any way. This is particularly relevant to nursing research, as nurses by way of their very profession have a duty of care to advocate for the well-being of people. Therefore, in keeping with this notion ethical nursing researchers must “guarantee that no harm was done to any person involved in the research process. They also guarantee the validity of the research findings so that those clinicians who apply those findings to client
care can have confidence in them” (Taylor, et al., 2006, p. 99). For the purposes of this study the ethical considerations are quite clear; the participants were asked to take part in a study that asked them to discuss highly personal questions. In addition, the themes generated could be used by other practitioners to formulate management interventions that could ultimately be applied to other nurses.

According to Schneider et al., (2007) there are five core principles identified in the Universal Declaration on Bioethics and Human Rights (19 October 2005) adopted by the United Nations Educational, Scientific and Cultural Organisation (UNESCO) that must be maintained and respected at all times (p. 83). These core principles are as follows:

- Respect for autonomy and individual responsibility (informed consent)
- Respect for privacy, anonymity and confidentiality
- Respect for justice, beneficence
- Respect for human vulnerability and personal integrity
- Respect for cultural diversity

It is therefore important for a research proposal to address the ethical implications associated with each of these human rights.

Respect for autonomy and individual responsibility (informed consent).

The respect for a person’s autonomy “acknowledges their right to hold views and make choices based on personal values and beliefs and acknowledges that they are capable of deciding what happens to them” (Schneider, et al., 2007, p. 83). In the case of this study
this core principle was respected and was not violated in any way because recruitment into the study was entirely voluntary relying solely upon the potential participants own interest to be involved. Threats to the participant’s autonomy may occur in the form of “coercion, covert data collection and deception” (Schneider, et al., 2007, p. 85). There was no risk of coercion during this study, as it did not involve any overt threat of harm or excessive reward evident in recruitment or retention of the participants. There was no covert information collection involved in the study as all information came directly from the participants and was reviewed by them following transcription. Finally there was no chance of deception as each prospective participant was provided with both a verbal and written description of the study’s purpose and their level of involvement and was required to sign an informed consent form prior to being involved in the study (See Appendix D). In order to obtain informed consent potential participants were given information on the form and purpose of the study via the Plain Language Statement (See Appendix C) as well as the researcher making himself available to answer any questions the potential participant may have. Only when the study had been fully explained and the potential participant was happy to voluntarily sign the form was the interview process commenced.

**Respect for privacy, anonymity and confidentiality.**

Respect for a person’s confidentiality and anonymity requires that a person’s identity and the information that they provide remain private and not be divulged to any person who is not authorised to have access to it; “Ethically, respecting a person’s privacy in research involves protecting their anonymity and keeping their information confidential” (Schneider, 2007, p. 86). In the case of this study confidentiality was addressed by the fact that no information was released by this researcher without the participant’s permission
and that all records were treated as confidential and could only be accessed by this researcher (Mr Alistair Ross) and his supervisors (Associate Professor Phillip Maude & Associate Professor Anthony Welch). The right to anonymity requires that there is no link between the participant and the information that they provided (Burns & Grove, 2007). In this study this was achieved through the fact that each participant’s identity was replaced with an identifying letter (A to L as was required) which was assigned randomly. Only the researcher (Mr Ross) and his supervisors (Associate Professor Phillip Maude & Associate Professor Welch) had access to the identity of each participant and their ascribed letter identity to allow cross-referencing as is required by the methodology of the study. The video recordings of the interviews will be destroyed once the study has been completed. The transcripts of the interviews will be stored at RMIT in a cupboard under lock and key for 5 years after completion of this study as per RMIT University Policy.

**Respect for justice and beneficence.**

The “ethical principle of justice requires fairness in dealing with others” (Schneider, 2007, p. 87) and in the case of research relates primarily to the fair selection of the participants. In terms of this study this was not particularly relevant as there was no bias or inequity in the process of selecting participants: the researcher included all potential participants who met the inclusion criteria for this study, and all participants in the study were asked to participate in the same process thus allowing the researcher to collect the data.

The “ethical principle of beneficence involves doing good, as well as preventing and removing potential harms” (Schneider, 2007, p. 88), requiring that the researcher must not
violate the participant’s right to be protected from harm through their participation in the research. This core principle was respected through the fact that the perceived risk of harm through involvement in the study was low, as the participants were recruited into the study by their own (voluntary) choice and were involved in discussing pre-existing issues and experiences of their normal working life. Furthermore, the participants were experienced mental health nurses all of whom were considered to possess considerable experience in therapeutic communication by virtue of their employment. Therefore it was understood that they would be sufficiently skilled in the practice of interpersonal communication to discuss the phenomenon in question without an adverse impact upon their psychological health.

**Respect for human vulnerability and personal integrity.**

This core principle acknowledges the fact that “some groups of people are more susceptible to physical or psychological hurt or injury and are said to be vulnerable” (Schneider, 2007, p. 88). In terms of this study this was not particularly relevant, as the participants that were recruited into the study were not considered to be from a vulnerable population. In paying respect to the participant’s personal integrity, the researcher ensured that all participants were treated in a respectful courteous and appreciative manner that paid attention to their humanness, and treated them well (Schneider, 2007, p. 89).

**Respect for cultural diversity.**

This core principle acknowledges the fact that “individuals are also members of various groups that inform their sense of identity and values. The cultural nature of these
groups is not restricted to ethnicity, but may also include sexual orientation, religious affiliation, employment status, disability and age” (Schneider, 2007, p. 90). In the case of this study the only significant cultural consideration for the participant group was that they were all mental health nurses working on CAT and ECAT Teams about which the researcher was well qualified to be mindful given his own membership in this cultural group.

Rigour of the Study

The issues surrounding validity, trustworthiness and rigour in qualitative nursing research have existed largely unresolved for at least a quarter of a century (Rolfe, 2006, p. 304). According to Chapple and Rogers (1998) (cited in Whitehead 2004) “Qualitative research continues to be regarded by some as a ‘soft option’ lacking scientific rigour and open to possible bias or fraud” (p. 512). This notion has led to the development by numerous social scientists of a multitude of checklists, guidelines, and other protocols in an effort to meet the perceived demand for qualitative research to be scientifically rigorous, and in doing so “remain tied to the apron strings of quantitative method … adopting procedures used by quantitative researchers without considering the appropriateness of their purpose, rationale, or underlying assumptions” (Chapple & Rogers, 1998, p. 557). Sandelowski and Borroso (2002) have similarly observed:

Scholars across the practice and social science disciplines have sought to define what a good, valid, and/or trustworthy qualitative study is, to chart the history of and to categorise efforts to accomplish such a definition, and to describe and codify techniques for both ensuring and recognizing good studies… after all this effort, we
seem to be no closer to establishing a consensus on quality criteria, or even on whether it is appropriate to try to establish such a consensus. (p. 2)

With regards to the development of rigour specifically within the phenomenological method, Rolfe (2006) states that “Husserlian phenomenology is now an established and well respected methodology in nursing research” (p. 307) whilst Powers and Knapp (cited in Rolfe, 2006) describe the “phenomenological methods of data analysis such as those offered by Colaizzi and Giorgi as consistent “with views of what constitutes a scientific approach in the natural and social sciences” (p. 307). This clearly supports the scientific validity and trustworthiness of Colaizzi’s (1978) method for data analysis, however Powers and Knapp (cited in Rolfe, 2006) go on to describe these methods as “a slavish approach to prescribed techniques [which] compromises individuals’ imaginative, interpretive styles” (p. 307) again highlighting the dichotomy facing phenomenological researchers in addressing the issues of rigour.

Nonetheless, “the issue of rigour is one that was given particular consideration by the researcher as “the issue of rigour in qualitative research is important to the practice of good science” (Streubert-Speziale & Rinaldi-Carpenter, 2007, p. 97). Essentially the principle aim of rigour in qualitative research is to “accurately represent what those who have been studied experience” (Streubert and Rinaldi-Carpenter, 1995, p. 25), and in doing so, ensure the trustworthiness of the research.

Holloway and Wheeler (2010) have outlined and discussed a comprehensive description of Guba and Lincoln’s (1985) general framework that identified the concepts of credibility, transferability, dependability and confirmability in achieving trustworthiness, a term used
to mean “methodological soundness and adequacy” (Holloway & Wheeler, 2010, p. 302). The researcher utilised these concepts along with the concept of auditability as outlined by Streubert-Speziale and Rinaldi-Carpenter (2011) to examine and address the issues of rigour in this study as is discussed below.

**Credibility.**

In order for the study to clearly establish credibility it is crucial that the researcher “must ensure that those participating in research are identified and described accurately” (Holloway et al., 2010, p. 198). In the case of this study, the researcher and participant worked together to generate a brief, descriptive outline of who that person was and how it was that they came to be in the environment wherein they were exposed to the experience of the phenomenon under investigation. This background information, often referred to as the participants ‘story’, was referred to in Chapter Six and included in greater detail as Appendix B, as a precursor to the discussion of the study’s findings.

According to Holloway and Wheeler (2011), another element that adds to the researcher establishing credibility is for the researcher to personally engage in involvement with the environment, culture, or phenomenon under investigation; “credibility is enhanced when researchers describe and interpret their experience” (Koch, 1994, p. 977). In the case of this study the researcher was working on a ECAT Team through the majority of the time spent undertaking the study, and had chosen to investigate the phenomenon in question due to his observations of its occurrence in his working environment at the time. This also served to establish “prolonged involvement” in the specific cultural environment of CAT and ECAT Teams, which fulfils the suggestion that the participants can only be “clearly
understood when researchers have invested enough time in the setting” (Holloway et al., 1997, p. 164).

Another strategy that contributes to credibility is the regular review of the researcher’s analysis and conclusions by experienced supervisors. This concept of ‘peer review’, as described by Holloway and Wheeler (1997) suggests that: “(i) supervisors who have the skills for the particular research approach are necessary and (ii) higher degrees students need to meet regularly during the research process with their designated supervisor, to ensure rigour” (Holloway & Wheeler, 1997, p. 165). For this study regular review by the researcher’s supervisors, all highly respected academics with a background in phenomenological research, assisted at all stages of the study’s development and application to ensure credibility.

Finally, clearly outlining the guidelines of the methodology to be used, and then closely adhering to them at all times during the project assists in promoting credibility. In the case of this study the researcher chose to utilise the seven steps of data analysis as outlined by Colaizzi (1978), a proven and widely accepted methodology. For the researcher this meant following each of the steps closely, along with frequent reference to Colaizzi’s (1978) work to ensure it remained fresh in the researchers mind. It also involved being very mindful of the fact that the participant transcripts informed the emergent themes accurately, a process, which involved constant reviewing, and ultimately, taking the outcomes of the thematic analysis back to the participants themselves to ensure the analysis was indeed genuinely reflective of their experiences (as discussed earlier in this chapter).
**Dependability.**

Dependability is the second criteria necessary for establishing the trustworthiness in qualitative research. It is seen to replace reliability (Munhall, 2012) and refers to fact that “if the findings of a study are to be dependable, they should be consistent and accurate” (Holloway & Wheeler, 2010, p. 303). Streubert and Rinaldi-Carpenter (1995) state “dependability is met through securing credibility of the findings” (p. 314) which has been discussed in the previous section, whilst Munhall (2012) also states that it refers to “consistency” (p. 518) along with the stability of information over time (Taylor, Kermode & Roberts, 2007).

In order to achieve dependability in this study the researcher closely adhered to the philosophical underpinnings and research process to ensure that the research findings would remain consistent over time. In keeping with Holloway and Wheeler’s (2007) suggestion that “an audit trail is necessary” (p. 303) the researcher’s supervisor (who is experienced in the methodology employed in order to be able to provide meaningful supervision), was involved at each stage of the project’s development and application to examine its dependability.

**Transferability.**

Transferability refers to “the probability that the research findings have meaning to others in similar situations” (Streubert-Speziale & Rinaldi-Carpenter, 2011, p. 49). According to Holloway and Wheeler (2010) this can be achieved through “ensuring that the decision trail of the research is clear and comprehensive enough… a full account of the
theoretical framework is given” (Holloway & Wheeler, 1997, p. 167), as this allows others to access the research and through examination of the theoretical framework determine for themselves whether the situations described may be applied to other settings. To this effect, the phenomenological methodology used by this researcher was clearly outlined by him including discussion of the stages of participant selection, participant access, information (data) collection, and analysis, as well as all relevant ethical considerations in this and earlier chapters within the thesis. Furthermore, the rationale behind the decisions made by the researcher, were also clearly outlined to allow clear access by any who may access the research in the future. In doing this, the researcher has made the ‘decision trail’ explicitly clear, and in doing so ensures the study is considered transferable.

**Confirmability.**

Confirmability refers to “a neutral criterion for measuring the trustworthiness of qualitative research. If a study demonstrates credibility, auditability, and fittingness, the study is also said to possess confirmability” (Streubert and Rinaldi-Carpenter, 1995, p. 314). In the case of this study confirmability was achieved as credibility, auditability, transferability, and dependability were established, as “the data are linked to their sources for the reader to establish that the conclusions and interpretations arise directly from them” (Holloway & Wheeler, 2010, p. 201).

**Auditability.**

Auditability refers to the capacity of a study to be repeated by another following the process outlined in the original study and reaching the same conclusions. Research is
considered “auditable if readers or other researchers are able to follow the methodological process of the first researcher” (Holloway & Wheeler, 2010, p. 337). In the case of this study auditability was attained through a number of strategies:

- Strict adherence to the methodological steps and processes set out by the method ensured that the research processes could be easily followed.
- The generation of the results was completed following Colaizzi’s steps faithfully, ensuring that the results of the analysis were congruent with the significant statements drawn from the participant interviews.
- The research was completed with the input and guidance of the PhD supervisors, who were experienced in the methodology employed (in order to be able to provide meaningful supervision). The researchers supervisors were involved at each stage of the project’s development and application to provide guidance and feedback. This provided an immediate point of review in ensuring that the researchers process resonated for others.

**Summary of the Chapter**

This chapter has provided an exploration of the research process from the researcher’s perspective, clarifying the focus of the study through the delineation of the research question, and has examined the process of participant recruitment and data collection. The method of data analysis set out by Colaizzi (1978) has been identified as the foundation for the study, with the seven steps of Colaizzi’s (1978) method described and explored in detail as they applied to the data collection process within this study. The chapter went on to discuss the ethical issues and considerations, and concluded with an
examination of the issue of rigor as it applied to the study. The findings of the study as revealed through thematic analysis will be presented and discussed in Chapter Six.
Chapter Six

Study Findings: The Participants Lived Experience of Transcending Burnout

This chapter presents the study findings as they are reflected in stages four to six of Colaizzi’s (1978) data analysis process. In keeping with the requirements of the fourth stage the nine themes are presented and discussed in terms of their formulated meanings (Colaizzi, 1978) accompanied by supporting excerpts from the participant’s interview transcripts. The experience of transcending burnout as described by each of the participants is presented through exploration of these significant statements from each of their interviews. The chapter then goes on to provide a crisp and reflective exploration of each of the participant’s descriptions of their experience of transcending burnout through the development of key themes before going on to provide a comprehensive description of transcending burnout as described by the participants in the study (Colaizzi’s 5th stage of analysis). Finally, in meeting the expectations of Colaizzi’s sixth stage, the researcher presents the exhaustive description of the investigated phenomenon as an unequivocal statement of the fundamental structure (commonly referred to as the essential structure of the phenomenon) providing an explicit and unambiguous description of the phenomenon under investigation.

Overview of the Participants

The participant group comprised 12 nurses from various CAT Team services working within the Melbourne metropolitan area. All reported having working within both CAT Team and ECAT Team settings (as is the norm with most CAT Team services). Ten of the participants were female and two were male. There was a wide range in the length of experiences of the participants from less than two years to over fifteen years. All
participants considered their role as CAT Team / ECAT Team nurses to be important and all displayed a strong sense of pride in, and commitment to their work. All of the participants had described experiencing a period of burnout in their CAT Team practice leading to the experience of coming to terms with this and overcoming, or moving through and past feeling burnt-out whilst continuing to practice in CAT Team nursing roles. (For a more detailed description of the participants please refer to Appendix B). All of the participants met the inclusion and exclusion criteria outlined in Chapter Four.

**The Emergent Themes**

In keeping with Colaizzi’s (1978) data analysis process as outlined in the previous chapter, the fourth stage of the analysis process was to identify and explicate all aggregate formulated meanings into theme clusters. Nine emergent themes were explicated:

(One) Personal Strength: Grim Determination, Pragmatism and Optimism.

(Two) Reaching for Support.

(Three) Weathering the Storm.

(Four) Making Sense of the Personal Non-Sense and Re-Finding Clinical Meaning.

(Five) Regaining Balance and Lost Control.

(Six) Transcending through Connection with the World Outside.

(Seven) Rebuilding the Boundaries and Affirming Realistic Expectations.

(Eight) Transcending Burnout as the Road Goes Ever On.

(Nine) Increasing Confidence in Credibility.
Theme One: Personal strength: grim determination, pragmatism and optimism.

For a number of the participants in the study the experience of transcending burnout required them to draw on personal strengths and hold on with grim determination, to take a pragmatic stance and be optimistic. Participant A described drawing on personal strength as a type of gritty determination leading to a refusal to allow the situation to overwhelm her:

A4: The way that I worked through it was my natural nature, was to stick things out cause I’m not one to go into something and then go ‘blow you, I’m out of here’ … [A12] the first thing [that] came was my personality, sticking it out, because that[s] what I do, I don’t give in.

This notion of a tenacious refusal to be ‘beaten’ by the experience of burnout was pivotal to transcending as described by Participant C who stated:

C37: There was a bit of anger at the CATT role … I couldn’t just leave the CAT Team, I could not leave in that situation, I couldn’t just leave because for me then it would be ‘well they’ve just beat it out of me and I’ve had to go’ … [C39] I needed to win … I don’t know who against … but I needed to win, um, it gave me the motivation, it gave me the strength, it gave me the drive, um, I could not give into this, I could not leave under these circumstances.

Participant J described the importance of having a well-developed and resilient sense of self-confidence underpinning her actions that she felt was essential in combating the experience of burnout:
**J9:** If you don’t have those internal resources to be confident in your own clinical judgment and skills, you know even if it is a political thing or a process thing, if you don’t have the confidence to challenge people on that … you’ve got to be able to carry that off and if you can’t… then you are going to burnout.

In the case of Participant E, her sense of determination had less of a combative quality, reflecting instead a more measured, quiet quality drawn from her core beliefs about persistence as a person. For her, determination was related to staying faithful to her beliefs and principles which was reflected in her description of the experience of transcending burnout:

**E22:** For me, part of it comes down to bettering myself, but also feeling useful, feeling that I contribute, and I guess it comes down to your own personal drives and motivations I guess, but for me I always had it instilled by my father and my parents, you work hard and you have a good work ethic, and you show up and you’re there to do a job, and you’re there to do it by the best of your ability.

By contrast, some of the participants drew upon the more positive aspects of their personalities to underpin their process of transcending burnout. For Participants A, I and J, humour, optimism and pragmatism were the qualities that they relied upon:

**A25:** I just laughed but it was stressful, I had to deal with it and prioritise it but I just laughed.
I6: I suppose if you look at it generally ... I could be very pragmatic about it; I think that’s how I am; a pragmatist generally; and I’m an optimist as well ... a personality characteristic sort of thing; that helps as well.

J11: You’ve always got to keep your sense of humour; if you don’t laugh about it you’d cry.

The quality of pragmatism described above by participant I was also reflected in Participant D and G’s description. In each instance the tendency to allow practical considerations to have a strong influence on the individual’s actions provided a steadying influence:

D14: For the moment I’ve moved through that burnout and I’m staying where I’m at now because it’s ... well it pays well, my job pays well ... and I’m not in a position to, to look at an alternative career, so I still hang on to what I like about the job.

G5: What I try and look at is that, okay this is part of the job, this is not going to be something new, then you need to get a grip, you need to deal with it and just do your job because it’s not going to change.

For other participants it was personal qualities that they had developed through their previous experiences in life that now informed their thoughts and actions. Participants A and I both described their strong personal sense of their broader life achievements as being important in transcending burnout:

A32: You have to work hard to remind yourself I’ve worked hard... I’ve done this, I’ve done that ... [A33] I have to keep reminding myself, that’s how I got through that angry phase.
I23: I suppose by all my whole life, fortunately, other experiences aren’t always being a psych nurse; before that I was in lots of other roles being lots of other things and I think all those things I can draw on now, sometimes I think ‘well yeah you done that, so you can do this, this is nothing’.

In the case of Participant L, the decision to endure and not to give up in the face of her experience of burnout was motivated by a deeper, life-long desire to remain true to the type of person that she wanted to be:

L25: It really made me question how I want to be at the end of my life. I don’t want to be a sour, burnt-out, dried out prune, one of these crabby old women who can’t even relate to people; that was my biggest fear, so I think that’s really motivated to me to stand my ground and keep on the pathway that I’m going.

In keeping with step five of Colaizzi’s (1978) methodology, the theme of ‘Personal Strength: Grim Determination, Pragmatism and Optimism’ has been included in the formulation of the exhaustive description, included in the penultimate section of the chapter.

**Theme Two: Reaching for support.**

For the majority of the participants in the study, the experience of transcending burnout involved reaching out to gain support from others around them. Stemming from the sense of having been isolated by their experience of burnout, participants looked to others to provide emotional and practical assistance where needed:
Participant A described her experience of reaching out to her colleagues on the CAT Team for practical ‘front line’ support when coping with feeling burnt-out:

A5: *Part of that was seeking some support from somewhere, which is usually a collegial support … [A26] it does make a huge difference of that experience of burnout … the person that you work with.*

The value of reaching for and receiving support through conversation and direct interaction with immediate colleagues on the CAT Team was echoed by Participants D and E who also described the important role this had in their experience:

D7: *I think also having my colleagues share their feelings [about coping with the experience of burnout], probably because I force them into discussions about it all the time, but it’s just nice also to know that other people … other people are in my position.*

E7: *The thing that got me through that [burnout experiences related to a difficult clinical situation] was the support of colleagues yeah people were just willing to, assist … to relieve that stress was really about knowing that people were there to help out, people were there to support.*

In both cases the fact that their fellow CAT Team members knew first-hand the perils and challenges associated with the job and had shared in the experience of CAT Team nursing was seen by the participants to be a particularly important factor. It meant that the support offered was ‘insider support’ from one who understood what is was to be a CAT Team nurse and as such possessed a stronger sense of authenticity and relevance for the participants.
For Participants B and C, support from their colleagues served to provide validation for their feelings leading to improvement in self-belief and self-confidence:

*B28. The actual [CAT] team itself... gave me that ability to sort of think, ‘I can do this, I will go back and try again’.*

*C11: My colleagues also would ring and visit; they almost gave me permission to be away from work, which was important because we all get that guilt when we’re not at work [but] on sick leave... that was very helpful as well.*

In the case of other participants in the study, reaching for support meant looking outside of their CAT Team colleagues. In the case of Participant H, this stemmed from the belief that sharing her experience of burnout with her CAT Team colleagues would result in her being criticised or looked down upon:

*H9: I need to be able to express what’s happening for me in a safe environment ... often you don’t feel comfortable talking to your work colleagues about it because you don’t want to seem weak, you don’t want to seem like you haven’t got it sorted ... it allowed stuff to be presented to me in a different way and the suggestion that I might have been burnt-out, raised in a safe place, whereas if your colleagues raise it, you sort of, think you’re having a go.*

Participant H went on to describe quite clearly the opportunities provided by undertaking supervision, as it allowed her to challenge her negative fears about her practice as well providing her with an environment where she could accept that she had become burnt-out:
H10: It was really valuable to me, having a good supervisor; at one stage I was seeing her weekly I think ... was invaluable ... it really helped... ... I lost a lot of confidence, and felt I couldn’t do what I had to do to do my job ... always trying to cover my tracks all the time ... it was all getting out of control, and I think the supervision validated that I was actually doing a good job and ... that it’s okay to go through these periods of time.

For Participant F supervision offered a separate environment where all other issues could be laid aside and the focus of conversation could be solely hers:

F4: I think for me the most effective way I kind of dealt with my burnout was; as ‘wankey’ as it sounds, through supervision; though taking my experience to an external, objective source and having an environment that was purely there to support me ... [F6] so for me supervision was fortnightly, or maybe even weekly at times depending on how much I was carrying and how able I was to carry it ... at times that felt more like therapy than supervision, yeah that happened.

Participant L also spoke very clearly about the importance of supervision as a tool for managing work-place stress and as a place to safely address issues associated with her experience of burnout that she had never discussed before:

L29: I’ve started getting supervision internally and that’s been a life changing experience for me ... talking about the traumas, the accumulative trauma, for the first time in my whole career at work, that was life changing because I spoke about things I have never even spoken about before... [L34] It was just the support and the compassion that he showed [her
supervision provider], the understanding and the sharing … it was about having that space to talk about myself.

Participants also described reaching for more informal support outside of their colleagues in the CAT Team, though this support was often sought from individuals who had some understanding of the specific details of CAT Team or broader mental health nursing practice. In this more informal type of interaction participants were able to gain support from other mental health ‘aware’ clinicians that related less to the specifics of their daily nursing practice but maintained the broader understanding and insight relevant to the role in general. Participant G described the value of using friends who had mental health nursing experience as an informal support network:

G11: The transcendence for me is … all my friends are actually in psych in some way shape or form, so it’s always good to have a few days out with them drinking red wine, and just bitching and moaning and that seems to work for me.

Participant J echoed the same sentiment, describing in more detail the various functions her friends fulfill in supporting her in transcending burnout:

J6: The informal stuff … when you catch up with nursing girlfriends they always end up to a conversation and if there’s anything stressful; and at the time if I’m worried about anything clinically at the time there’s always someone to talk to … [J12] so it’s having people that can keep you grounded that you know … people that will tell you; you know if you’re beating yourself up about something people remind you, kind of where you stand normally, … they keep you grounded, they keep you sensible, they also remind me that there is hope.
In keeping with step five of Colaizzi’s (1978) methodology, the theme of ‘Reaching for Support’ has been included in the formulation of the exhaustive description, included in the penultimate section of the chapter.

**Theme Three: Weathering the storm.**

For many of the participants, the experience of transcending burnout involved having to weather the storm of adversity, discomfort and uncertainty. This reflected a need to push on and continue to practice through adversity with the sense that this was the pathway towards transcending burnout. Participant C described her experience of having to ‘hang in there’ and endure the experience of burnout while all the time knowing that it was gradually changing and improving, though a slow and difficult road:

_C13: It moved, it was a moving stage initially had very bad days and a couple of good days and it sort of slowly balanced out and then it became more good days than bad days, but that took some time._

Having to persist and carry on whilst practicing day-to-day as a CAT Team nurse, was also described by Participants A and B:

_A6: The second part was, giving it time, and I’m old enough to know that if you give things time... you get used to it ... [A11] it was about re-establishing myself._

_B39. I suppose part of the experience is knowing that it has happened; there is the potential for it to happen again in the job that we do, and it’s about I suppose being aware of the cues_
and the signs that things maybe leading in that direction, and stopping them before they happen … following through on some of the things that we’ve passed on.

For a number of the participants weathering the storm involved being able to accept what was happening, which was in itself a fundamental aspect of the experience. Participants A and G both clearly articulated how this was for them:

A28: But then in the end I couldn’t stay angry, because you can’t so I thought well, I kind of accepted that … [A35] once I got past that [the anger and self-doubt] I got to the acceptance phase.

G14: For me I accept that it’s [burnout] going to happen for periods, when things get worse.

G46: The period of transcending … I just know it’s done and it’s over … maybe it would be acceptance, maybe as a feeling; I just feel a sense of acceptance; well this is how it is and just move on, you know just accept.

In the case of other participants in the study, weathering the storm involved maintaining an ‘escape raft’ should they feel that they had reached a point where they could no longer cope and chose to ‘abandon ship’. Knowing that they had this option available to them was important as it allowed participants to feel that they had a choice rather than feeling trapped, as described by Participant A:

A13: I thought well I don’t have to be here in six months … [A65] That’s still my attitude largely, it’s kind of still there; I don’t have to do this, I mean it’s a job … and I’ll do it and
be professional and do it at the standard that I think it needs to be, but I don’t have to do it cause I can do a whole heap of other things.

Participant D shared similar thoughts about the importance of not feeling trapped, expanding this idea to include the concept of feeling like a victim when describing her perception of not having any capacity to change her situation:

D33: I don’t feel trapped now, I’m always… thinking if I get to the point where I feel trapped like I did before I have to be the one to physically change … I don’t want to feel like a victim anymore.

For Participant G, the act of examining and exploring her options outside of CAT Team Nursing offered a sense that there were alternatives to her current situation even though they remained very much theoretical in weathering the storm:

G34: So I go to [a work colleague] and I talk to her ... looked at what options I have to stay or to leave; so it’s really about, yeah, it is identifying what options are available to me.

Participant B also explored how having the capacity to remove herself from CAT Team nursing to explore other options in her life (as an alternate path if this one became unbearable) served to help her move forward in her experience of burnout as a CAT Team nurse. This exploration helped her move from feeling disengaged and on the periphery to feeling reconnected with the role and her practice:
B33. It was that whole process of I suppose, sitting down and re-looking at your choices in life, and that fact that I had multiple choices at the time, and didn’t have anything to do … it didn’t have to have anything to do with the healthcare system, that I suppose redirected me back into it.

A number of participants also spoke about their experience of transcending burnout as being an ongoing process. They expressed the notion that the fundamental nature of the CAT Team nurse role remained an ongoing high risk factor in the development of burnout. Participant B, in reflecting on this suggested that as far as she was concerned becoming burnt-out in this working environment was an inevitable feature of the working landscape:

B1. My thoughts are that most people who work in psychiatry for a long enough period will experience burnout at one time or another, and especially if you work in the acute setting, such as CATT or ECATT, its more likely to happen because of the stress that you place yourself … [B2] I think if you continue to work in this job you will experience it [burnout], and you will work through it.

Participant K expressed similar sentiments in describing the view that burnout and subsequently transcending burnout was an ongoing cycle in her career as a CAT Team nurse:

K30: The transcending burnout to me; there’s a picture for me about little episodes; I’m not sure it could be one long episode over your career.
In keeping with step five of Colaizzi’s (1978) methodology, the theme of ‘Weathering the Storm’ has been included in the formulation of the exhaustive description, included in the penultimate section of the chapter.

**Theme Four: Making sense of the personal non-sense and re-finding clinical meaning.**

For many of the participants in the study, the experience of transcending burnout involved a process of coming to terms with their confusing and overwhelming experience of burnout, and being able to make sense of the experience itself. In doing this, these participants described being able to ‘reclaim’ their sense of purpose and meaning that they attached to their clinical practice. Participant A described this as an increased sense of insight and purpose that came from having developed a clearer sense of what she was going through:

*B21: I suppose that understanding, that there are great aspects in this job, that made me realise that I could work through this, or that I had worked through it realistically because I wanted to.  

This theme of increased intrapersonal understanding as a key element reflected an increased sense of awareness, and comfort with the emotional aspect of the experience whilst also being more tolerant and better able to keep a check on oneself through the experience of transcending burnout. This was reflected by Participant A, F and J who stated:
A40: That was one of the big questions … I’m not adjusting well so I have to do something different so that I can; there was that whole reflection process … [A34] I had to keep myself talking, and it was a lot of self-talk.

F27: For me looking at the whole relation of transcending burnout is being aware of my own internal process and where I sit, within that … for me it’s been about building awareness around my own language, or my response, and my tolerance to the language of my colleagues.

J18: It’s always about checking your internal processes, it’s about being comfortable with it, and it’s about if you’ve had a clinical flaw that you avoid that happening again, you make support …[J25] It’s about keeping in check, keeping grounded, keeping balanced, and … checking yourself … it’s all those resources around you that allow you to understand and hear.

In the case of Participants B and G, making sense involved being able to clearly accept the capacity and limitations that they possessed as clinicians:

G52: When I’m at work I get angry, really angry that we’re not doing enough and then when I’m at home by myself can I sit down and say ‘okay, as a person you’ve done the best that you can, and surely God will understand that you’re doing what you can, and you can’t fight powers that you just can’t fight’; so I try and look at it that way, but it’s only when I [transcend burnout] that I can do that.
The pressure’s still the same there’s still multiple people asking you for things all the time, but it’s about, my knowing when to say no, me knowing what it is I need to protect myself… from burnout; whether that be supervision, or whether that be spending weekends down the beach with my dog.

This notion of being able to develop a clearer and more reasonable sense of one’s capacity as an individual was an important element in making sense of the non-sense as described by Participant F:

F41: It’s lighter [transcending]; there is a lightness; the whole burnout feels like a burden; everything is a burden, listening to someone’s experience is a burden; transcending that I lose that sense of burden; it doesn’t feel like I am being put upon, or I’m being asked to give more than I’m capable of; I don’t feel depleted … and I don’t feel like my clients are sucking the life out of me, I’m better able to regulate [the situation].

For Participant B making sense of the non-sense involved considering the various elements that made up her work environment and delineating between those that were a positive influence and those that were a negative influence. In taking this personal inventory Participant B was able to enhance her sense of connection with the positive elements:

B17: Personalities, and politics, which unfortunately in any job plays a role, but if you can remove yourself from those then you actually discover what it is you like about the job, not the things that you don’t like about the job.
This process by which participants engaged in an exploration of their experiences and roles as CAT Team nurses allowed them an increased personal understanding of each of the different elements. They were able to identify and explore the differences in each area leading to increased understanding about the nature of their experiences. This in turn lead them to being able to ‘reconstruct’ the elements in a way that made greater sense for them as described by Participant C:

*C34: I felt like I was able to compartmentalise… I’m doing okay, I’m functioning, no one’s worried about my work; I keep an eye on myself, just take it easy… I was empowered at that point … I knew that there was still stuff that needed to be sorted … I definitely felt, okay.*

This idea was also expressed in a more focused manner by a number of participants who described the importance of being able to make sense of the stress associated with some of the more difficult aspects of clinical decision-making:

*I5: If you talk about transcending, that’s how I transcended; by you know, balancing up… things and balancing up the consequences for those actions and how I reassured myself.*

*G51: I don’t want to make the same mistake … I can reflect, and it’s reflecting nicely with peace and contentment, yeah, it’s completely different.*

For Participant L, this process of making sense of the non-sense also involved the need to better understand the impact that providing care for certain consumers in her professional life had had upon her:
L32: I didn’t realise the impact of certain clients I’d seen, certain experiences, and just really taking the time … it freed me up, it was like a weight lifted off my shoulders, it was like this cement taken out of my soul or something, it made me feel lighter.

Equally, the need to better understand and feel comfortable with personal safety was raised by Participant I who stated:

I17: Developing that part of yourself, that strong part that can reassure you, give you that self-talk; ability to support yourself in those dire situations when you feel shaky, when you feel it’s all caving in on you.

Being able to make sense of the non-sense was also described by Participant E who spoke about the need to step back and take stock when facing overwhelming stress associated with their work situation:

E9: That [potentially dangerous situations] starts the stress levels going up, but how high the stress levels get I guess is; I know for me when they got to high levels that’s when I’d start stewing about work, ruminating and … it was time to have a break and take a step back from things.

Within the experience of making sense of the non-sense, many of the participants described the importance of reconnecting with clinical meaning in their day-to-day mental health nursing practice:
A38: There were a few emotions attached to that ... going home feeling happier, because I've done my job ... I'm happy with that ...

A18: That was probably the most important part, when I had patient contact, that was what I was paid to do; that was what I wanted.

B20. I don’t know if there was an actually specific moment [of transcending burnout], but it was that fact that I actually had passion for doing what I was doing ... [B48] it was about re-finding what it was that I liked in the position to begin with ... what I liked in that chosen career path and focusing on that as opposed to the negatives ... they don’t have to be the main focus.

H27: For me it was trying to find, like trying to get interest; it’s like we always joke about, you know, I’m dying for a first onset ... getting something else to put your teeth into, or getting a project ... something to re-spark the interest and to make it; get that excitement back.

In keeping with step five of Colaizzi’s (1978) methodology, the theme of ‘Making Sense of the Personal Non-Sense and Re-Finding Clinical Meaning’ has been included in the formulation of the exhaustive description, included in the penultimate section of the chapter.

**Theme Five: Regaining balance and lost control.**

Central to each participant’s description of transcending burnout was the notion of regaining lost control. For the participants attempting to regain a sense of control ranged
from disengaging from feeling stressed and overwhelmed to feeling more organised and able to structure and re-engage with managing their practice setting as described by Participant A:

A3. I started to recognise that, feeling, that overwhelming sort of pressure, so there’s that; and that working through it comes down to rationalising it, and then feeling less stressed, feeling like I'm in control

Similar sentiments were echoed by Participants C and D in sharing their experiences of coming to experience and understand their loss of control, along with the subsequent emergence of their desire to regain control:

C23: I did feel really disempowered … it was a strange place to be when you’ve always … you know what you’re doing … part of me wanted that power back … I needed, that back.

D34: I think it’s important to have a voice, to feel you have a voice so you don’t feel like … so you don’t feel like you’re being dictated to and taken advantage of.

The importance of regaining a sense of control of one’s life was also shared by Participants G and I who were strong in their belief about the need for control:

G49: I feel in control; and I think that’s another big thing, I feel in control, in a job, in a place where you cannot have that kind of control ... [I10] That really was quite crucial [to transcending burnout] to that … is that you had that sense of control, because the people that you were dealing with often weren’t in control at all.
For Participant J regaining a sense of balance and control also involved regaining one’s enjoyment along with developing a positive outlook about work and the work place:

J22: It [transcending burnout] is about taking control … it’s about being assertive, it’s about being confidant, it’s about being happy in your clinical practice, it’s about being happy in your work environment and … I guess it is taking the bull by the horns.

For other participants, the need for balance and control was more about setting limits and taking time to disengage and assess their position and limitations in their work situation:

B30: I think it’s about … knowing when to step back, knowing when to say ‘I can’t do this at the moment’, not taking on too much, being able to say ‘no’.

H15: It was about putting limits on myself, about how much I was gonna do; the work /life balance, because that’s what I found when I [was] burning out, that the work/life balance goes pear shaped.

Knowing one’s strengths and weaknesses in setting limitations on oneself was similarly reflected in the importance of setting boundaries in regaining a sense of control and balance in one’s life as expressed by Participant C:

C8: For me really … I knew that my thinking boundaries were just out of whack, I needed someone to take control, I needed someone to tell me what to do.
For Participant J re-establishing control and balance meant coming to terms with accomplishing less than she might have liked whilst at work, for the sake of a sustainable feeling of wellbeing:

J23: So I only achieve what I achieve in my work hours and I’m happy; I am happy with that, at times I think I’d like to do more but then I think I’m probably not prepared to sacrifice time with my kids … is that about taking control [?] …probably.

For a number of the participants the experience of regaining balance and control involved practical changes in their daily pattern of work. In this they described making specific, pragmatic changes that reflected their evolving emotional awareness in the ‘real world’, which ultimately resulted in a greater intrapersonal sense of control:

B29. I have put in those safeguards that some people just don’t do, so I do get supervision now, I do have time out from my job, I’ve changed my hours.

The need for practicality in order to regain balance and lost control in the workplace was echoed by Participant E who stated:

E10: For me … moving through that [burnout] is about, practically tackling the issue [and] about having a good idea of what the problem is and how to move through that…

E6: [Transcending Burnout] … is about trying to resolve whatever the issue is, I guess I’m fairly pro-active in that sense, seeking supervision, or seeking some sort of resolution to whatever the current problem is, but then planning to have a bit of a break as well.
Participant’s J and I also underlined the importance of regaining balance and lost control as being an active process; for her it meant *doing* things differently:

\[ J21: \text{To [transcend burnout] you have to change to get a different outcome, so it’s mixing it up. … [19] If you tried to do all those things that would be overwhelming, so you picked out the things you could achieve and prioritised them … prioritised what I could achieve and made some sense of it that way} \]

The importance of regaining lost control also manifested as needing to regain a sense of balance in their lives at both a professional and personal level as articulated by Participant E in stating:

\[ E4: \text{It was about having that good balance outside of work but also having that good balance inside of work as well.} \]

The significance of reasserting a subjective sense of work / life balance in their experience of transcending burnout was described by Participant F who said:

\[ F43: \text{It’s easier, it’s so much easier … my life is not about work and sleep, my life is about the other things except work and I can give more headspace to socialising and school work and family as opposed to my life is work, sleep, work, work, work, work, sleep.} \]

In keeping with step five of Colaizzi’s (1978) methodology, the theme of ‘Transcending Burnout through Regaining Balance and Lost Control’ has been included in the formulation of the exhaustive description, included in the penultimate section of the chapter.
Theme Six: Transcending through connection with the world outside.

For the majority of the participants in the study, the experience of transcending burnout involved an increased awareness of the importance of their life outside work. As they struggled through the experience of burnout in their work environment many of the participants became increasingly conscious of the need to use their life outside work as a catalyst in transcending burnout.

Participant B described her experience very succinctly, exploring the need to spend time away from work on her own and then with her friends and family:

B37. I think it was essential to actually have that space; to actually be by myself, not be at work, not be responsible for other people … other people constantly asking you questions, or wanting things from you; it was about spending time with me; rediscovering who I was, in my own time… it was about spending quality time with me, and then that moved onto spending quality time with my family and friends.

This notion was explored by participant F as well who described the impact of burnout upon her behaviour whilst at home, linking transcendence to an increase in her level of interest and activity in her personal life:

F44: I think it’s doing the social stuff, forcing myself to do it; getting out of hermit land back into life … as part of transcending burnout; the more burnt-out I get the more isolative I get, recognising I haven’t rung anybody, and haven’t gone anywhere, cause he [husband] goes out all the time and I won’t go.
For Participants E and D, having a strong social network that acted as a source of enjoyment outside of the work environment was important:

_E1:_ *Interests outside of work that have sort of kept me going, families been important, hobbies catching up with friends has always been important.*

_D3:_ *Having a decent life outside work, where I have days where I'm not there ... and it's easier to forget what’s going on at work so when you attend work any of that sort of heaviness feeling that sort of comes with, I feel, the burnout feeling where you, you can’t give anymore; it’s fine because it’s sort of not there before you’re off again, and that’s how I feel I’ve managed to move through it.*

In exploring the importance of a strong social network, a number of the participants identified the role played by close family members in giving them a time and place to debrief and ventilate regarding their frustrations about their experiences at work:

_D28:_ *He [the participant’s husband] very much understands when I’m frustrated with my job, so I think debriefing to him at times has been a very big help ... [D29] he does understand and if he doesn’t understand he’ll actively listen … and validate my feelings … and once I’ve sort of off-loaded it, I feel good.*

_H18:_ *At home I was lucky, [be]cause I had someone at home who was going ‘you’re spending too much time at work’, and ‘when are you coming home, what are you doing’, so that helped having a supportive; very supportive relationship.*
J3: Catching up with girlfriends [fellow nurses] ... has been a bigger support mechanism for me ... I also find that my mother is one of my greatest informal supports because she has a nursing background as well, so she kinda has greater empathy and understanding.

For many of the participants activities outside of work gave them a sense of distraction and a different focus as described by Participants A, G and K:

A60: I actually coped with work by taking on more in my personal life so that I’m busy, not going home thinking about it ... knitting, getting into the garden... I sort of do things to get away from the thoughts of work... [A63] I picked something hard, (rock climbing), that I had to work on and concentrate on ... so that I didn’t think about that [burnout] and that was planned.

G15: One of the things that I like, when it comes to taking time doing things I like, is actually art ... it’s really simple stuff and because you’re so focused on having to get your lines straight, your mind just vacate; you’re not participating in anything else in the world apart from getting these lines straight, and for me that just gives me the complete time away, so I really like doing that ... [G38] It’s distraction, I generally do art or I sing; I can’t sing either but I love singing and dancing. I think I’m a little Britney Spears; I do little groovy things [dancing gesture], and it’s because again it’s that not thinking of psych at all; I’m focused on doing whatever I’m doing.

K5: I like to cook, I like to lie on the couch, I get a bit of exercise, I eat well; sleep, I’m a good sleeper, so those sorts of things I think really support me physically and mentally.
For other participants, there was a strong need to actively and deliberately engage in self-soothing / caring activities as described by Participants F and L:

\[ L36: \text{I did quite a few alternative, creative things there, I had Reiki, and I started having massages about that time; I’ve had a lot of massages over the years, I notice I’ve got a lot of pain in my body from a lot of burnout I think.} \]

\[ F7: \text{I have drunk a lot; when I have felt particularly burnt-out alcohol has been there as well, and chocolate; it’s true, very much comfort things.} \]

The use of alcohol as a tool to help unwind and switch off was raised by other participants in the study. Participants G, J and K spoke about using alcohol as part of activities designed to help with transcending burnout:

\[ G16: \text{The drinking, well, I suppose we grow up in a culture where alcohol is acceptable and you get to laugh and have fun which I think … in our job, we’re always so serious; it doesn’t have to be but it’s a pretty serious job, and sometimes it’s just nice to sit back with other people who know your clients or know what: the sort of stuff you do and just laugh about it … it’s just nice to have a laugh because I don’t think we get to laugh much.} \]

\[ J19: \text{Sometimes you do just need to have a drink, and you need to switch off … it’s just doing something different from your normal routine to mix it up, to change it… you just change it, you change the processes of it I think it helps you kind of work through it.} \]
K4: Coming home and really; I take good time out, I’ve got a group of girlfriends, a couple of groups actually, really close friends who I’ve known for a lot of years who can be honest with me, I’m honest with them, so they give me feedback [laughs], have a few drinks.

In keeping with step five of Colaizzi’s (1978) methodology, the theme of ‘Transcending through connection with the World Outside’ has been included in the formulation of the exhaustive description, included in the penultimate section of the chapter.

**Theme Seven: Rebuilding the boundaries / setting and affirming realistic expectations.**

For a number of the participants in the study, the experience of transcending burnout involved having to take a look at their intra-personal expectations and interpersonal boundaries, as these had often become unrealistic and ineffective.

For Participant F the experience of transcending burnout involved needing to rebuild her sense of the interpersonal boundary that existed between her and the consumers she was looking after which she considered to be very important in allowing her to engage effectively with these individuals:

F42: I feel; when I’m burnt out I lose that sense of separateness; this is my stuff, this is the clients stuff, this is where the boundary is; when I’m burnt-out I lose what’s my stuff and what’s their stuff, when I’m transcending burnout I know where I end and I know where they start; there is a clear distinct boundary that is very, very evident for me … my sense of
objectivity is back … I can look objectively and hold my stuff and work objectively with theirs.

Participant K described the need to be able to establish boundaries that set limits on the negative elements of her practice. In doing this she needed to be able to remain aware of the people, situations and events that were happening around her, whilst maintaining the discretion to maintain her own separateness when required:

K27: I've had to learn to really bracket things off, and to not … listen to it, but also not get hooked up.

For Participant I the process of developing effective boundaries in her practice involved being able to set and accept realistic expectations of herself in her practice:

I8: I suppose it was pragmatism; yeah; pragmatism … I left idealism along the way a bit and focused on the practical as a way of coping, sometimes feeling guilty a bit about not being the ideal sort of clinician … there was a little downside to the pragmatism, the idealism got lost there a bit.

This was also reflected by Participant H who described the importance of being able to see that she had become burnt out in order to make practical changes in what she expected of herself:

H14: I think it’s a mindset that; removing yourself from work as evidenced by my leaving the CAT Team to get away from it is not the solution … I don’t think for me it’s about
recognising it, and trying to make some small changes in the method of working and putting limits too for me.

For participant F this change was reflected in the degree to which she felt she personally shouldered the responsibility for treatment and their outcomes. In transcending burnout she was better able to set realistic boundaries on her own sense of self-expectation:

F34: When I look at how the shift in my own perspective has transcended my burnout … I am not ultimately responsible for the twenty five people who are currently on the CATT board; I share their journey with them, I contribute to them but at the end of the day my dimensions are clear … [F36] For me transcending takes a lot of the ‘I’ out of it; it makes it more about the ‘we’ thing; we do this, we as a team do this, ‘we’ as a multi-disciplinary team involving everybody provide you with care … for me that shifts the sense of power.

Participants H and I both reflected upon the importance of having a boundary between work and home life. They described that while experiencing feelings of burnout this boundary was ineffective and quite permeable. This meant that work related stress often carried over into the home environment. As the participants transcended burnout they became much stronger and effective in keeping work stress ‘at work’, ensuring that their home environments remained untroubled by this:

H43: The ability to be able to go home and then realise that you haven’t thought about work for twenty-four hours is quite extraordinary for me … and that’s when you know you’ve kind of made it.
I22: I don’t know if I consciously do it [disconnect]; it’s like I don’t care when I go out the door; I don’t care about what happens. It’s like I’m a psychopath, I don’t give a stuff and walk out of there, and then I’ll walk back in and I will give a stuff and want to do it.

In exploring the difference between the professional working environment and personal life, Participant F described the importance of being able to clearly make this distinction in being able to operate effectively:

F11: It’s like ‘what’s my personal shit and what’s my professional shit? … the two meet and where are the boundaries in between them, if I’ve spilt from one area to another.

In keeping with step five of Colaizzi’s (1978) methodology, the theme of ‘Rebuilding the Boundaries / Setting and Affirming Realistic Expectations’ has been included in the formulation of the exhaustive description, included in the penultimate section of the chapter.

Theme Eight: Transcending burnout as the road goes ever on.

In reflecting upon their experience of transcending burnout participants offered a number of differing perspectives on what it was like and how they were now making sense of what had happened from the position they now occupied.

For a number of the participants in the study the experience of transcending burnout was seen as being a temporary state of affairs on a backdrop of an ongoing struggle against burnout. Participant D, whilst quite clear that she had transcended burnout, saw the reprieve as being more temporary than permanent:
D40: I don’t feel like it’s a big cloud hanging over my head anymore and I’m going to run, I’m not going to run anymore; that’s not necessarily true, there are times when I could just … drop everything and leave, but I don’t feel like that’s a constant.

This notion was also echoed by Participant A, who expressed the belief that experiencing burnout / transcending burnout was an ongoing process that she was still working on:

A48: Its [transcending burnout] not there yet by any means and I don’t think it ever will be.

For a number of the participants in the study the experience of transcending burnout was seen ultimately as being a positive experience that had provided them with the opportunity to evolve and grow as a person, as was summed up by Participant C:

C27: I saw the world so differently; saw myself a bit better after all of that, and, felt like I was a better nurse after that … [C30] I’ve definitely changed for the better, I can see things in a different light, … I see the world very differently … [C31] I’m a much better person for it [transcending burnout].

This sentiment was echoed by Participant K, who described transcending burnout as an opportunity to increase her sense of self-awareness and learn more about herself and those around her, with the belief that it had the potential to help her improve her practice as a CAT Team nurse:
K23: But I guess it’s about really getting to know yourself, having people in your life; friends or supervisors or managers who you can have an honest dialogue with about how can we do it better; how can I as a clinician do it better.

For Participants F and H the experience of transcending burnout meant that they had been able to re-find and appreciate their full emotional range as their ‘normal’ state of being rather than having negative emotions, particularly in relation to their experience of their working life:

F50: It’s light, it feels light [feelings associated with transcending], it feels … I feel emotion as opposed to; I feel a broader emotional range as opposed to the darker side of my emotional spectrum; I feel like I can tap into some of the joy; it’s easier to access laughter or happiness … not everything is grey

H44: Enjoying life and wanting to go back to work, wanting to: having a couple of days off and actually looking forward to getting back, but not from that desperation point of what happened with that client, what happened with that client, just wanting to go back and thinking ‘I wonder what’s happening today’; an absolute, it’s a real casual feeling of this is where it all should be really, it’s just a really, really nice feeling.

For Participant F the experience of transcending burnout also meant that they were able to feel good without needing to turn to alcohol or other substances to act as a catalyst to elicit these feelings:
F55: I can get happy, I can go out and laugh, I don’t need to self-sooth as much with the drugs and the alcohol, or the food and the alcohol these days.

In keeping with step five of Colaizzi’s (1978) methodology, the theme of ‘Transcending Burnout as the Road Goes Ever On’ has been included in the formulation of the exhaustive description that is presented below.

**Theme Nine: Increasing confidence in credibility.**

For a number of the participants in the study the experience of transcending burnout involved re-finding their sense of confidence in their sense of credibility in how they saw themselves and in their clinical practice.

Participant A described her experience of an inconsistent sense of confidence whilst being burnt out replaced with a stronger and more robust sense of confidence as she transcended burnout, which in turn led to her sense of being seen as a more credible clinician as a result:

A24: So you start to build up that confidence again and the regaining of your credibility …

[A32] I felt more confident in myself because during that period [of burnout] of course your confidence waxes and wanes.

This notion of feeling capable and confident as things improved sat in stark contrast to having earlier felt incapable and useless as described by Participant B who stated:
B24. At that stage it was like ‘I actually really like my job’ and I had some thoughts of maybe I wasn’t too bad at it, where three or four months previously all I thought about was ‘I hate this job and I’m crap at it’, and that’s the difference.

Participants C and F both reflected upon the intrapersonal experience of shifting from struggling to see themselves as being competent and having confidence in their practice to re-finding that sense of capability as a tangible sense within their intrapersonal awareness that they could rely upon:

C15: I was very frightened about going back and falling in a heap on the first home visit … that was really, that was a fine line, like I needed to get back there, but I wanted to get back there and function, I didn’t want to get back there and be a burden …

F54: So doing the work, not feeling pissed off and sitting with myself becomes easier; that sense of fraudulence, that sense of façade diminishes and I’m better able to access both the light and the dark side.

These ideas were echoed by Participants A and E who described the significance of feeling more positive in their attitude towards work:

A37: Then there was that regained confidence … it was like this [participant gives up and down gesture] for a while, but that solid sort of steady feeling of confidence in your own competence and clinical judgment was still there and I haven’t lost it after all.
E17: The experience is about not having that sense of doom, coming to work more positive as opposed to a very negative mindset … it’s actually about coming into work looking forward to working on some of the things that are really, really exciting.

In the case of Participant L, lost confidence came with a strong feeling of being stupid and almost worthless whilst re-finding that sense of competence and capacity reflected an increased sense of value to others within the clinical environment:

L26: Cause you really start thinking you’re dumb; you’re lost all your confidence, you don’t think you’re capable of anything … you just think you’re a burnt-out human being … your brain’s all burnt-out, it doesn’t function … I’ve discovered that it’s not true, so I think it’s about getting confidence back…realising that you are capable and you have got something to contribute and you have got something to offer.

While for Participant C this sense of swinging confidence reflected in not being able to trust herself, was further exacerbated by the notion that as a CAT Team nurse she shouldn’t feel this way. As a result, for Participant C, the experience of transcending burnout was closely related to re-finding a way to regain a sense of trust in self:

C36: Yeah, I had this expectation that, this [burnout] shouldn’t be happening to a CATT clinician … I was embarrassed [C43] I don’t think I ever went in there and said ‘this is a problem, we’ve got to address it’, because at that point I didn’t trust myself, I didn’t know ... [C45] I had to feel I could trust my own judgment; it got better as I got better.
For Participant G, her experience of shifting confidence was linked to the need to have her credibility acknowledged by her colleagues, as this was important in allowing her to move past negative thoughts and rebuild her sense of confidence:

\[
G36: \text{If you don't feel that you're validated it just puts more pressure on you when you think 'maybe I'm just overreacting, maybe I'm a bad person, maybe I'm not a nice person', all that sort of stuff ... you started to not believe in yourself; and I think getting that validation makes you feel 'no, no, I'm okay, I'm right and I'm okay', and I can plod on.}
\]

In keeping with step five of Colaizzi’s (1978) methodology, the theme of ‘Increasing Confidence in Credibility’ has been included in the formulation of the exhaustive description that is presented below.

**Exhaustive Description of the Phenomenon**

In keeping with step five of Colaizzi’s (1978) methodology, all of the nine themes presented and discussed in the preceding section of the chapter are presented below as the formulation of the exhaustive description of the phenomenon.

[One] Transcending Burnout through *Personal Strength: Grim Determination, Pragmatism and Optimism*, involved participants being able to know and tap into their own strengths and capacity to endure and evolve through hardship. Whether it was clinging on through tenacious grim determination or by being able to laugh at the situation each had allowed themselves to be guided by their own pragmatic needs or even by deeper lifelong values.
The participants drew heavily upon their intrapersonal qualities in rising above and beyond the hardship of burnout.

[Two] Transcending Burnout through *Reaching for Support*, involved participants being able to interact and converse with others [primarily colleagues] within the mental health profession, particularly other CAT Team nurses. It required being able to communicate with others in a manner where the participant could feel both safe and able to reveal their feelings of uncertainty, vulnerability and loss of confidence. Participants describing reaching for support from CAT Team colleagues within the work environment, through supervision with other MH nurses in the services or informally through their social networks of MH nurses, though in all cases it was the sense of being understood and of not being alone that was the essential element.

[Three] Transcending Burnout through *Weathering the Storm* involved participants persisting and pushing on through difficulty and adversity with the sense that this was the way forward. It involved not only the willingness to carry on and stick with it, but also the capacity to accept this as being an integral element in transcending burnout that would ultimately have some value for the participant despite the personal and emotional discomfort this involved. In many cases participants described the importance of constructing and maintaining an escape hatch that served to inform a feeling of choice that was so important in weathering the storm; they remained because they wanted to, not because they had to. Finally, some participants spoke of burnout as being an unavoidable hazard of the CAT Team working environment, describing their experience of moving past and beyond it as being an ongoing journey that would ebb and flow, but which ultimately had no end in sight.
[Four] Transcending Burnout through *Making Sense of the Personal Non-Sense and Re-Finding Clinical Meaning* involved participants developing an increasing sense of intrapersonal understanding of the nature and characteristics of the situation they found themselves in. This involved examining and making sense of their abilities and limitations as clinicians in light of the impact that feeling burnt-out had had upon them. By reflecting upon the changes they had experienced in their various roles, responsibilities and expectations (coming both from within and without) of their working environment and ‘reconstructing’ these elements in a way that make sense for the individual they were able to again find a way to understand their experiences. In accomplishing this difficult and at times uncomfortable process the participants described being able to reconnect with their sense of clinical meaning and again make sense for themselves of the value of their clinical practice.

[Five] Transcending Burnout through *Regaining Balance and Lost Control* involved participants firstly being able to recognise and understand when they felt that they had a poor sense of control and balance. It involved being able to rationalise and organise their interpretation of their surroundings in order to allow the participants to start to make decisions about the scope and limitations of their practice. Once accomplished, this new sense of intrapersonal clarity and awareness lead to the individual being able to assume this newly regained control in practical behaviours that had the resultant effect of returning their life to a more balanced state where they no longer feel burnt out.

[Six] Transcending Burnout through *Connection with the World Outside*, involved participants being able to understand and appreciate the role that their life outside of work played as a counter-weight to the hardship of burnout. The presence of a strong social network to provide opportunities for simple enjoyment whilst time spent with close trusted
family members allowed participants to unload their negative emotions with the support of an understanding listener. At other times the participant’s world outside offered opportunities for activities that provided simple distraction and the chance to think about something else. Finally for many of the participants self-caring and self-soothing activities [spending simple time by themselves through to socialising and drinking with friends] allowed them to engage in feeling happy and relaxed in their experience.

[Seven] Transcending Burnout through *Rebuilding the Boundaries / Setting and Affirming Realistic Expectations*, involved participants being able to repair and rebuild their intrapersonal and interpersonal boundaries based upon a foundation of realistic self-expectation. This required that they were able to consider and accept the limits of their own practice with in the broader working environment, separating the idea from the actual and accepting the practical limitations that this entailed. This also involved setting limits on themselves, not taking on more than they could handle and being willing to disseminate the responsibility for consumer care outcomes with colleagues. Transcending burnout in this way also meant ensuring the boundary between work life and home / personal life was kept in good repair to ensure that the division between the two domains was maintained.

[Eight] Transcending Burnout *as the Road Goes Ever On* involved the participant’s idea that whilst they been able to move beyond their recent experience of burnout further episodes may emerge for them in the future. This reflected an acknowledgement of the highly challenging nature of working in the CAT Team environment, though this was accompanied with a clear sense of calm acceptance rather than the resistance that had accompanied the earlier episode. Participants described a clear sense of growth and broader understanding of themselves and their feelings related to transcending. Out of the discomfort and suffering of
burnout they had been able to re-find aspects of themselves previously thought lost as well as developing new strengths and resources that they could identify as being important for their working lives in the future. This was the rainbow at the end of the storm.

[Nine] Transcending Burnout through *Increasing Confidence in Credibility* involved participants undertaking a journey from feeling uncertain and unsure of their own ability as a CAT Team nurse to again feeling capable and competent in their practice. For the participants this was an inconsistent and unreliable process, as their sense of confidence and credibility waxed and waned over time however eventually there was the clearly defined experience of these qualities gradually returning as the participant’s transcended burnout.

**Fundamental Structure of the Phenomenon**

In keeping with step six of Colaizzi’s (1978) methodology, all of the nine themes presented and discussed in the preceding section of the chapter are presented below synthesised into the formulation of the fundamental structure of the phenomenon.

**Phase One: The Storm Clouds Burst.**

In the earliest phase of the experience, the experience of transcending involved hanging on using whatever came to hand; for most this was those things that were most readily available, namely their own person qualities and attributes (including Grim Determination, Pragmatism and Optimism) that formed the basis for their decision to push forward and endure the adversity they were experiencing. At the same time they reached out reflexively to those around them as an instinctual reaction trying to grasp an emotional /
experiential hand or arm to try to cling to in an attempt to stop themselves from being washed away by the experience of burnout. In this first phase transcending burnout involved enduring the initial deluge and clinging on to whatever was at hand to stop from being washed away in the flood.

Phase One: Themes.

- [One] Transcending Burnout through Personal Strength: Grim Determination, Pragmatism and Optimism.
- [Two] Transcending Burnout through Reaching for Support.

Phase Two: Weathering the Storm.

In the second phase of the experience of transcending burnout there began a gradual shift in the participant’s state of motion. Beginning gradually they shifted slowly from just holding their position to being able to exert some push back against the adversity that they were facing. Having endured the initial deluge they shifted to weathering the storm, setting a course that would allow them to move forward in the belief that given time the downpour would abate. Elements of the initial experience of burnout which had been confusing and disorienting were at first uncomfortably tolerated and then with increasing certainty explored and understood allowing a reconnection with the sense of clinical significance (essential to a sense of purpose as a clinician) that had appeared to have been washed away in the initial downpour. From this exploration and growing clarity regarding both themselves and their clinical practice, the individual was gradually able to better manage their situation.
Phase Two: Themes.

- [Three] Transcending Burnout through Weathering the Storm
- [Four] Transcending Burnout through Making Sense of the Personal Non-Sense and Re-Finding Clinical Meaning
- [Five] Transcending Burnout through Regaining Balance and Lost Control

Phase Three: A Clearing Sky.

In the third phase of the experience of transcending burnout there began a gradual broadening of the individual’s experience of transcending as relationships and activities in the wider world were re-claimed as a source of positive emotion that helped to further push back the negative emotion associated with their experience of burnout. Critical to this phase was the individual’s experience of gradually repairing and rebuilding their intrapersonal and interpersonal boundaries that had previously been damaged by the impact of burnout. Transcending involved re-establishing the individual’s identity, capacity and limitations based upon a foundation of realistic self-expectation drawn from growing self-awareness gained through their journey thus far.

Phase Three: Themes.

- [Six] Transcending Burnout through connection with the World Outside.
- [Seven] Transcending Burnout through Rebuilding the Boundaries / Setting and Affirming Realistic Expectations.
- [Eight] Transcending Burnout as the Road Goes Ever on.
A Barometer through the Storm

Straddling all three phases, the notion of the swinging pendulum of credibility and confidence reflected initially the negative impact of the experience of burnout upon the individual oscillating heavily towards the ‘diminished’ end of the scale. As the individual began to experience transcending more perceivably the pendulum began to swing more broadly, reflecting gradual improvements in their sense of credibility and confidence, until by the final stages of the experience the pendulum once again sat more consistently at the high end of the scale. Some degree of movement still occurred but this was more reflective of the day-to-day challenges of the role and in keeping with having transcending the experience of burnout.

Phase Three: Themes.

Visual Conceptualisation of the Fundamental Structure of the Phenomenon

Figure One: Visual representation of the lived experience of Transcending Burnout

The diagram above provides a visual representation of the lived experience of transcending burnout. The experiential journey of the individual is reflected by the purple line running across the diagram straddled at different points along the way by the three main phases of transcending burnout (The Storm Clouds Burst, Weathering the Storm and A Clearing Sky). Running concurrent to the experience itself is the final element (A Barometer through the Storm) that oscillates upwards and downwards, reflecting the ebb and flow of the participants confidence and credibility, though its overall arc is upward reflecting the participants overall experience of transcending burnout.
Summary of the Chapter

This chapter presented the findings of the study, as they emerged through the process of thematic analysis. Nine distinct themes were identified by the participants within their lived experience of transcending burnout. Each of the themes has been outlined and explored, and for each an exhaustive description was generated. The chapter culminated in the development of an “unequivocal statement of identification of the fundamental structure of the phenomenon” (Colaizzi, 1978, p. 61) that provided the final, absolute description of the phenomenon of transcending burnout. The findings of the study as revealed through nine emergent themes discussed in this chapter will be discussed in relation to the existing literature in Chapter Seven.
Chapter Seven

Discussion of the Study Findings in Relation to Existing Literature

This Chapter discusses the study findings in relation to contemporary research literature. An overview of the literature search strategy is provided. The chapter presents a discussion of the literature relevant to the principle focus of the study (transcending burnout). This is followed by a detailed discussion of the literature as it relates to the nine themes. A summary of each theme is provided, leading into a discussion of the literature relating to the respective theme. The chapter concludes with a summary of the overall literature in relation to the exhaustive description of Transcending Burnout as outlined in the previous chapter.

Phenomenological Research Findings and the Existing Literature

Prior to presenting the discussion regarding the results of this study and the existing literature it is useful to frame this with a comment regarding the nature of the results generated through a phenomenological study. As was discussed earlier in the dissertation, phenomenology is the approach of choice when undertaking initial pieces of research into areas of human experience where there is little or no existing research. Equally, the methodology of the study results in the generation of findings that are specific to the context in which the study was conducted. This study makes no claim for the findings to be relevant to any broader situation. Nor was it the intention to produce results that are generalisable to the wider world (though others in similar situations might find them relevant).
When examining the results in the context of the existing literature it is important that these two key aspects of phenomenological inquiry are kept in mind as they have a significant influence on the relationship between this study’s results and the wider literature. The original nature of the research means that the findings will often be quite new and unique, with the result that there may be little else like it in the extant literature. This does not constitute a weakness or limitation; rather it is an expected outcome of phenomenological research that requires discussion in relation to a broader range of literature, or the acknowledgement that a specific finding is unique. Findings that are not reflected in the existing literature are sought, as they constitute a new piece of knowledge to the phenomenon. Equally, given the context specific nature of the findings they do not need to correlate with existent literature, replicate other study findings or be based upon the use of validated measures to be deemed relevant. Establishment and maintenance of rigour (as discussed in Chapter Five) ensures this already.

**Overall Literature Search Strategy**

In examining the existing literature for research of high quality that was relevant to the various themes (and to the phenomenon of Transcending Burnout as a whole) the original search strategy employed in the preliminary review of the literature presented in Chapter Two was adopted and revisited. A series of literature searches utilising databases such as CINHAL, Proquest, PubMed and Scopus were conducted using the search terms outlined in the table below. This literature was added to the existing literature uncovered in the preliminary literature review at the study commencement, to form the body of literature utilised in this discussion. Additional literature searches were conducted for each theme using the same four databases with terms relevant to each theme. These are outlined in the
relevant theme discussion section below. The two tables below present a summary of the strategies used to update the search for literature relevant to Burnout in Community Mental Health Nursing 2009-2013 (Table Four) and the phenomenon of Transcending as Human Experience 2009-2013 (Table Five).

Table Five: Burnout in Community Mental Health Nursing 2009-2013 Search Summary

<table>
<thead>
<tr>
<th>Data Base</th>
<th>Search Terms / Process</th>
<th>Reduced to articles with Relevance to the Study</th>
<th>After removal of Duplicates</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Burnout</td>
<td>And Mental Health</td>
<td>And Nursing</td>
</tr>
<tr>
<td>CINAHL</td>
<td>1542</td>
<td>118</td>
<td>30</td>
</tr>
<tr>
<td>SCOPUS</td>
<td>5015</td>
<td>748</td>
<td>148</td>
</tr>
<tr>
<td>PUBMED</td>
<td>2635</td>
<td>403</td>
<td>94</td>
</tr>
<tr>
<td>PROQUEST</td>
<td>14935</td>
<td>1394</td>
<td>183</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

When added to the literature located in the preliminary literature review (33 significant articles) this resulted in a total of 46 significant articles (relating to Burnout in Community Mental Health Nursing) included in the overall body of literature examined for relevance related to the findings of this study. Of these 46 articles 41 are discussed in the following section examining the literature related to the topic of Burnout in Community Mental Health Nursing. The remaining five articles are discussed in the subsequent section that explores the literature related to the key themes.
Table Six: Transcending as Human Experience 2009-2013 Search Summary

<table>
<thead>
<tr>
<th>Data Base</th>
<th>Search Terms / Process</th>
<th>Reduced to articles with Relevance to the Study</th>
<th>After Removal of Duplicates</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Transcending</td>
<td>And Human Experience</td>
<td></td>
</tr>
<tr>
<td>CINAHL</td>
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<tr>
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<td>3</td>
</tr>
<tr>
<td>PROQUEST</td>
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</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td>7</td>
</tr>
</tbody>
</table>

When added to the literature located in the preliminary literature review (19 significant articles) this resulted in a total of 26 significant articles (relating to Transcending as Human Experience) included in the overall body of literature examined for relevance related to the findings of this study. These are discussed in the section exploring the literature related to the explicated themes later in the chapter.

Overview of the Literature related to the Lived Experience of Transcending Burnout in Nursing

The search for literature relating to Transcending Burnout in Nursing was revisited at the conclusion of the data analysis process, and revealed no additional literature specific to this concept than had been the case at the commencement of the study. The only article identified in either search on any of the data bases searched was the literature review by Edward and Herceleskyj (2005) already discussed in Chapter Two. With regards to the findings of the study (given that the findings of the current study were not yet available to the researcher when initially reviewing the article) this article does not relate specifically to
any of the themes generated by this study and as such is not particularly relevant to the findings of this study. The concept of resilience as it relates to the findings of this study is discussed later in the chapter.

**Burnout and Community Mental Health Nursing**

**Summary of the Preliminary literature review findings (1993-2006) related to the outcomes of the study.**

Exploration and discussion of the literature related to the experience of transcending burnout in CAT Team nurses commenced with a re-review of the literature identified in the initial literature review conducted prior to the data analysis stage of the study. The majority of the studies contained within the initial review such as Fielding and Weaver (1994), Fagin et al., (1995), Carson et al., (1995), Wykes, Stevens and Everitt (1997), Ford et al., (1997), McLeod (1997), Edwards, Coyle and Hannigan (2000), five articles associated with the The All-Wales Community Mental health Nurse (CMHN) Stress Study (2000) along with Robinson, et al., (2003) and Pinikahana and Happell (2004), Edwards et al., (2001) focused primarily on describing the nature of burnout in community mental health nursing. The initial review also contained additional studies that examined the impact of various factors contributing to the development of burnout, including Hopkinson et al., (1998), Walsh and Walsh (2001), Whittington (2002), Gunstone (2003), McGuiness (2003), Sturm (2004), Thompson, Powis and Carradice (2008). These studies did not focus on the experience of overcoming burnout and as a result bear little connection to the results of this study. That said, it is worth noting that the experience of burnout outlined in these studies compares closely with the descriptions of burnout provided by the participants involved in this study.
Literature was also located in the preliminary literature review that focused on comparing the community mental health setting with other mental health settings and included articles by Coffey (1999), Barling (2000), Coffey and Coleman (2001), Imai et al., (2004), Sorgaard et al., (2007) and Ward and Cowman (2007). Articles by Taormia and Law (2000) and Funakoshi, Miyamoto and Kayama (2007) explored the impact of personal and team management on the development of burnout however, as with the articles discussed in the previous paragraph, none of these studies focused on the experience of overcoming burnout and as a result provided little significance to the results of this study.

**Summary of the recent literature review findings (2007-2013) related to the outcomes of the study.**

In terms of the broader literature on burnout in community mental health nursing, a detailed review of the literature concerning job satisfaction and burnout in community mental health teams was published by Onyett in 2011. This review examined all of the literature published between 1997 and 2010, concluding that the body of literature as a whole was characterised by “contradictory findings and inconsistent methodologies” (Onyett, 2011, p. 198) along with small sample sizes, poor response rates, a wide variation in the measurement tools used and difficulties in identifying practice context. Onyett (2011) did not identify any research in his review that examined the concept of transcending as a conceptual lens to understand how community mental health nurses might overcome burnout.

Crawford, Adedeji, Price and Rutter (2010) examined levels of burnout and factors that either increased or decreased the risks associated with this phenomenon in 87 clinicians.
from various disciplines working in 11 community based services treating mental health consumers with Personality Disorders in the UK. The study reported strong teamwork, clear leadership and opportunities for group reflective practice were found to be significant protective factors. As with the other studies discussed in this section Crawford et al., (2010) did not examine the experience of overcoming burnout where it had actually occurred with limited relevance to the findings of this study.

A further study by Rossi et al., (2012) explored burnout, compassion fatigue and compassion satisfaction amongst 260 community mental health staff of various disciplines (including nursing) working across four community mental health services in Verona, Italy. The authors explored the factors most likely to correlate with higher Burnout and Compassion Fatigue scores, noting psychiatrists to be at the highest risk along with the female gender and having experienced a negative event in the last year. The authors reported that higher Burnout and Compassion Fatigue scores were recorded the longer clinicians spent working in the community mental health setting. This last finding certainly points to CAT Team nurses being at higher risk of Burnout given their length of time working in the community however the study does not undertake any exploration of the experience of overcoming burnout in the community mental health setting limiting its significance to the results of this study.

In another study examining burnout in community mental health care Kraus and Stein (2013) explored the relationship between recovery-model driven practice and burnout and job satisfaction in 114 case managers (primarily social workers or psychologists) working in Ohio, USA. The authors reported a positive relationship between case managers working in more recovery oriented services and lower levels of burnout along with higher levels of job
satisfaction. The study did not examine the perspective of working in recovery oriented services for those clinicians who did experience burnout, not did it examine overcoming burnout for case managers working in this environment with the result that this remains unknown territory.

An Australian study by Harvey, Killaspy, Martino and Johnson (2012) explored community team composition, process and model fidelity in 44 clinical staff members working across four Mobile Support and Treatment Teams (MSTT) exploring staff burnout as one of their goals. The authors reported low levels of burnout overall though noted that increased levels of burnout (where they occurred) were associated with shorter time in the role, lack of team/colllegial support and inconsistency between individual and team approaches to practice. The MSTT setting of this study was the most similar to that of a CAT Team setting however the study did not explore the concept of overcoming burnout in any way. Work such as the current study on Transcending Burnout will fill this gap in the literature. The importance of collegial support (noted inversely as a contributing factor to burnout when absent) was however consistent with Theme Two of this study wherein participants reached for collegial support in transcending burnout.

The impact of transformational leadership on burnout was the focus of a study by Green, Miller and Aarons (2013) in which they examined the experiences of 338 mental health care providers (from a variety of different disciplines) providing community mental health care to children, adolescents and families. The authors surveyed the perceived level of transformational leadership, characterised by “idealized influence, inspirational motivation, intellectual stimulation and individual consideration” (p. 374) in the participants supervisors and compared it to levels of emotional exhaustion. This study found that higher levels of
transformational leadership correlated with lower levels of emotional exhaustion and intention to leave. Being primarily focused on exploring a specific factor influencing the occurrence of burnout did not provide for any exploration regarding the impact of transformational leadership on individuals that were already burnt out, resulting in it having little relevance for the results of this study.

**Burnout and Mental Health Nursing**

Given the paucity of literature available relating to burnout in community mental health settings, the review also considered literature from other areas of mental health nursing. Overall much research in this area (burnout in mental health nursing) continues to focus on examining the incidence, characteristics and contributing factors in the development of burnout in a variety of clinical settings. Specific settings have included acute inpatient units (Jenkins & Elliot, 2004) or in those working in city environments (Sherring & Knight, 2009). The importance of context is also explored by Lasalvia et al., (2009) who explored the impact of perceived organisational factors on job burnout in a large scale study of 1328 mental health service staff employed across a wide range of clinical settings. The authors concluded that the development of burnout is associated with both individual and organisational factors, noting that strategies proposed thus far in treating burnout (including changing roles and skills training) have only been partially effective. Additionally the authors argue that the organisational factors have a significant impact, made more complex by the fact that they vary significantly from working environment to working environment. In terms of the results of this study these specific focus adopted by these studies is consistent that with the idea that research in this area needs to take into
account the specific context of the clinicians working environment (focusing specifically on the CAT Team setting as this study has done).

Singh (2011) reported that being male and having a higher level of qualification correlated to a higher risk of burnout in Australian mental health nurses. No comment was made regarding the implications for overcoming burnout for those who fell into either of these two groups. This study was unique in identifying gender as being a risk factor for burnout, whilst it’s finding that nurses with a higher qualification level (along with more practice experience) runs contrary to the findings of most other studies. Hamaideh’s (2011) study focused specifically on burnout in Jordanian mental Health nurses (N=181) with the author reporting similarly high levels of burnout in this group of mental health nurses and concluded that interventions at an individual and organisational level were required as a matter of priority.

A review of the literature pertaining to burnout in the mental health workforce undertaken by Paris and Hoge in 2009 examined the findings of 145 articles in the area of behavioural health. Despite the substantial number of articles reviewed the authors concluded that burnout was a widespread and alarming issue in the mental healthcare workforce that manifested as a “variable, complex and inconsistent manner, rather than as a unitary phenomenon” (p. 526). The authors also noted that whilst “there have been substantial efforts to define, measure and validate the construct [of burnout] … the literature on burnout in mental health, as a whole, is quite weak” (p. 526), particularly in the areas of evaluating the effectiveness of interventions on burnout. In terms of the relevance of this review to the current study, Paris and Hoge’s (2009) conclusions emphasise the relevance of this study into a specific area of mental health nursing practice (as undertaken by this study) given the
variable and inconsistent manner in which burnout occurs. The authors also reiterate the potential value and need for research examining not only how nurses become burnt-out, but how they recover from it as well.

**Burnout and Nursing**

Given the small amount of literature available relating to burnout in community mental health settings the review also considered more recent literature (>2009) from other areas of healthcare where there were some similarities to the focus of the existing study. Xie, Wang and Chen (2011) focused on the relationship between occupational stress and nurse burnout in 527 nurses (from a wide range of healthcare specialties) working across 41 hospitals in Shanghai, concluding (perhaps unsurprisingly) that high levels of occupational stress were associated with high levels of nurse burnout. The authors concluded that steps were needed to decrease the level of occupational stress faced by nurses. The study did not extend to a discussion regarding how this would be accomplished given the fact that high levels of occupational stress are unavoidable in many clinical environments (including CAT Teams) given the core nature of the work. In this regard the findings of this study are valuable in that they focus on overcoming burnout whilst accepting the characteristics of the clinical environment in which the affected nurses are practicing.

A study by Sawatzky and Enns (2012) explored the predictive factors of retention in emergency nurses in which they included the concept of engagement in relation to burnout. Part of a larger mixed-methods study involving 261 Emergency Department nurses in Canada, the authors described the concept of engagement as “the opposite of burnout … positive, fulfilling work-related state of mind”, concluding that higher levels of engagement
(characterised by professional development pathways, good collegial relationships, reasonable workload and flexible rostering) correlated with lower levels of burnout (and higher levels of retention). Unfortunately the study provided little insight into the process of overcoming burnout, focusing more on the impact of the work environment on the development of burnout and poor staff retention as a consequence. Engagement was also the focus of a study by Fiabane, Giorgi, Sguazzin and Argentero (2013) who examined the factors that impacted on levels of work engagement and occupational stress in hospital staff (N=110) from a wide variety of disciplines including nursing (although not mental health nursing). The authors concluded a variety of organisational factors (workload, a match in clinician and organisation values and a supportive work community being the most significant) and personal (mental health, locus of control and job satisfaction being the most significant) influenced the participants level of engagement in their work resulting in their being better able to cope with the occupation stress experienced.

The review also identified five studies that examined strategies intending to alleviate or reduce burnout in different areas of healthcare and specific areas of nursing practice. These were included due to [i] the paucity of relevant intervention studies specific to mental health nursing settings and [ii], in the belief that they may have some relevance to the results of this study despite their broader focus. Oman, Hedberg and Thorensen (2006) explored the impact of meditating on a passage from a spiritual text as a strategy to reduce perceived stress in healthcare [N=30] professionals, reporting little significant improvement in their result regarding the experience of burnout. A study by Italia, Favara-Scacco, Di Cataldo and Russo (2008) examined the use of art therapy in paediatric nursing staff (N=33) with significant reduction in the scores on the MBI as a result, though the authors reported being unable to specifically identify which aspect of the intervention had been primarily
responsible for the improvement. Their ideas regarding the importance of recreation are discussed in theme seven below.

Paediatric oncology was also the setting for a study by Sands, Stanley and Charon (2008) in which the authors examined the impact of narrative therapy training on 19 paediatric oncology staff members (including 12 nurses). The authors reported an improvement in the participant’s empathy and teamwork though no improvement in their levels of burnout. Equally, a study by Turner et al., (2009) examined the impact of communication skills training on a variety of practice areas (including burnout) in 32 oncology nurses. Turner et al., (2009) reported an improvement in the areas of self-care and confidence however no significant change in their level of burnout was reported. Finally Edmonds, Lockwood, Bezjak and Nyhof-Young (2012) investigated the effect of a one day ‘Care for the Professional Caregiver’ Program (a combination of education and relaxation sessions) on emotional exhaustion in oncology nurses reporting a significant reduction in the level of emotional exhaustion at the 1-month and 7-month follow up testing. The authors do not identify or explore which are the specific elements of the program that lead to the improvement. However the information provided indicates increased understanding and awareness as a result of the educational component and recreational value from the relaxation component; these are included in the theme discussion below.

A review of the literature on coping with burnout conducted by Awa, Plaumann and Walter (2010) examined 25 different Burnout prevention intervention programs that utilised a combination of person directed interventions (N=17), organization-directed interventions (N=2) or both together (N=6) across a wide range of clinical settings and disciplines. The authors reported that 80% of participants reported a reduction in their burnout symptom
scores that lasted a year on average. The studies included within this review utilised a wide range of therapeutic interventions (including cognitive behavioural therapy, psychotherapy, supervision, communication and relaxation training) however none of them incorporated the concept of transcending burnout as it has been conceptualized and explored in this study.

In summary, whilst there has been a great deal of research examining the construct of burnout in the community mental health setting as well as broader areas of mental health care, much of this is focused on different or mixed disciplines as well as a broad range of differing settings making any firm conclusions very difficult to achieve. Certainly, within nursing specifically there has not been any other research study completed that has examined the experience of transcending burnout in any type of community mental health context (let alone specifically related to CAT Team nurses). In this regard the findings of this study constitute a unique explication of understanding and the contribution of new knowledge in a hitherto unexplored area of mental health nursing practice.

**Literature related to the Explicated Themes**

The second area of discussion regarding the implications of the study’s findings and the current literature focuses on the specific themes explicated through the data analysis process. As discussed in the previous chapter (nine) emergent themes were explicated:

(One) Personal Strength: Grim Determination, Pragmatism and Optimism.

(Two) Reaching for Support.

(Three) Weathering the Storm.

(Four) Making Sense of the Personal Non-Sense and Re-Finding Clinical Meaning.
(Five) Regaining Balance and Lost Control.

(Six) Transcending through Connection with the World Outside.

(Seven) Rebuilding the Boundaries and Affirming Realistic Expectations.

(Eight) Transcending Burnout as the Road Goes Ever On.

( None) Increasing Confidence in Credibility.

Each of these themes is discussed in relation to the existing literature in order to position the findings of the study within the context of the broader literature. The review of the literature was conducted via the CINAHL, Proquest, PubMed and Scopus data bases using the terms outlined in the table below and revealed a limited body of literature pertaining to the themes explicated by this study. The terms used to inform the theme specific literature search are outlined below, whilst the far right column provides the number of articles included in the review. Inclusion was determined by a review of the abstract, followed by a review of the full article where warranted; final inclusion was determined by the article’s relevance to the ideas and concepts incorporated within the themes themselves.

**Table Seven: Theme Specific Literature Search Summary**

<table>
<thead>
<tr>
<th>Theme</th>
<th>Search Terms</th>
<th>New articles discussed</th>
<th>Total articles discussed (including articles used in multiple themes)</th>
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</thead>
<tbody>
<tr>
<td>(1) Personal Strength: Grim Determination, Pragmatism and Optimism.</td>
<td><em>Transcending, burnout, personality, personal strength, pragmatism, personality, [and] optimism.</em></td>
<td>11.</td>
<td>11</td>
</tr>
<tr>
<td>(3) Weathering the Storm.</td>
<td><em>Transcending, burnout, persistence, perseverance, endure [and] endurance.</em></td>
<td>7.</td>
<td>7</td>
</tr>
</tbody>
</table>
### Theme One: Personal Strength: Grim Determination, Pragmatism and Optimism

Central to each participant’s description of transcending burnout was the importance of Personal Strength: Grim Determination, Pragmatism and Optimism. This involved participants being able to know and tap into their own strengths and capacity to endure and evolve through hardship. Various participants described clinging on through tenacious grim determination, being able to laugh at the situation or allowing themselves to be guided by their own pragmatic needs or even by deeper lifelong values as part of their experience of

<table>
<thead>
<tr>
<th>Theme</th>
<th>Transcending, burnout, sense, reflection, reflexivity [and] self-awareness.</th>
<th>14</th>
<th>17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regaining Balance and Lost Control</td>
<td>Transcending, burnout, balance, [and] control.</td>
<td>4</td>
<td>11</td>
</tr>
<tr>
<td>Transcending through Connection with the World Outside</td>
<td>Transcending, burnout, perspective, opening up, recreation, [and] relaxation.</td>
<td>5</td>
<td>10</td>
</tr>
<tr>
<td>Rebuilding the Boundaries and Affirming Realistic Expectations</td>
<td>Transcending, burnout, boundaries, [and] expectation[s].</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Transcending Burnout as the Road Goes Ever On</td>
<td>Transcending, burnout, process, chronic, ongoing [and] re-occurring.</td>
<td>7</td>
<td>10</td>
</tr>
<tr>
<td>Increasing Confidence in Credibility</td>
<td>Transcending, burnout, confidence, [and] credibility.</td>
<td>0</td>
<td>9</td>
</tr>
</tbody>
</table>

**Totals:** 59 89

A full discussion of the nine themes in relation to the existent literature is presented below.
transcending. The participants drew heavily upon their intrapersonal qualities in rising above and beyond the hardship of burnout.

**Theme One: Discussion relating to the literature.**

The individual qualities of tenacity and grim determination contained within this theme are consistent with previous literature relating to the importance of personality traits as a mediating factor in the development of burnout. Kobasa (1979), Kalimo, Pahkin, Mutanen and Toppinen-Tanner (2003), Sheard and Golby (2007) and Garrosa, Moreno-Jimenez, Liang and Gonzalez (2009) identified hardiness (characterised by the qualities of control, commitment and challenge) as a highly significant protective factor in burnout. Garrosa et al., (2011) explored the relationship between job stressors, hardy personality, coping resources and burnout in 98 Portuguese nurses (though not specific to the mental health setting). The authors reported that a “hardy personality” (p. 205) was a significant resource in coping with the symptoms of burnout, correlating with lower rates of burnout in the participating nurses.

The significance of hardiness as a personal quality was also reflected in the findings of a meta-analysis of the literature conducted by Alarcon, Eschleman and Bowling (2009) that examined the relationships between personality variables and burnout. Their review included 114 articles across a wide range of settings and reported that not only that “hardiness yielded relatively strong negative relationships with all three dimensions of burnout” (p. 258), but that it was one of the most significant personality traits in the development of low burnout scores. Although representative of a very wide range of sources of literature, the findings of this review are consistent with the findings of this
study which identified the key qualities of hardiness across Themes One, Four and Five (to be discussed in greater detail below).

The concept of personal hardiness was further reiterated by Gustafsson, Persson, Eriksson, Norberg and Strandberg (2009) in their study comparing personality traits in burnt-out (N=20) and non-burnt-out (N=20) out healthcare personnel in the same workplace wherein they stated that a hardy personality is an important quality in resisting the effects of burnout. This is reflected in the characteristics of this theme, particularly reflecting the notion of challenge where the participants exhibited a willing attitude towards accepting and engaging with the changes that were occurring rather than simply retreating from them. Indeed, this theme has extended this concept further in identifying hardiness as an important element in transcending burnout where this has occurred (as well as acting as an important protective factor). Other elements of hardiness (Control & Commitment) are discussed in relation to Themes Five and Nine respectively later in this chapter.

In terms of the importance of personal strengths, Freeman’s (2002), description of ‘transcending circumstance’ explored the experiences of concentration camp prisoners during World War II. Freeman stated that prisoners in the Auschwitz camp described personal “ways of coping” (p. 33) that were critical to their being able to transcend the situation in which they found themselves. These included optimism and humour consistent with the reliance on (positive) emotional qualities reflected in this theme.

The findings of this theme are consistent with Reker’s (1997) article examining personal meaning, optimism and choice in the context of depression and the elderly with the author highlighting the importance of personal traits in responding to adversity. Sapolsky’s (1994)
article exploring individual differences and the stress response reflected some elements of
the theme, in particular the experiences described by participants as the experiential
elements of the experience of transcending, though none of the studies identified related
these to the experience of transcending burnout specifically.

The results of this theme were also reflective of Mellors et al.,’s (2001) study that explored
the experience of transcending the suffering of AIDS where the theme of self-care was
described as encompassing the notion of beating the odds, and the need to survive. Both of
these notions highlight the importance of hanging in and enduring regardless of the degree
of discomfort being experienced also described in this theme.

The literature identified in relation to this theme primarily identified and examined the role
of personality traits and qualities in the development of burnout, with the main intent being
to predict the likelihood of developing burnout. This theme reflects the importance of
personality traits not only in relation to burnout but also to the experience of transcending
burnout. In particular, this theme has illustrated the significance of personality traits in
coping with and overcoming burnout where it has already occurred to an individual. This
finding is unique to this study. In addition, no other studies were identified that have
examined this concept from the same perspective in the same participant group (CAT Team
Nurses), or even to similar healthcare workers (i.e. nurses in other areas, social workers,
physicians etc.) working in CAT Team settings. As a result this makes a significant
contribution to the current understanding of the experience of transcending burnout, as it
reveals fresh insights into the lived experience of this phenomenon.
Theme Two: Reaching for Support

For many of the participants in this study the experience of transcending burnout involved Reaching for Support, wherein participants interacted and conversed with others within the mental health profession (particularly other CATT nurses), about their experience of burnout and their journey through and past this. It involved communicating with others in a manner where the participant could feel safe and secure enough in the interaction to be able to reveal their feelings of uncertainty, vulnerability and loss of confidence. Participants describing reaching for support from CATT colleagues within the work environment, through supervision with other MH nurses in the services or informally through their social networks of MH nurses, though in all cases it was the sense of being understood and of not being alone that were the essential elements.

Theme Two: Discussion relating to the literature.

In a study researching healthcare students patterns of self-comfort in dealing with stress (Dahlqvist, Söderberg & Norberg, 2008) explored the experiences of 168 nursing, occupational therapy, physiotherapy and medicine student. The authors described transcending as being one of the key themes in the findings from the study. This concept was further divided into ‘Finding new perspectives’, which was described by the authors as follows; “Transcendence made the participants mindful of their relatedness to the community of people (p. 481) …in transcendence the fragility of life becomes the shared reality” (p. 482). This concept reflects the findings within this theme (from this study) whereby participant’s experience of transcending also involved the experience of moving from the intrapersonal to the interpersonal and drawing support from those around them.
The findings of this theme also reflected the results of a study by Mellors, et al., (2001) in which the experience of transcending the suffering of AIDS was explored. Using a descriptive exploratory design to examine how patients with AIDS transcended the emotional and physical suffering associated with the illness, this study reported “creating a meaningful life pattern, connectedness, and self-care” (p. 239) as the key findings. In the context of this study “Connectedness was expressed in the concepts of … relationships” (p. 241) that was similarly described in the findings of this theme, wherein participants reached for support from others seeking to feel connected, understood and not alone.

The theme also reflects De Bendetto’s (2007) notion that being listened to by others allows the individual to “transform their chaos stories into quest stories … quest stories are stories of transcendence” (p. 1277). In De Bendetto’s (2007) narrative article describing the experiences of family physicians working with terminally ill patients in Brazil the author constructs the action of reaching for support through human interaction not only as a way of connecting with others but as a medium by which transcending is actually achieved by the individual. This is reflected in the findings in this theme wherein the participants described the process of talking to colleagues about burnout as actually being an important aspect of their experience of transcending burnout.

The importance of relationships in the experience of transcending burnout was consistent with Freeman’s (2002), description of ‘transcending circumstance’ wherein she described the importance of support from friends and family who were also prisoners in the same camp. Although differing in the nature of the adversity the importance of these people in the individual’s life served to provide a connection of great importance and significance that provided a practical source of support in transcending adversity.
The results of Coward and Khan’s (2005) study examining the experience of transcending breast cancer also make very clear reference to the importance of reaching out for support within the experience of transcending “All reached out to family, friends, and acquaintances who had had breast cancer or to survivors at the local breast cancer resource center” (p. 273). This concept was also evident in Bowlanda, Biswasb, Kyriakakisc, and Edmondd’s study (2011) that entitled ‘Transcending the Negative: Spiritual Struggles and Resilience in Older Female Trauma Survivors’ (though this study had a strong religious focus). In their findings the authors found that the “search for community was a theme that commonly emerged … the search for community was related to active steps women made to create a layer of social support” (p. 328). These findings are mirrored in the findings of this theme as the participants in this study described seeking support from close colleagues through to friends and family of their own as part of transcending burnout.

The importance of professional relationships (identified within this theme) in response to overcoming burnout is consistent with Edward’s (2005) phenomenological study examining the phenomenon of resilience in relation to the high risk of burnout faced by Crisis Care Mental Health Clinicians. Edward’s (2005) study is unique amongst the existing literature examined in the review as it alone looks specifically at clinicians’ working on Crisis Care Mental Health team (though it was not limited to nurses). The finding ‘team as a protective veneer’ reflected the important role professional relationships had in transcending burnout though relevance of this similarity is limited by the Edward’s (2005) focus on resilience as a process of ‘springing back’ from adversity such as burnout rather than transcending it. This theme also reflected Jenkins and Elliott’s (2004) finding that the understanding and availability of work colleagues were important factors in coping with burnout in acute mental health inpatient nursing staff.
The findings of this theme support the results of a 2006 study by Edwards et al., (2006), that reported on the positive impact of effective clinical supervision in reducing burnout. Supervision was a useful tool for a number of the participants in this study though it was interesting to note that not all participants reported it to be useful. Critical here was Edwards et al., (2006) point that the supervision has to be deemed effective to have any value. These findings were also consistent with the results of a literature review by Fearon and Nicol (2011) that reported on the positive impact of effective clinical supervision in reducing burnout as well as Gonge and Buus’ (2011) study which also found clinical supervision to be an effective tool in minimising burnout across both inpatient and community mental health services along with Sherring and Knight’s (2009) finding that mental health nurses who had regular supervision had much lower levels of emotional exhaustion than those who did not, again indicating it was an important aspect in reducing the personal impact of burnout. Awa, Plaumann and Walter’s (2010) review of 25 different burnout prevention intervention programs also noted the importance of clinical supervision in managing burnout, however none of them incorporated the concept of transcending burnout in their discussion.

The literature explored in relation to this theme reflected the importance of being able to reach out for collegial support in the context of experiencing burnout. In exploring the experience of burnout from the perspective of having transcended it, this theme has demonstrated the continued importance of support from colleagues in coping with and overcoming burnout where it has already occurred in an individual.
Theme Three: Weathering the Storm

For many of the participants in the study the experience of transcending burnout through ‘Weathering the Storm’ involved persisting and pushing on through difficulty and adversity with the sense that this was the essential pathway toward transcending burnout. It involved not only the willingness to carry on and stick with it, but also the capacity to accept this as being an integral element in transcending burnout that would ultimately have some value for the participant despite the personal and emotional discomfort this involved. Constructing and maintaining an escape hatch served to inform a feeling of choice that was so important in weathering the storm; they remained because they wanted to, not because they had to. Finally, some participants spoke of burnout as being an unavoidable hazard of the CATT working environment, describing their experience of transcending burnout as being an ongoing journey that would ebb and flow, but which ultimately had no end in sight.

Theme Three: Discussion relating to the literature.

The findings incorporated within theme Weathering the Storm reflect a number of the aspects of resilience described in earlier studies. In their 2007 literature review on personal resilience in the face of workplace adversity Jackson, Firtko and Edenborough describe resilience as “the ability of an individual to adjust to adversity … continue to move on” (p. 3), reflecting the notion of persisting and pushing on through difficulty and adversity described in this theme. Garcia and Calvo (2011) described it as “the confrontation process that makes a person stay intact in spite of adverse situations (p. 102) whilst Edward, Welch and Chater (2005) described it as the ability of people to roll with the punches and cope with
life events” (p. 588) both of which are reflected in the concept of *willingness to carry on and stick with it* as described in the theme.

It is however important to note that whilst the theme *Weathering the Storm* certainly reflected the overall concept of resilience, there were some areas where the two concepts differed. According to Ruysschaert (2009) and Charney (2004), resilience includes ten specific identifiable elements: “altruism, having a moral compass, faith and spirituality, humour, having a role model, social supports, facing fear, and having a mission of meaning in life” (Ruysschaert, 2009, p. 167), some of which are reflected in the findings of this study. The second last of these elements (facing fear) is reflected in this theme as the participants chose to keep going despite their experience of adversity (burnout) and in doing so had to face their fears associated with this experience. The resilience ‘elements’ of humour and social supports also resonate with the findings of this study and are discussed in Themes One and Six respectively. This however, is the extent of the similarity between the concepts of resilience and transcending with the other seven identifiable elements of resilience not being reflected in the participant experiences or the themes explicated in this study.

In considering the literature concerning resilience and its relationship to this theme it is also important to note the limitations of personality traits as outlined by authors such as Blakeman and Ford (2011), and Schoon and Bartley (2008) who stated that it was important not to over-emphasise the importance of these traits in overcoming adversity. This is in keeping with the results of this study wherein the traits described by participants in *Weathering the Storm* were a significant aspect of transcending burnout, however they were not the only elements and the experience described extended well beyond these traits.
Theme Four: Making Sense of the Personal Non-Sense and Re-Finding Clinical Meaning

For the participants the experience of Making Sense of the Personal Non-Sense and Re-Finding Clinical Meaning was a key element of their experience of transcending burnout. This experience involved participants developing an increased sense of intrapersonal understanding of the nature and characteristics of the situation they found themselves in. This required examining and making sense of their abilities and limitations as clinicians in light of the impact that feeling burnt-out had had upon them. By reflecting on the changes they had experienced in their various roles, responsibilities and of their working environment and ‘reconstructing’ these elements in a way that make sense for the individual they were able to again find a way to understand their experiences. In accomplishing this difficult and at times uncomfortable process the participants described being able to reconnect with their sense of clinical meaning and again make sense for themselves of the value of their clinical practice.

Theme Four: Discussion relating to the literature.

The findings of this theme are consistent with findings from a study undertaken by Dahlqvist et al., (2008). The sub-theme, finding new perspectives was described by the authors as “… arriving at an understanding and a sense of meaningfulness … transcendence helped them to climb out of chaos towards new perspectives. Thoughts that had caused distress were sorted; worries took on more realistic proportions or became negligible” (p. 481). This notion certainly echoes the findings of this theme in which participants were able
to again find a way to understand their experiences, making sense of the non-sense through coming to fresh understandings (perspectives) regarding their experiences.

The opposing and contrasting nature of the concepts of sense and non-sense integral to this theme was consistent with Jenkins and Ogden’s (2012) discussion of transcending as an aspect of becoming whole again as described by women recovering from Anorexia Nervosa. The authors utilised an interpretive phenomenological approach to explore the experiences of 15 women recovering from Anorexia Nervosa and reported that recovery required transcending the dichotomies that their illness presented them with. This was reflected in the opposing concepts of sense and non-sense included in this theme, as the participants struggled to understand the new and unique aspects of the experience whilst having to question and revise things about themselves and their practice that had previously seemed certain. The ambiguous and often contradictory nature of this experience contributed to it being a difficult and at times uncomfortable process as described by the participants.

The participants experience of ‘reconstructing’ their various roles, responsibilities and expectations in a way that made sense for them as described in this theme was consistent with Liberman and Trope’s (2008) review of the literature in which they examined the literature regarding the psychology of transcending the here and now and concluded that “abstract thinking is used to transcend the present and expand one’s mental horizon by thinking farther into time and space and considering remote social targets and unlikely possibilities” (p. 1204). In doing this the participants in the study examined the way in which they were relating to what was happening to them and were constructing mental models of possible outcomes to allow themselves to look beyond what was happening to them in the here and now.
The notions of an increasing sense of intrapersonal understanding (internal reflection) and reflecting upon the changes they had experienced (external reflection) contained within this theme, were also consistent with Duggleby et al.,’s (2012) meta-synthesis of 20 qualitative research articles examining the notions of hope and chronic illness in adults in which transcendence was a major theme. The authors reported that transcendence involved “Reaching inward and outward in finding meaning and purpose” (1219), and closely mirrored the process described within this theme by the participants of this study. The importance of reflection in overcoming burnout as described in this theme was also reflected in Fearon and Nicol’s (2011) discussion of strategies useful in preventing burnout in nurses, where the authors reported that reflection had the potential to assist in “promoting well-being and reducing the risk of burnout” (p. 39).

The ideas within this theme are also consistent with Kinney’s (1996) description of transcending breast cancer through reconstructing and re-integrating her sense of her whole self in response to each of the stressors and challenges she faced. The theme also reflects the findings of Chiu’s (2000) study examining breast cancer survivors in Taiwan with the author reporting that transcending involved the capacity to reflect, thinking beyond the immediate situation and look for broader “life perspectives and purposes” (Chiu, 2000, p. 65).

Nugent, Moss, Barnes and Wilks (2011) examined the use of mindfulness-based reflective practice in a cohort of nine experienced healthcare practitioners of various professions working in England. They found “there was the sense that mindfulness practice does not often bring a sense of peace and calm as one new to practice may expect. It does not offer an escape from reality, but is an intense look at present experience” (p. 7). This notion of needing to engage with negative experience rather than distract of divert away from it is
consistent with the notion that transcending as described by the participants in this study was a difficult and at times uncomfortable process, however this was necessary in facing and working through the experience of burnout in order to transcend it.

Mindfulness was also a focus in Isaksson Ro, Gude, Tyssen and Aasland’s (2010) exploration of a workshop intervention designed to decrease burnout in 172 Norwegian nurses (from various clinical backgrounds). In this case the authors reported that increased self-awareness in making sense of the experience of burnout was an important aspect in overcoming it. The importance of mindfulness and self-awareness is reflected in the findings of Theme Four, which described the participant’s experiences in having to reflect upon and come to a better understand of their experience of burnout. Understanding, exploring and coming to truly understand the changes that the experience of burnout had brought about were the building blocks for an increased level of self-awareness that was an essential part of their experience of transcending burnout.

Mindfulness as a concept within an experience of transcending was also mentioned by Wolsko (2012) in his study of undergraduate psychology students in Transcribing and Transcending the Ego. This study focused primarily upon “salient upward and downward social comparisons, with particular attention to those experiences that triggered strong feelings of inferiority and superiority” in the absence of any significant adversity or hardship as experienced by the participant’s, therefore having little similarity to the focus of this study. As a result this study contributed little to the broader literature relating to the experience of transcending burnout. Studies by Wayment, Wiist, Sullivan and Warren (2011) and Travis and Shea (2010) also examined the concepts of transcending and mindfulness however these were both
specifically focused on the application of these concepts in a spiritual sense and so had no relevance to this study. Ultimately the aforementioned studies, whilst certainly sharing a focus on personal reflection within transcending differed significantly in their contexts, methodologies, and population samples, and as such provide limited support for this study.

Another example of the concept of making personal sense of things that initially don’t make sense can be found in Hong Chen’s (2011) reflective article in which the author explores the concept of transcending suffering in the context of the experiences of survivors of the 2008 Wenchuan earthquake in China. Hong Chen reports that the experience of transcending suffering is “intimately concerned with the way we view ourselves … and this provides us with unique avenues to personal exploration and self-realisation” (p. 214); this resonates with the fourth theme of this study in which the participants were seen developing an increasing sense of intrapersonal understanding and a redeveloped ability to understand their experiences. In both cases the experience of transcending suffering / burnout (as a specific type of suffering) entailed a deeply intrapersonal journal of change that provided the individual with opportunities to enhance and further develop their understanding of their world, albeit through a difficult and challenging period of time.

The notion of making sense of the non-sense is also presented as one of the findings in Idle-Okochi, Yamazaki, Tadaka, Fujimura and Kusunaga’s (2013) study examining the illness experience of adults with cervical spinal cord injury in Japan. Transcending limitations of disability was seen to include “seeing self from a new perspective” (p. 7) with Idle-Okochi et al., stating that “it was not until they could see their self from a new
perspective that they could re-enter the nondisabled world” (p. 7). The importance of
developing this new perspective is reflected in this theme of this study in which the
participants described developing a newly evolving sense of intrapersonal awareness in
response to the experience of feeling burnt out and a revamped sense of themselves in
understanding their experiences.

The notion of re-finding clinical meaning reflects the notion of engagement described in
various studies (Fiabane, Giorgi, Sguazzin & Argentero, 2013; Sawatzky & Enns,
2012). The concept of engagement described in these studies involved clinicians
possessing a positive, meaningful and fulfilling attitude towards their work. This
concept is consistent with the participant’s description of making sense (or re-engaging)
with their sense of re-finding clinical in their practice. Re-finding clinical meaning is
also reflected in the notion of finding value and therefore feeling valued at work and is
consistent with Sherring and Knight’s (2009) finding that a stronger sense of feeling
valued correlated with lower rates of emotional exhaustion (and vice versa), indicating
it was an important aspect in minimising the personal impact of burnout.

The notion of commitment as an aspect of a hardy personality is also reflected within this
theme. Commitment is the tendency for “believing in the truth, importance and value of
oneself, and ones work” (Gustafsson et al. 2009, p. 343). This is in keeping with previous
literature identifying a hardy personality as a significant factor in the development of
burnout (Garrosa et al., 2009; Garrosa et al., 2010; Garrosa et al., 2011; Gustafsson, 2009;
Kalimo et al., 2003; Kobasa, 1979, Maddi, 2006; Sheard & Golby, 2007). This is reflected
initially in the participant description of the loss of belief in the value and significance of
their clinical practice. However, the theme also captures the re-emergence of their belief in
(and connection with) the truth and importance of themselves as nurses and their work (commitment) as being an important aspect of transcending burnout.

**Theme Five: Regaining Balance and Lost Control**

Transcending Burnout through Regaining Balance and Lost Control involved participants experiencing a process where they first came to recognise and later understand their experience of having little control over the situation in which they found themselves leading to a loss of personal and professional balance. This process involved being able to rationalise and organise their interpretation of their surroundings in order to allow the participants to start to make decisions about the scope and limitations of their practice. Once accomplished, this new sense of intrapersonal clarity and awareness lead to the individual being able to assume a newly developed sense of control in practical behaviours that has the resultant effect of returning their life to a more balanced state (where they no longer felt burnt out).

**Theme Five: Discussion relating to the literature.**

The findings of this theme in relation of the notion of balance were consistent with research by Wainwright’s (1997) Grounded Theory study which looked at transcending chronic liver disease. The findings of Wainwright’s study concluded that “patients often transcended many aspects of their illness as they wanted a normal life” (p. 49). This notion of wanting a ‘normal life’ resonates with theme five of this study as in both cases the participants were trying to return to a state of balance, in which they were operating within the parameters of what was considered customary and conventional. Each of the CAT Team
nurses interviewed, in their experience of transcending, burnout had been seeking to find a way through to a state of equilibrium in their practice as a mental health nurse (and as a person), attempting to be seen (by both themselves and others) as capable, credible and ‘normal’.

The importance of control in coping with stress (related to burnout) was also described in reverse by Hopkinson et al., (1998) in their study of community mental health nurse’s attitudes towards occupational stress. The authors found that a lack of control was linked to higher rates of stress and burnout in the 15 community mental health nurses who participated in the study. This finding is relevant as it provides context to this theme where the opposite is true for the experience of transcending burnout as shown by the importance of re-establishing control in transcending burnout as described by this study’s participants.

The importance of control explicated in this theme is consistent with previous literature relating to control as one of the three key aspects of a hardy personality, which was found to be a significant factor in the development of burnout (Garrosa et al., 2009; Garrosa et al., 2010; Garrosa et al., 2011; Gustafsson, 2009; Kalimo et al., 2003; Kobasa, 1979, Maddi, 2006; Sheard & Golby, 2007). Control in this context is not a “naive expectation of being able to totally influence all events and results, but refers to a control that includes a realistic perception of what it is possible to be in control of” (Gustafsson et al., 2009, p. 343). The impact of the individual’s sense of control is reflected both in the significance of the loss of control when experiencing burnout described in this theme followed by the development of a ‘realistic perception’ of scope and limitations of their practice based on a review of their surroundings leading ultimately to the re-emergence of their sense of control. As with the previous discussion of the elements of hardiness in coping with
burnout, this theme has taken further the understanding of the importance of control not only in resisting burnout but in overcoming it as well.

In their 2005 article Coward and Khan (as previously discussed) explored the lived experience of Transcending Breast Cancer identifying the initial loss (and later re-establishment) of control as being a key finding from the study. The study initially described women as being “on an out-of-control emotional roller-coaster” (p. 271) in the initial phase of the experience through to the later period where “they felt more in control of the physical and emotional effects” (p. 275) associated with their experience. The authors concluded that “in clarifying and changing personal values and behaviours to relieve their distress, women restore their sense of control” (p. 278). This finding strongly reflects the findings of this study where the participants moved through a clearly detailed period of feeling overwhelmed and out of control through to being able to better understand what was happening to them. This led to their regaining a sense of control and in doing so re-find their sense of personal and practice ‘meaning’.

Theme Six: Transcending through the World Outside

For the majority of the participants in the study the experience of transcending burnout involved an increased awareness of the importance of their life outside work. Participants became increasingly able to understand and appreciate the role that their life outside of work played as a counter-weight to the hardship of burnout they experienced as CATT nurses. The presence of a strong social network to provide opportunities for simple enjoyment whilst time spent with close trusted family members allowed participants to unload their negative emotions with the support of an understanding listener. At other times the
participant’s world outside offered opportunities for activities that provided simple
distraction and the chance to think about something else. Finally for many of the participants
self-caring and self-soothing activities [spanning simple time by themselves through to
socializing and drinking with friends] allowed them to engage in feeling happy and relaxed
in their experience of transcending burnout.

**Theme Six: Discussion relating to the literature.**

The findings of this theme in relation to the positive role of family relationships are
inversely consistent with the results of Majomi et al.,’s (2003) study in which they
concluded that home-based stressors were a significant contributing factor to the overall
stress experienced by community mental health nurses. As a potential source of both stress
and support in most facets of life, families have the potential to both ameliorate and
exacerbate levels of stress in an individual. In the case of the participants in this study it was
the former which sits opposite to Majomi et al.,’s (2003) finding, however together they
complete the spectrum of potential family influence upon the experience of stress and
burnout in the community mental health nurse context. The significance of support from
close family in the experience of transcending burnout was also consistent with research by
Skogrand et al., (2005) who reported that the spousal support played a significant role in the
experience of transcending adversity (as described by married adult childhood trauma
survivors) through the provision of practical and emotional support. This was consistent
with the descriptions of the participants in this study who described the role-play by
supportive partners in listening and showing love for them whilst they (the participants)
transcended burnout.
The findings of this theme in relation to engagement in external activities and distractions was reflected in Freeman’s (2002), description of ‘transcending circumstance’ described by concentration camp prisoners in World War II. Freeman described prisoner’s use of music and art as activities to distract or to remind the individual of the broader context of life, consistent with the participants in this study turning to enjoyable activities to re-establish their connection with the ‘normal’ aspects of their life outside of the difficult situation they found themselves in.

The importance of engaging in external activities in order to help overcome burnout described in this theme is also consistent with the findings of Garrosa et al., (2010) who reported that “coping resources were also relevant predictors of burnout dimensions … active coping had an inverse temporal effect on depersonalisation and lack of personal accomplishment” (p. 209). For the participants in this study these activities played an important role in transcending burnout though as with the findings of Garrosa et al.,’s (2011) study the benefit gained from these activities was passing in its nature and required persistence and repetition in their use by the participant to maintain their effectiveness.

The importance of family and personal life outside of the working environment was also described by Edwards et al., (2001b) in their article describing the findings of the The All-Wales Community Mental health Nurse (CMHN) Stress Study. In this the authors described the most important coping strategies used by CPN’s as having a stable family life, good social supports an external activities (such as hobbies) that they enjoyed doing. This is clearly reflected by the descriptions of the participants within this theme.
Previously discussed in relation to themes Two and Four, the study undertaken by Dahlqvist et al., (2008) also identified the sub-theme of Opening up (to be discussed below) as part of their theme of transcending. Opening up was described by the authors as “being present, contemplating and feeling connected to life through nature … made participants feel able to reach out beyond ordinary limitations, being actually in the moment and enjoying it” (p. 481), which was echoed in a number of the participant’s descriptions of increased interest and enjoyment of activities and experiences outside of their working environment. The authors went onto state that participants described “the state of presence and embodiment in which they re-access the relaxed state of feeling at home in life” (p. 482), which was also reflected in the findings of this theme where participant’s described re-finding their enjoyment of their ‘home’ lives as being a significant theme in their experience of transcending burnout.

The findings of this theme were also consistent with one of the key findings of a study by Mellors et al., (2001) which explored the experience of transcending the suffering of AIDS. This study reported the importance of, “creating a meaningful life pattern” (p. 239) along with life satisfaction and living life to the fullest as the key findings. This is reflected in this theme through the participant’s description of their increasing involvement in activities they saw as having meaning in their lives. The importance of social networks and activities in transcending the limitations of disability (as adversity) were also reflected in Idle-Okochi1, Yamazaki, Tadaka, Fujimura and Kusunaga’s 2013 study examining the Illness experience of adults with cervical spinal cord injury in Japan. This importance of social networks and activities in transcending adversity described by Idle-Okochi1 et al., (2013) is consistent with the increased awareness of the importance of their life outside work included within this theme.
The findings of this theme are consistent with the role of “therapeutic recreation” (McCormick & Iwasaki, 2008, p. 5) in transcending life challenges. In their review of the literature the authors concluded that therapeutic recreation is an important aspect of transcending challenges in life, stating that this involves going “beyond simply surviving from a passive or reactive perspective … involves thriving from a pro-active perspective” (p. 5). The importance of engaging in enjoyable though meaningful activity as an integral aspect of transcending the challenge of burnout was mentioned by many of the participants of the study, reflecting this concept in practice. The significance of leisure activities (as reflected in this theme) was also consistent with Kleiber, Hutchinson and Williams (2002) study in which they reported that leisure activities often constituted one of the initial areas where the individual coping with adversity could actually experience transcending, as these activities afforded them the opportunity to actually enjoy themselves free from the effects of the adversity they were facing.

This theme also reflects a point made by Italia et al., (2008) in discussing the findings of their study examining the use of art therapy in paediatric nursing staff. In finding a significant improvement in levels of burnout following the implementation of an art therapy program, the authors reported being unable to specifically identify which aspect of the intervention had been primarily responsible for the improvement though they felt the fact that most participants had seen the session “more like a recreational activity” (p. 679) was highly significant. Such a finding links to the importance of recreational activity as described by participants in this study. This notion was also reflected by Neville and Cole (2013) in their study exploring the relationships between health promotion behaviours (including biking, yoga, gym memberships, walking, running and swimming) and compassion fatigue and burnout in 214 nurses practicing in a community medical centre.
The authors noted a moderate positive association between health promotion behaviours and decreased levels of burnout, highlighting the significance of these behaviours in coping with burnout overall.

**Theme Seven: Rebuilding the Boundaries and Affirming Realistic Expectations**

Transcending Burnout through Rebuilding the Boundaries / Setting and Affirming Realistic Expectations, involved participants being able to repair and rebuild their intrapersonal and interpersonal boundaries based upon a foundation of realistic self-expectation. This required that they were able to consider and accept the limits of their own practice within the broader working environment, separating the idea from the actual and accepting the practical limitations that this entailed. This also involved setting limits on themselves, not taking on more than they could handle and being willing to disseminate the responsibility for consumer care outcomes with colleagues. Transcending burnout in this way also meant ensuring the boundary between work life and home / personal life was kept in good repair to ensure that the division between the two domains was maintained.

**Theme Seven: Discussion relating to the literature.**

The literature review identified a paucity of research that included the key notions of boundaries and realistic expectations in relation to transcending burnout as contained within this theme. The findings were consistent with Isaksson Ro, Gude, Tyssen and Aasland’s (2010) study which focused on the importance of being able to “accept disease and personal limitations” (p. 192) in overcoming burnout. For the participants in Isaksson Ro et al.,’s (2010) study accepting these personal limitations was an important part of overcoming
burnout. For the participants in this study it was also an important aspect in their experience of transcending burnout as well.

The paucity of literature identified in relation to this theme suggests that this finding is unique to this study. Although there is a substantial body of professional nursing literature that focuses on the concepts of professional boundaries and realistic practice expectations, this has not been previously associated with the experience of overcoming or transcending burnout. No other studies were identified that combined these two concepts with the same participant group (CAT Team Nurses), nor even to nurses in broader clinical settings. Therefore this theme contributes to current understanding of the experience of transcending burnout, as it reveals fresh insights into the lived experience of this phenomenon.

**Theme Eight: Transcending as the Road Goes Ever on**

The experience of *Transcending Burnout as the Road Goes Ever On*, reflected the concept described by many participants that whilst they had been able to transcend their recent experience of burnout there may be further episodes emerge for them in the future, which in turn may lead to further experiences of transcending this burnout. This was based upon an understanding of the highly challenging nature of working in the CAT Team environment, and was accompanied with a clear sense of calm acceptance rather than the resistance that had accompanied the initial episode. Participants described a clear sense of growth and broader understanding of themselves and their feelings related to transcending. Out of the discomfort and suffering of burnout they had been able to re-find aspects of themselves previous thought lost as well as developing new strengths and resources that they could
identify as being important for their working lives in the future. This was the rainbow at the end of the storm.

**Theme Eight: Discussion relating to the literature.**

The ongoing and unfolding notion contained within this theme is also reflected in Kinney’s (1996) description of transcending breast cancer, which she described as “an evolving and integrating process that is ongoing and ever-building” (Kinney, 1996, p. 202). Although different in the source of the adversity this was clearly reflected by the participants in this study who saw transcending burnout as an ongoing process stretching out into their future as CAT Team nurses. This is also in keeping with Gosselink and Myllykangas (2007) who in exploring the concept of transcending barriers associated with illness in order to enjoy leisure experiences reported that the participant’s experience of transcendence appeared “to mature …formed a continuum” (p. 16). This again reflects the idea within this theme that transcending is a gradual and ongoing process wherein the participants may experience and transcend burnout again in their future, though with a much stronger sense of themselves in doing so. The findings of this theme are also consistent with a study by DeFrain et al., (2005) in which the authors described the experience of surviving and transcending a traumatic childhood. Both studies found that transcending adversity for the participants was an ongoing process rather than a single or ‘one-off’ experience.

The sense of personal growth associated with transcending burnout incorporated within this theme is consistent with Mitchell et al., (2007) who described transcendence as involving “the sense of becoming more than they were before, of becoming physically,
mentally, emotionally stronger” (p. 134). This idea is closely reflected in the description of this theme wherein participants described a clear sense of growth and broader understanding of themselves and their feelings related to transcending. In this study transcending was not described as a return to the way they had been prior to experiencing adversity but instead as new growth and evolution through the adversity they had faced. The concept of growth as an essential aspect of transcending was also identified by Fex, Flenser, Ek and Soderhamn (2010) who explored the health-illness transition in 10 participants using advanced medical technology at home through a phenomenological research approach. The authors described the participant’s experience of transcending into a new state of living as an active and conscious process “characterized by human growth” (p. 259), again reflecting the significance of growth as part of the experience of transcending burnout included within this theme.

The concept of growth within transcending is also consistent with the findings of King et al., (2003) who, in examining the experience of living with chronic disabilities, introduced the concept of transcending as a process wherein the individual was able to experience a negative event however through this emerged an opportunity for a new gain that had not been there before. It is also in keeping with the results of a study by Egnew (2005) who in exploring the notion of transcending suffering in physicians, concluding that “transcending suffering is surely personal growth” (p. 260). Although the participant groups in these studies differ significantly from the CAT Team nurses that were the focus of this study, all studies included the opportunity for growth in overcoming adversity as an intrinsic quality in the experience of transcending. The findings of this theme were also consistent with Brion, Menke and Kimball’s (2013) concept of growth as an integral part of transcending. In their qualitative descriptive study exploring the work of transcending loss in 24 HIV-infected gay
men, the authors reported that “Individuals who process losses by exploring their meaning and constructing new personal narratives may experience physical and emotional changes leading to growth and transcendence” (p. 516). This finding of their study is again consistent with the participant’s reports of growth within this theme.

In their 2005 article Coward and Khan (other aspects have previously been discussed) described the paradoxical situation facing those who had transcended breast cancer. They had recovered but despite this were still facing a future where relapse remained a very real risk. Transcending in this sense required an acceptance of both possibilities for themselves: “They expanded their concept of self to include both healthiness and breast cancer” (p. 279). This mirrors the findings contained within this theme where many of the CAT Team nurses, having transcended burnout were moving forward having accepted the potential for further episodes of burnout (due to the highly acute and personally demanding nature of the environment), and in doing so were having to expand their concept of self to include both ‘burnt-out’ and ‘transcended’ versions of themselves in the future. Coward and Khan (2005) also found that “participants expanded their previous self-conceptual boundaries to construct meaning from their experience” (p. 271) an idea also reflected in the findings of this study wherein the participants were able to see some purpose and value in their experiences that may have some use in the future.

The findings of this theme are also consistent with Awa, Plaumann and Walter’s (2010) review of 25 different burnout prevention intervention programs (discussed earlier in this chapter) that reported 80% of participants described a reduction in their burnout symptom scores that lasted six months to a year on average. Subsequent to these periods of improvement the authors noted that the symptoms of burnout in most of the programs
returned, reflecting the ongoing nature of burnout as a problem facing healthcare providers. The findings of this theme clearly echo this point in relation to the notion of transcending burnout.

Dunford, Shipp, Boss, and Angermeier (2012) conducted research on a large number of employees working in a private healthcare organisation in the United States, ranging from clerical staff through to nurses, physicians and manager, examining whether burnout was static or dynamic in its nature. The results of the two year study concluding that “burnout is slightly dynamic for newcomers and job changers but rather stable for organizational insiders” (p. 647), which was at odds with the perspective of the participants of this study most of whom saw burnout as an intrinsic hazard of the role, whereby continuity in the role of CATT nurse did not reducing the risk of burnout. That said, the aforementioned study differed significantly in both its methodology, and participant population, and as such had limited relevance to the findings of this study.

**Theme Nine: Transcending Burnout through increasing Confidence in Credibility**

Transcending Burnout through *Increasing Confidence in Credibility* involved participants undertaking a journey from feeling uncertain and unsure of their own ability as a CATT nurse through to again feeling capable and competent in their practice. For the participants this was an inconsistent and unreliable process, as their sense of confidence and credibility waxed and waned over time however over time there was the clearly defined experience of these qualities gradually returning as the participants transcended burnout.
Theme Nine: Discussion relating to the literature.

As with Theme Seven, the literature review identified a paucity of research that included the key notions of confidence in credibility in relation to transcending burnout as contained within this theme. Within the area of community mental health Elsom, Happell and (2007) examined the notion of confidence in community mental health nurses regarding expanded practice roles. This research focused primarily on confidence in relation to this specific issue and as a result has little relevance to the experience of transcending burnout.

Mental health nurses confidence regarding the physical health issues and care of consumers was a focus in studies by Bradshaw and Pedley (2012), Robson, Haddad and Gournay (2013), Unsworth, Mckeever and Kelleher (2012). These studies specifically examined the confidence of mental health nurses around the provision of physical health care to their clients. Though these studies did examine mental health nurses confidence in an aspect of their practice the nature of this was markedly different to the focus of the current study, limiting their relevance to the findings of this theme.

The issue of student nurse confidence in the mental health setting was also the topic of articles by Fiedler, Breitenstein and Delaney (2012), Happell and Platania-Phung (2012) Ross, Mahal, Chinnapen and Rana (2013) whilst a study by Cleary, Matheson and Happell (2009) included the notion of confidence in newly graduated nurses in their first year of practice. The focus of this area of research regarding confidence in mental health was student nurses and nurses at the beginning of their careers rather than those with significant clinical experience (as is the case with CAT Team nurses) and therefore had little relevance to the findings of this study.
Finally, with regards to the literature on confidence in relation to transcending there was a similarly little available. A study by Chou, Yu, Liaw and Tang (2007) exploring the life attitudes of ten patients with nasopharyngeal carcinoma identified the need to rebuild their confidence to survive and learn to embrace life as an important aspect in dealing with this illness. It reflects the negative impact on confidence that facing adversity entails seen in the current study though the context is very different.

The scarcity of significant literature identified regarding this theme suggests that this finding is unique to this study. Although there is a substantial body of professional nursing and other health literature that focuses on the concepts of confidence and its influence upon the individuals sense of credibility in their clinical practice this has not been previously associated with the experience of overcoming or transcending burnout. No other studies were identified that combined these two concepts with the same participant group (CAT Team Nurses) or even to nurses in broader community mental health clinical settings. Therefore this theme contributes to current understanding of the experience of transcending burnout, as it reveals fresh insights into the lived experience of this phenomenon.

**Summary of the Findings related to Key Concepts in the Literature.**

The literature reviewed and discussed in this chapter has reiterated the ongoing issue of burnout in community mental health nursing (Edwards, Coyle & Hannigan, 2000; Fagin et al., 1995; Fielding & Weaver, 1994; Ford, et al., 1997; Wykes, Stevens and Everitt, 1997; McLeod, 1997; Pinikahana & Happell, 2004; The All-Wales Community Mental health Nurse (CMHN) Stress Study, 2000; Robinson, et al., 2003) along with numerous studies that examined the impact of various factors upon the development of burnout (Crawford et al.,
A number of the findings of this study were consistent with the concept of resilience as described in the literature. The concept of resilience overall was reflected in Theme Three *Weathering the Storm* whilst a number of the key aspects of resilience according to Ruysschaert (2009) and Charney (2004), where also reflected in the findings including humour (Theme One: *Personal Strength: Grim Determination, Pragmatism and Optimism*), social supports (Theme Six: *Transcending through Connection with the World Outside*), and facing fear (Theme Three *Weathering the Storm*). That said, the concept of hardiness (Kobasa, 1979; Kalimo et al., 2003; Sheard & Golby, 2007; Garrosa et al., 2009) as characterised by the qualities of control, commitment and challenge was equally significant in the experience of transcending burnout. The three key elements of this concept were
strongly reflected in Themes One, Five and Nine contributing behavioural qualities that were central to the lived experience of transcending burnout.

The application of transcending as a conceptual lens by which to understand the individual’s experience of overcoming adversity has been shown to have significant validity, though from this review of the literature it appears to be the only example of it being applied to adversity in the form of burnout. The application of the concept of transcending to the human experience of overcoming adversity has been utilised in a significant number of research studies into areas of adversity including breast cancer (Chiu, 2000; Coward & Kahn 2005; Kinney, 1996; Mitchell, et al., 2007), various forms of illness including spinal cord injury (Idle-Okochi l et al., 2013), HIV AIDS (Brion, Menke, & Kimball, 2013; Gosselink & Myllykangas, 2007; Newshan, 1998), and liver disease (Wainwright, 1997). Many of the key findings of these studies (such as the importance of support, the process of having to reconsider existing concepts of self and rebuild these in response to the experience of adversity, the existence of an opportunity for growth and the ongoing nature of transcending) were reflected in the themes of this study. In accomplishing this, the results of this study provide a fresh perspective for understanding the essential experience of prevailing over burnout by transcending it. In applying this conceptual model of human experience to the phenomenon of burnout (as experienced by CAT Team nurses) this study has illuminated an innovative way of understanding the experience of overcoming burnout and therefore appears to constitute a significant contribution to the current understanding of the experience of transcending burnout, revealing fresh insights into the lived experience of this phenomenon.
Summary of the Chapter

This chapter has provided a detailed exploration of the study findings in relation to the existent literature, in order to contextualise them within the broader knowledge around this topic. Literature related to transcending burnout as the essential focus of the study was introduced and examined, followed by an exploration of the literature related to the nine core themes. The next (and final) chapter of the thesis will present the strengths and limitations of the study and consider implications for future nursing and research practice. The chapter will conclude with the researcher’s reflections on the research journey in undertaking this research project and dissertation.
Chapter Eight

Implications of the Study Findings and Researcher Reflection

This chapter begins by presenting a discussion on the strengths and limitations associated with the findings of the study. The chapter continues with a discussion of the researcher’s experience of the research process before exploring the implications of the study’s findings both for clinical practice and further research. Recommendations for each area are provided.

The chapter concludes with the researcher’s reflection on the process and experience of completing the study. Presented in a more informal, narrative style this section provides a window into the researcher’s experience of undertaking the study.

Strengths of the Study

In considering the strengths of the study the researcher considered the strengths associated with the method utilised. Phenomenological research provides for the generation of in-depth understanding of individual phenomena, drawn from the rich data gained through a process of intimate engagement with the experiences of individuals. For a profession such as nursing where “practice is enmeshed with people’s life experiences, phenomenology as a research approach is well suited” Streubert-Speziale & Rinaldi Carpenter, 2011, p. 73) The study was able to generate data that provided a true window of insight and understanding into the lived experiences of a unique group of individuals practicing in an exceptional clinical practice environment.
The use of a phenomenological approach “gives deep insight into the lived world of the participants and does not stay on the surface” (Holloway & Wheeler, 2010, p. 225), which allowed the highly complex nature of the experiences of the participants unfold with a level of detail that was necessary for a deep understanding. Exploring the participant’s experiences (of transcending burnout) in depth (rather than at a superficial level) was critical as it allowed the true nature of the human experience to be explicated. Transcending burnout for these nurses was not a causal, passing experience but rather a complex, multifaceted one that occurred across many different aspects of themselves. Developing a genuine and true understanding of this required a research approach that had the capacity to collect and analyse data at this intensely human level.

**Limitations of the Study**

Due to the underpinning (and entirely necessary) requirement that the participant group consist of a small, purposive sample group comprised of individuals with experience in the phenomenon under investigation the findings of the study were never intended to generalisable in the strict scientific sense to the broader population. That said, the results may be utilised to emphasise a number of a variety of critical developments contained therein, which will serve to enrich further study of these issues and as such “they can prove relevant to other people and settings” (Finlay, 2009, p. 478). It is worth noting however, that this was always the expectation of the study design and therefore should be understood as a limitation rather than a weakness.

The paucity of literature currently available regarding transcending burnout may also be viewed as imposing a minor level of limitation upon the ability to contextualise the results
of this study within the broader literature on the topic. This has been addressed as
effectively as possible in the preceding chapter though this experience is in keeping with
the situation often faced by phenomenological researchers where the topic under
investigation constitutes a new area of inquiry and there has been little research already
undertaken (Holloway & Wheeler, 2010). Indeed, this is considered one of the key criteria
for selecting a phenomenological approach in the first place (Munhall, 2012) and the
explication of findings that are a new contribution to the literature should instead be
considered a strength of the methodology.

The collection and analysis of data by a single researcher (albeit under supervision), as has
occurred in this study, means that the findings were explicated through a single perceptual
lens rather than as a collaboration of multiple perspectives (Polkinghorne 2007). The
involvement of 12 participants (considered appropriate for a phenomenological study) and
the inclusion of a second interview to validate the researcher’s findings with the
participants themselves, did serve to mitigate the impact of this limitation substantially.

The study utilises the English language as its principle tool in collecting and
conceptualising data in the study. This process is restricted due to the differences in
meaning that each individual attributes to words and phrases (O’Toole, 2008) along with
the inherent limitations that language has in capturing the true detail and intensity of
human emotion and experience (Polkinghorne, 2007). In order to minimise this limitation
the participants’ own words voices were utilised as the building blocks of the data analysis
process with the researcher taking special care to ensure that the conversational context
surrounding the participants’ words was retained in the analysis process.
Personal Research Implications and Recommendations

Undertaking a PhD level research study using a phenomenological methodology has been a daunting and at times entirely overwhelming experience, due mainly to the great depth and complexity this approach entails. Phenomenology is a huge and complicated field of human knowledge that encompasses everything from a discipline of philosophy through to a method for conducting scientifically rigorous research. Within the field there are numerous elements, movements and often-competing perspectives not to mention its own nomenclature all of which can easily confound and overwhelm the novice researcher. In undertaking this project and effectively managing the requirements phenomenological research this researcher had to embark on a challenging process of ongoing education. This was a process that has continued right throughout his candidature and has at times been both a distraction and a barrier to the practical research process as the research got waylaid by new insights or blocked by a lack of them.

To assist in this process for other neophyte phenomenological researchers this researcher offers the following recommendations.

Personal research recommendation one.

It is suggested that a neophyte researcher intending to undertake phenomenological research must begin this process with an intensive period of education regarding the philosophy and discipline of phenomenology. Not only is this essential in ensuring that a phenomenological approach is warranted in the first place, but it is critical to ensure that firstly the right school (descriptive vs. hermeneutic) is selected and then within that the
most appropriate method for data collection and analysis. In addition it is important to understand the goals and objectives of phenomenological research as they remain at odds with the expectations of many other forms of research. Without his understanding it is easy to lose focus on what constitutes ‘good research’ within the phenomenological paradigm and find oneself being torn by different perspectives that may compromise the integrity of a study.

**Personal research recommendation two.**

It is suggested that a neophyte researcher intending to undertake phenomenological research engage in a very robust and creative process around the practical application of the concept of phenomenological reduction (bracketing). Bracketing is one of the most difficult and contentious aspects of the phenomenological research process and has been the subject of ongoing debate in the literature. Achieving it is critical to the success of phenomenological research as it creates the clear intrapersonal ‘space’ necessary for the phenomenological research to actually undertake phenomenological data analysis. Journaling, reflection, conversation, self-videotaping and supervision are all possible vehicles to achieving this goal but each researcher needs to actively engage in practical strategies that work for them. To coin a sports phrase: ‘bracketing is not a spectator sport’.

**Personal research recommendation three.**

It is suggested that a neophyte researcher intending to undertake phenomenological research consider well their method or approach to data collection and analysis. This process lies at the very heart of the phenomenological research process and given the
variety of different approaches available the research must examine each and consider its suitability for both the research project as well as it’s ‘fit’ with the research themselves. The method provides the only real structure in what is otherwise a highly fluid and subjective process and as such needs to be an accessible and applicable process that the researcher has a genuine faith in.

Clinical Practice Implications and Recommendations

This study has revealed a number of important issues that have significant implications for contemporary nursing practice. The participants generally described an inadequate subjective understanding of the phenomenon of transcending burnout as it was occurring for them, particularly in the initial phases of the experience. They had not been prepared in any way for the experience and this lack of preparedness meant that they lacked the understanding or resources needed to organise themselves to deal with the situation they were in. This in turn led to significant feelings of self-directed stigma along with fear of stigma from colleagues and though this rarely materialised it still served as a barrier to more effective collegial support.

The participants also described their experience of transcending burnout as occurring in an intrapersonal fashion, often feeling isolated and disconnected from their colleagues and often the management structure of the team they were working on. Whilst many of the participants described gaining support from close colleagues in an informal manner, there was no clearly identified and accessible team structure or processes readily available to support them in transcending burnout.
The scope of the issue of burnout in community mental health nursing (in terms of its scale, frequency and persevering nature) along with the significant negative impact it has upon the profession as reported by 20+ years of research. This needs to be addressed as an urgent priority as this problem is unlikely to go away of its own accord. In order to better prepare the workforce to deal with this ‘workplace hazard’ more attention needs to be paid to the concept of coping with and overcoming burnout in the education of mental health nurses.

**Clinical practice recommendation one.**

It is recommended that a professional development education package exploring the processes utilised in transcending burnout be developed for CATT / ECATT nurses working in the community / Emergency Department setting. This package would be based upon the findings of this study and would aim to improve nurse’s practical awareness and skills regarding the practical process of transcending as a conceptual approach for coping with burnout. Broad delivery of such a package would also have the potential to facilitate a wider change in the culture of nursing and to improve understanding about the nature of coping with and overcoming burnout.

**Clinical practice recommendation two.**

It is recommended that a professional development education package exploring the concept of transcending burnout be developed for CAT Team nurses working in the community / Emergency Department setting. This package would strive to challenge the existing stigma and perceived hopelessness associated with burnout through the re-conceptualisation of it as being an unfortunate reality associated with working in this
environment that could be effectively managed through a better understanding and acceptance of transcending burnout as a professional process.

**Clinical practice recommendation three.**

It is suggested that professional team building exercises, involving CATT and ECATT nurses along with their team managers, coming together as an entire group would be highly effective in developing a consistent broader expectation within these teams regarding effective identification of those engaged in transcending burnout whilst maximising the supports for nurses in this situation.

**Clinical practice recommendation four.**

It is suggested that improved education and ongoing professional development activities for CATT and ECATT team managers (informed by the findings of this study) would be useful in up-skilling these managers in better supporting CAT Team nurses in transcending burnout. The capacity to better provide support and guidance for the nurse in the process of transcending burnout would be ensure these managers had were able to enhance this process greatly.

**Clinical practice recommendation five.**

It is suggested that educational content exploring the concepts processes utilised in transcending burnout be developed and included in Post Graduate mental Health Nursing education programs. The inclusion of such materials would provide novice mental health nurses with a framework for understanding and responding to burnout in their own
professional practice at a foundational stage in their careers that would serve to improve their preparedness for burnout should it occur in their practice.

**Clinical practice recommendation six.**

In consideration of the seriousness and scale of the issue of burnout for the community mental health nursing profession over the last twenty years interventions to address this at a policy development level are warranted. The findings of this study could be considered in the development of future policy and practice development guidelines pertaining to the structure, role and practice of CAT and ECAT Teams in Victoria.

**Future Research Implications and Recommendations**

The issue of burnout in community mental health nursing remains a significant one that continues to cost the profession at both a personal and professional level. What is clear from a review of the existing literature is the seriousness of this issue as well as the lack of research on interventions proven to ameliorate the impact of burnout when it occurs. This study has explored the experience of transcending burnout and in doing so has identified some significant themes essential to this phenomenon. In doing so the increased degree of understanding of this complex and challenging phenomenon that has been generated through this study also offers some clear implications for further research in the area.
Clinical research recommendation one.

In order to facilitate a greater understanding of the phenomenon a broader examination of Crisis Assessment and Treatment team nurses experiences of transcending burnout, research involving the further exploration of CATT nurses attitudes and personality characteristics, assessment of contributing factors, management strategies, and cultural expectations would prove valuable.

Clinical research recommendation two.

The completion of a larger qualitative study (using the findings of this study to guide its development) designed to explore CATT nurses experiences of transcending burnout may contribute further insight and understanding into this complex and costly phenomenon. Data obtained from such a study may potentially allow for the development of greater understandings regarding transcending burnout in the broader context.

Clinical research recommendation three.

A joint research project with a local Area Mental Health Service to develop and measure the effectiveness of a set of guidelines designed to use the characteristics identified in this study to enhance and support the strategies being used to transcend burnout in CATT nurses would prove a practical, real world initiative in understanding and managing this phenomenon.
Clinical research recommendation four.

The results of this study will be made available to any interested mental health professionals and other interested parties for consideration through the dissemination of the findings in refereed journals and at conference presentations.
Reflections on the Journey

I suspect that most candidates who come to the end of their PhD are faced with a variety of emotions reflecting their sense of achievement and accomplishment at having been able to complete this massive task. I would include myself in this group as I am certainly aware of such feelings, though I’m also becoming aware of a gentle sense of sadness and loss that appears to be growing on me as I draw close to the end of the journey that I have undertaken. It is akin to feelings of gentle mourning seen after a golden summer as autumn draws on and the leaves start change colour and then drop from the trees. The mornings have become colder, the first dews can be seen on the grass and golden tones of summer have given way for the grey hues of the approaching winter.

As I spend time with this rather unexpected situation I have come to believe that this sense of sadness emanates from the natural human response to the end of a high endeavour in an individual’s life. It is the end of a great journey in my life that has consisted of wonderful and terrible moments, periods of great certainty mingled with crises of faith; however all were part of something greater, an undertaking of great significance that was worth fighting for. And now it is finished, and I am reminded of the moment when one gets to the end of a wonderful story where the last page is read and closed and the reader finds themselves shut out of the world of the story and left back in the mundane world of modern reality. I do, of course, understand that in time there are other books to be read, and will be other adventures, but for now I sit at the end of this one and try to soak up as much of the last few days of sun that I can.
Bilbo’s Last Song

Day is ended, dim my eyes,
but journey long before me lies.
Farewell, friends! I hear the call.
The ship's beside the stony wall.
Foam is white and waves are grey;
beyond the sunset leads my way.
Foam is salt, the wind is free;
I hear the rising of the Sea.

Farewell, friends! The sails are set,
the wind is east, the moorings fret.
Shadows long before me lie,
beneath the ever-bending sky,
but islands lie behind the Sun
that I shall raise ere all is done;
lands there are to west of West,
where night is quiet and sleep is rest.

Guided by the Lonely Star,
beyond the utmost harbour-bar,
I'll find the heavens fair and free,
and beaches of the Starlit Sea.
Ship, my ship! I seek the West,
and fields and mountains ever blest.
**Farewell to Middle-earth at last.**

*I see the Star above my mast!*

(J. R.R. Tolkien, 2004, p. 1028)

**Taking the hidden paths that run: final reflections of the candidate.**

Looking forward to a world where I am no longer working on my PhD is a rather odd notion. As a creature of habit (as most of us are), I am mindful that I’ve been slowly chipping away at this for the best part of a decade. When I began I was in my early thirties and had three very young children; I am now in my early forties and my children are passing into adolescence. If I consider this as being the final chapter in my tertiary education it brings to conclusion a twenty-one year undertaking that began with my Bachelor of Nursing in 1993.

Over the course of completing my PhD I have often noticed many a “new road or secret gate”, but due to the commitment a PhD involves have always had to pass them by. Occasionally I have paused, starring at them wistfully; flirting at times with the temptation of ‘One day…’, but after a few moments have always turned away and continued on the course I had set for myself.

Not anymore! I find myself becoming increasingly excited about the possibilities that lie before me, whether it be returning to paths that I have passed that lie still unexplored or seeking new roads that I am yet to discover. In completing my PhD I have come to believe that the individuals who are drawn to such an undertaking are driven in part by the desire to be part of something bigger, to seek out paths in life that offer something more than the
predictable and the mundane. The rewards offered at the end of such a journey can be substantial though the paths themselves can be quite difficult or treacherous along the way. In the end it is the need to seek out and live the adventure that has set me on the path of my PhD and will continue to drive me as I journey on beyond, where ever my road may lead me.

Still round the corner there may wait

A new road or secret gate;

And though I oft have passed them by,

A day will come at last when I,

Shall take the hidden paths that run,

West of the Moon, East of the Sun.

(J. R.R. Tolkien, 2004, p. 1028)
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Appendix A: RMIT Ethics Committee Approval

13th April 2005

Alistair Ross
20/12-14 Unsworth Road
Ringwood North
Vic 3134

Dear Alistair

FLSAPP 32 – 04 ROSS The lived experience of transcending burnout in mental health nurses working within the Crisis Assessment and Treatment (CAT) Service

Thank you for submitting your amended application for review.

I am pleased to inform you that the committee has approved your application for a period of 3 years to April 2008 and your research may now proceed.

The committee would like to remind you that annual reports are due during December for all research projects that have been approved by the Human Research Ethics Sub Committee.

The necessary form can be found at:
http://www.rmit.edu.au/browse;ID=6e6q7j3d0wp;STATUS=A;QRY=human%20ethics&STYPE=ENTIRE

Yours faithfully,

Barbara Polus,
Chair, Science Engineering & Technology
Portfolio HREC Sub-committee (Life Sciences)

cc: Anthony Welch
Appendix B: Overview of the Participant Group

Participant A

Participant A was a 43 year old female who had completed her nursing training in her early twenties and had worked in a general hospital setting before stopping nursing to raise her children. On returning to nursing in her mid-30’s she had decided that she wanted a change of setting and so had sought work in a mental health inpatient setting at a large metropolitan hospital. After three years working in this setting she had joined the CAT Team from the same service and had managed to settle in quite well though she had first noticed the symptoms of burnout 4-6 months after joining the team. These gradually worsened over the ensuing 6 months as she felt increasing worn out, overwhelmed and lost in the role. Her experience of transcending occurred in the 6-9 months leading up to the initial interview. Her essential transcending burnout statement was:

*It’s a little bit like... I’m into rock climbing at the moment; you know that indoor… it’s a little bit like that. It’s sort of like you know where you want to go, and you can pick, you can, you know where you want to go from that whole period … you know where you want to go, you’ve got the safety harness on, you can see the places where to put your feet, but for some reason or another you slip, or you can’t quite get your legs up quite long enough to get in that one so you have to take an alternative step or route… eventually you get there, and even when you get there you may still slip a little bit and you climb back up … my rock climbing analogy.*
Participant B

Participant B was a 35 year old female who had graduated University as a Registered Psychiatric Nurse in her early twenties and had been working in the mental health setting ever since. She had initially specialised in the Aged Persons Mental Health setting having worked her way up through the inpatient units before spending four years working in the Aged Persons Community Mental Health Team as a case manager. She had then moved across to the Adult Mental Health Service working initially in the Continuing Care Team before beginning with CATT where she had been working for four years during which time she had taken six months off as Long Service Leave to go travelling with her partner. She described her experience of burnout as involving a loss of enjoyment of her job, struggling in going to work and not enjoying sending time with the people she was working with. She also described not sleeping, weight loss, avoiding her friends and isolating more from family all over a five month period.

Her essential transcending burnout statement was:

That’s definitely what it was for me, it was about re-finding what it was that I liked in the position to begin with … what I liked in that chosen career path and focusing on that as opposed to the negatives, and they’ll always bubble along in the background because that the nature of … of working in a large organisation, or working for the health system as such, but, they don’t have to be the main focus.
Participant C

Participant C was a 29 year old female who had graduated University as a Registered Psychiatric Nurse in her early twenties and had been working in the mental health setting since then. She had initially specialised in the Aged Persons Mental Health setting ultimately working as an Associate Unit Manager on the Aged Persons inpatient units before being recruited to join the CAT Team three years earlier. During this time she had been seconded off the team for three months to assist in setting up of the local Psychiatric Triage Service. She described her experience of burnout as involving a loss of confidence, feeling thought disordered, preoccupied and easily distracted, hypersensitive to criticism, tending to personalise things in a negative light. She also described her boundaries as being ‘out of whack’ along with feelings of anger and guilt. Her essential transcending burnout statement was:

*I felt like I was able to compartmentalise… I’m doing okay, I’m functioning, no one’s worried about my work, um, I keep an eye on myself, just take it easy… I felt like I was in control, and I was empowered at that point … I knew that there was still stuff that needed to be sorted, so definitely, I definitely felt, okay, I am, I’m out of the woods, I felt out of the woods.*

Participant D

Participant D was a 31 year old female who had graduated University as a Registered Psychiatric Nurse and had been working in the mental health setting since then. She had worked in the Adult Inpatient Service setting her whole career, initially working in the
Adult Inpatient setting for 5 years before getting a 6 month secondment to the local CAT Team which she had greatly enjoyed. However, there was no permanent position available on the CAT Team when she finished so she had returned to the inpatient unit before getting a permanent position on a CAT Team from a different service a few months later. She worked in this position for another two years before getting a position back on the original CAT Team (she cited geographical convenience as the main reason for this last move) where she began to experience burnout approximately a year later. She described her experience of burnout as involving an overwhelming sense of frustration, a loss of control, a physical sense like a heaviness that she would have to carry around and difficult in maintaining her work / home boundaries.

Her essential transcending burnout statement was:

*I don’t feel trapped now, I’m always in my mind thinking if I get to the point where I feel trapped like I did before I have to be the one to physically change, I can’t expect that something within my work environment is going to change to make it better for me, that I will have to be the one to be active about it but I don’t want to feel like a victim anymore.*

**Participant E**

Participant E was a 38 year old male who had graduated University as a Registered Psychiatric Nurse and had been working in the mental health setting since then. He had worked in the Adult Mental Health Service setting his whole career, initially working in the Adult Inpatient setting for 3 years before getting a permanent position on the local CAT Team around the time of their initial inception. He had been working as a CAT Team nurse for over ten years at the time of the study, citing his involvement in various
projects through this time as the key to his longevity in the role. He had also spent some time as an acting manager of the team, though he had done this role part time and had continued to practice as a CAT Team nurse the whole time. He described his experience of burnout as involving an significant increase in his stress levels, ruminating and stewing about work at home to the point where it would affecting his sleep pattern and he would lose his ability to manage a reasonable work / life balance.

His essential transcending burnout statement was:

> To move through that stress it was about just smaller problem solving things, … my best way to describe it was just, just cap the stress for the time being, it’s a juggling act, you were just juggling all the time, and you were aware at any point that those balls could fall. The experience is about not having that sense of doom, coming to work more positive as opposed to a very negative mindset, so rather than coming to work thinking ‘what’s today going to bring?’ or you know ‘how am I going to get through today?’ or ‘what, what problems are going to happen?’.

**Participant F**

Participant F was a 33 year old female who had graduated University as a Registered Psychiatric Nurse and had been working in the mental health setting since then. She had worked in the Adult Inpatient Service setting her whole career, initially working in the Adult Inpatient setting for 3 years before joining a local CAT Team at the point of its creation (the local Area Mental Health Service had decided to split it’s one larger CAT Team into two smaller ones necessitating the recruitment of significant numbers of new staff) which she had both enjoyed and found overwhelming. She had left this team after
three years to travel internationally for a year before returning and re-joining another CAT Team where she had been for the previous 5 years. She described her experience of burnout as involving an increased resistance to going to work due to fatigue, a decreased capacity to listen to peoples stories, to problem solve what needs to happen, to tolerate her own anxiety around the events at work, increased interpersonal conflict within the team and an increased inability to discharge consumers due to second guessing what could potentially happen to them.

Her essential transcending burnout statement was:

*It's not a subtle shift, it's not something that is there one day and gone the next, it's a conscious, considered ‘all right fuck, I'm fucked off’, when I'm talking my language changes, I can hear it now as I'm talking about it, I swear more, document less, I either arrive late or leave early my attention and presence is not … and transcending that is looking at all of those, in the context of what's happening and whether my work environment, and my emotional response to my work environment is happening externally that contributes; and what has to change in order for my overall presence to change … sometimes it's about increasing the frequency of my supervision, it's about … for me it's about just stopping being present and looking for what … I know.*

**Participant G**

Participant G was a 35 year old female who had graduated University as a Registered Psychiatric Nurse and had initially worked in a Neurological setting for 6 years before transitioning into the mental health setting. She had initially worked on an Adult Inpatient setting for 2 years before joining a Continuing Care Team where she had worked as a case
manager 18 months. She had not enjoyed this work and so had subsequently applied for and obtained a secondment to the local CAT Team which lead to her obtaining a permanent position on the team CAT Team. She had been in this role for almost 6 years though she had taken a period of Long Service leave for 3 months around the middle of this time due to workplace stress. She described her experience of burnout as feeling fearful to go into work, because of the pressure caused by not coping, and the anxiety that she would make a mistake. This was coupled with being able to identify that her level of concern for the consumers she was caring for was diminishing, along with a loss of motivation in completing the roles of the CAT Team nurse effectively.

Her essential transcending burnout statement was:

_There’s a sense of contentment and peace and a fair bit of joy, and achievement, a sense of achievement, um, feeling warmth; I feel warm, I feel cosy and happy with myself and just this sense of overall contentment; I feel happy, I feel nice; everything’s good and I have a talent and I’m really quite comfortable where I am at the moment._

**Participant H**

Participant H was a 29 year old female who had graduated University as a Registered Psychiatric Nurse in her early twenties and had been working in the Adult Mental Health Service setting her whole career. She had initially working in the Adult Inpatient setting after graduating, working her way up to Associate Unit Manager, a position she held for almost two years before obtaining a permanent position on the local CAT Team. She had been working as a CAT Team nurse for over seven years at the time of the study, though she had taken a year of leave without pay after her mother became unwell to help with
the family business, returning to the CAT Team (two years prior to her involvement in this study) once the family situation had been resolved. She described her experience of burnout as including not enjoying my job, dreaming about work, thinking persistently about work when she was at home, not feeling confident with anything that she was doing, and getting all ‘blurred’ about what she was doing. She also described getting really stressed about work when at home, and would start waking up really anxious and worried about it, such that by the time she got into work she was ‘an absolute mess’.

Her essential transcending burnout statement was:

*I had to get to point where it was like ‘no, it’s okay, I’ve done everything I can do, I’m not responsible for that anymore and it’s okay and whatever happens will happen, and you can’t control the whole universe’; yes it is about control, but then at the same time feeling like I haven’t done as good a job as I could have done because I haven’t been as on top of it, so it’s all about balance really, the whole things all about balance and trying to find the balance and just losing that.*

**Participant I**

Participant I was a 56 year old male who had trained as a mature age student in the hospital system in the UK and had spent the first ten years of his mental health nursing career working in large psychiatric institutions. Following deinstitutionalisation he had move out into the community where he had worked in a wide variety of role from case management to the management of primary health initiatives. Upon immigrating to Australia he had briefly worked in Adult Inpatient unit before being quickly recruited to the local Cat Team once his level of clinical experience became evident. He had worked
on this first CAT team before moving to a second CAT Team as it was based much closer to home. He described his experience of burnout as including high levels of anxiety leading to him feeling overwhelmed easily overwhelmed, with persistent anticipatory dread leading to low self-confidence and high levels of self-doubt that he felt were a significant barrier to his practice.

His essential transcending burnout statement was:

*Developing that part of yourself, that strong part that can reassure you, give you that self-talk; ability to support yourself in those dire situations when you feel shaky, when you feel it’s all caving in on you … then you have to sort of: I developed that thing that comes to my rescue, if I remember; it might take me a while to think ‘aah shit, you know … you’re not going to die here’.*

**Participant J**

Participant J was a 31 year old female who had graduated University as a Registered Psychiatric Nurse in her early twenties and had been working in the Adult Mental Health Service setting her whole career. She had initially working in the Adult Inpatient setting after graduating, working her way up to Associate Unit Manager, a position she held for a year before obtaining a permanent position on the local CAT Team at the point of its inception (the local Area Mental Health Service had decided to split it’s one larger CAT Team into two smaller ones necessitating the recruitment of significant numbers of new staff). She had remained on this CAT Team for 4 years before obtaining a position at another CAT Team closer to home where she had been for 4 years before moving again to a third CAT Team (again in the context of convenience from where she lived). All in
all she had been working on CATT for 9 years, though the last two of these had been
three days a week following the birth of her first child. She described her experience of
burnout as including increased feelings of distress and episodes of crying (related to
work issues), difficulty in interacting with colleagues over conflicting clinical issues,
difficult in maintaining empathy for ‘difficult’ consumers, uncertainty around her
confidence in her practice, and increased anxiety and agitation.

Her essential transcending burnout statement was:

*It probably is about taking control …it’s about being assertive, it’s about being
confidant, it’s about being happy in your clinical practice, it's about being happy in
your, um, work environment sort of thing and you know, I guess it is taking the bull by
the horns.*

**Participant K**

Participant K was a 47 year old female who had trained as a mental health nurse in the
hospital based system. She had been working at a major inner city Area Mental Health
Service for the previous twelve years in a variety of roles and had been working on the
CAT Team for the preceding five years. She described finding her work with CATT
highly rewarding however she had become increasingly concerned about what she
perceived as the reduction in services to consumers over this period of time, expressing
concerns regarding the limited scope of practice evident in contemporary mental health
nursing. She described her experience of burnout as including increasingly irritable and
anxious as well as feeling overly sensitive to what’s going on around her (whether that’s
aggro, or hype or elation) and finding it’s not as easy for her to maintain her professional boundaries.

Her essential transcending burnout statement was:

_In my mind I can see a cliff face and some waves, and now I’ve come along with some wet clay-sand and I’m just putting that bit of cliff face back where it’s been, where the waves have taken it out sea … so that cliff’s still there protecting the people who have got their little houses, and the sea’s still there, cause we need the sea; we actually need I think to be broken down and: that’s about change isn’t it… this is my subjective experience in the context of everyone else, the clients, the relatives, so we need the ocean pushing us around._

**Participant L**

Participant L was a 51 year old female who had trained as a mental health nurse in the hospital based system. She had begun working in this setting one of the first CAT Teams at the time of their initial inception in Victoria. She had worked with this CAT Team for two years before becoming burnout out after they were amalgamated with another team. She finally left after seven years and spent time working on a Continuing Care Team as a case manager before returning to a CAT Team from a different service four years ago. She found this team to be ‘boring’ and so eventually returned to her original CAT Team where she worked from two years, before again experiencing burnout though this time she had not left, resulting in her being able to overcome this and remain in the role. She had also begun training as a therapist in order to broaden her professional scope of practice and establish a connection with clinical practice outside of the CATT
environment. She described her experience of burnout as a gradual process in which she felt she had become ‘hardened’, emotionally detached and disconnected from her family. She felt she had lost her feminine side, and had become ‘a bloke’, losing her sense of self in the process.

Her essential transcending burnout statement was:

*Getting lots of support for myself; doing study, I think that keeping your mind updated on different things is the way to go … cause you really start thinking you’re dumb; you’re lost all your confidence, you don’t think you’re capable of anything … you just think you’re a burnt-out human being … your brain’s all burnt-out, it doesn’t function … I’ve discovered that it’s not true, so I think it’s about getting confidence back, through studying, realising that you are capable and you have got something contribute and you have got something to offer.*
Appendix C: Plain Language Statement

PLAIN LANGUAGE STATEMENT

Dear …………

My name is Alistair Ross. I am a student in the Science, Engineering and Technology Portfolio, RMIT University. As part of my Doctor of Philosophy research program, I am undertaking a study of the ‘lived experience of transcending burnout as described by community mental health nurses working within the Crisis, Assessment and Treatment Team (CATT) services’.

It is this researcher’s belief that this study has the potential to uncover fresh understanding and insight into this phenomenon that may challenge current practices and protocols involved in managing and recovering from burnout. This has the potential to inform the development of more appropriate and effective nurse support strategies, with the overall goal of diminishing the negative impact of burnout upon CATT nurses.

If you agree to be part of this study, you will be invited to participate in two, one hour interviews which will be video-taped. The first interview will explore your experiences of transcending burnout. The second interview will give you an opportunity to review your initial interview transcript and to ask questions or clarify any concerns.

Any information shared by you during the interviews will remain confidential and your identity will remain anonymous. The only people to have access to information provided by you, other than yourself and myself, will be my supervisors, Dr. Anthony Welch and Professor Gaye Edgecombe. Upon completion of the study the audio-visual tapes will be destroyed, and all relevant documentation will be stored under lock and key at RMIT for a period of five years (as per University protocol) before also being destroyed.

The study focuses on the phenomenon of transcending burnout as experienced by individual participants and involves the discussion of personal thoughts and feelings. As such there exists the mild potential for you to feel vulnerable or embarrassed
whilst discussing these issues. Should any distress arise from the discussion of these issues debriefing will be available from the researcher (an experienced psychiatric nurse with a background in counselling). In addition a senior CATT clinician and member of the Dandenong Area Mental Health Service critical incident debriefing team will be available to provide further counselling if required.

If at any time during the study you wish to withdraw, your decision will be respected. Any information shared by you will not be used as part of the study unless your permission is obtained. It is intended that the findings of this study will be disseminated through publication in a refereed Journal and Conference presentation however no information that may lead to your identity will be included.

If you wish to participate in the study, you will be required to give informed written consent prior to interview. If you require further information, please do not hesitate to contact me on (613) 9879-3864 or my senior supervisor, Dr. Anthony Welch on (613) 9925-7465.

Yours sincerely

Alistair Ross

M. Health Science., RN., RPN.

Any queries or complaints about your participation in this project may be directed to the Secretary, RMIT Human Research Ethics Committee, RMIT, GPO Box 2476 V, Melbourne, 3001. The telephone number is 61-3-99251745.
Appendix D: Informed Consent Form

Prescribed Consent Form for Persons Participating In Research Projects Involving Interviews, Questionnaires or Disclosure of Personal Information

Portfolio: Science, Engineering & Technology Portfolio.

School of: Nursing & Midwifery.

Name of participant: [Student Name]

Project Title: ‘The lived experience of transcending burnout as described by community mental health nurses working within the Crisis, Assessment and Treatment Team (CATT) services’.

Name(s) of investigators: (1) Alistair Ronald Ross. Phone: 0430118611

2. Phone: __________________________

1. I have received a statement explaining the interview/questionnaire involved in this project.

2. I consent to participate in the above project, the particulars of which - including details of the interviews or questionnaires - have been explained to me.

3. I authorise the investigator or his or her assistant to interview me or administer a questionnaire.

4. I acknowledge that:

   (a) Having read Plain Language Statement, I agree to the general purpose, methods and demands of the study.
   (b) I have been informed that I am free to withdraw from the project at any time and to withdraw any unprocessed data previously supplied.
   (c) The project is for the purpose of research and/or teaching. It may not be of direct benefit to me.
   (d) The privacy of the personal information I provide will be safeguarded and only disclosed where I have consented to the disclosure or as required by law.
   (e) The security of the research data is assured during and after completion of the study. The data collected during the study may be published, and a report of the project outcomes will be provided to the RMIT University Higher Degrees and Human Research Ethics Committees. Any information which will identify me will not be used.
Participant Consent

Participant:  
Date:  

(Signature)

Witness:  
Date:  

(Signature)

Where participant is under 18 years of age:

I consent to the participation of _____________________________ in the above project.

Signature:  (1)  (2)  Date:  
(Signatures of parents or guardians)

Witness:  
Date:  
(Witness to signature)

Participants should be given a photocopy of this consent form after it has been signed.

Any complaints about your participation in this project may be directed to the Executive Officer, RMIT Human Research Ethics Committee, Research & Innovation, RMIT, GPO Box 2476V, Melbourne, 3001. The telephone number is (03) 9925 2251.

Details of the complaints procedure are available from the above address.
Appendix E: Participant Significant Statements

Participant A Significant Statements

1. Working through it is a matter of, for me, and I don’t know about for others, cause I’ve been nursing a long time it’s about pulling things in, getting in control, be organising, and once I feel at a point where I’m in control.

2. The way I work through it, I don’t know about others is the rationalising.

3. I start to recognise that, feeling, that overwhelming sort of pressure, so there’s that; and that working through it comes down to rationalising it, and then feeling less stressed, feeling like I’m in control.

4. The way that I worked through it was that was my natural nature was to stick things out cause I’m not one to go into something and then go ‘blow you, I’m out of here’.

5. The second part of that was seeking some support from somewhere, which is usually a collegial support.

6. The second part was, giving it time, and I’m old enough to know that if you give things time, number one you get used to it.

7. That was probably the biggest thing, when I think about it, is deciding well that’s how they do it, I know that’s not how it should be done, I know that’s not how it should be done, how nursing is done.

8. How would I satisfy my own standards and feel comfortable with the practices that I’m doing.

9. The transcending was looking at the team itself, a bit of personality ‘I’m not going to give in’ type attitude.

10. That very beginning, that would have been the worst phase.

11. It was about re-establishing myself.
12. The first thing [that] came was my personality, sticking it out, because that what I do, I don’t give in.

13. That was part of the control thing; is that I had a finite time, I though well I don’t have to be here in six months.

14. Credibility fluctuated quite a lot, and my confidence fluctuated quite a lot.

15. It was a confidence sapping experience, which I had to completely try to bolster myself up with, and completely have to reassure myself that, ‘you have to give this time, you have to let things flow’.

16. The way I dealt with that in that initial phase was to check myself with my colleague.

17. Another positive part, getting the positive stuff from my colleagues at my level.

18. That was probably the most important part, when I had patient contact, that was what I was paid to do, that was what I wanted.

19. My way of dealing with that was just to do my job.

20. My way of dealing with it … and then I’ll go out as much as I can, with my dilly bag and my files and off I’d go and see as many patients as I could on my own.

21. I was really getting to the point where I was going to leave, and that was at the four to six month point.

22. It’s been one of um… that sticking it out nature that I’ve got.

23. I’m going to stay here because I want to be in control.

24. So you start to build up that confidence again and the regaining of your credibility.

25. I just laughed but it was stressful, I had to deal with it and prioritise it but I just laughed.
26. So it does make a huge difference of that experience of burnout, and being overworked, the person that you work with [commenting on the factors that influence her transcending burnout].

27. I was so angry I burst into tears and thought you stupid idiot, don’t be stupid…so I’d come back in the next day and I’d be really positive, really cheerful.

28. But then in the end I couldn’t stay angry, because you can’t so I thought well, I kind of accepted that.

29. I went from being angry and tearful …and then I’d get really annoyed, and then I eased that off a bit.

30. And then I went from that (angry) to being a bit more proactive. .. it was about being involved a bit more.

31. I felt more confident in myself because during that period of course your confidence waxes and wanes.

32. You have to work hard to remind yourself I’ve worked hard… I’ve done this, I’ve done that.

33. I have to keep reminding myself, that’s how I got through that angry phase.

34. I had to keep myself talking, and it was a lot of self-talk.

35. Once I got past that [the anger and self-doubt] I got to the acceptance phase.

36. So I started to feel a bit more useful … um … I started to feel I was contributing to the team.

37. There was that feeling of regained confidence, not that I’d really lost it, it was like this [participant gives up and down gesture] for a while, but that solid sort of steady feeling of confidence in your own competence and clinical judgement was still there and I haven’t lost it after all.

38. There were a few emotions attached to that ... going home feeling happier, because I’ve done my job, that’s my job, I’m happy with that.
39. I frequently wondered if it was of my own doing, which as a clinician you do, was there something I could have to have made that a better experience for myself.

40. That was one of the big questions … um … I’m not adjusting well so I have to do something different so that I can; there was that whole reflection process.

41. The realisation, you know, going through that, this was on reflection after that period ended and I started to stabilise a bit, and then thinking to myself, you know, that wasn’t all me, you know, they made you feel like crap dearie … and then a bit of anger, because I would never do that to another person.

42. There was kind of this reflection, what could I have done to have shifted that, made that different, but then was that all my responsibility [comments related to perceived lack of support from colleagues], and then feeling angry because no of course it wasn’t it was their responsibility to kind of include me in part of the team.

43. It’s a little bit like… I’m into rock climbing at the moment; you know that indoor… it’s a little bit like that. It’s sort of like you know where you want to go, and you can pick, you can, you know where you want to go from that whole period … you know where you want to go, you’ve got the safety harness on, you can see the places where to put your feet, but for some reason or another you slip, or you can’t quite get your legs up quite long enough to get in that one so you have to take an alternative step or route… eventually you get there, and even when you get there you may still slip a little bit and you climb back up … my rock climbing analogy.

44. Some days you can find your steps really easily on some days but that’s really dependant on the clinician sitting next to you in the car.

45. But I’m at that level now where I’m stable and you have little ups and downs [supports same with up and down hand gesture], and days when you doubt your own judgement.

46. I’m at that level where I kind of have; I’m, I’m okay now [supports same with steady hand gesture], and I feel confident and competent, and there are days where that may dip a little bit, but that fine, normal, but nothing like when I first started.

47. I’m being kind of dictatorial, I only work in blocks, and I’ve said to the roster person put me in blocks … I’ll do one month ED [ECATT] and one month CATT, that’s where I’m at, at the moment, I have some control… that’s given me a little more confidence, … in that I have that degree of control.
48. It’s [transcending burnout] not there yet by any means and I don’t think it ever will be.

49. All these emotions kind of wax and wane, but I feel at the moment I’ve come back to where, kind of homeostasis; I’ve come back to where I’m happy.

50. Yesterday I wrote down ten reasons why I hate CATT, and that was a coping mechanism too.

51. I’m basically the same person … externally to everyone else that I know everything’s the same, but I’m a much more wary person now.

52. I’m a much more wary person now with colleagues and people in senior positions.

53. I’m more cynical, and I’m a little … I haven’t let it affect my personhood now.

54. I’m positive about the experience [of transcending burnout] being a whole life-learning thing.

55. Whether or not I would repeat that faced again, I don’t know that I would, I think that I’d bail.

56. The redeeming feature is that I’ve maintained my credibility; and I’ve maintained a degree of, kind of rapport with all of the staff down in ED.

57. You’re never stuck; you make sure you have a plan [relating to the option of leaving if unable to transcend the burnout].

58. There were times when it was a little bit pervasive but I stopped short of letting it truly invade.

59. Positive things were I joined the gym, because I was so angry.

60. I actually coped with work by taking on more in my personal life so that I’m busy, not going home thinking about it … knitting, getting into the garden… I sort of do things to get away from the thoughts of work.

61. Distracting …they’re productive too because your garden looks nice … if you’re upset about something at work, you’re busy doing the next thing you’ve got to
do… enjoyment provoking, satisfaction provoking, which were all the things you weren’t getting from work.

62. I was enrolled to study, and then because I had such a bad experience I thought I’m not going to study, I don’t know that I want to keep doing psych nursing if this is the general picture at this level of psych nursing I don’t wanna do it.

63. So I picked something hard (rock climbing) that I had to work on and concentrate on … so that I didn’t think about that [burnout] and that was planned.

64. So that was a deliberated effort too, and it was kind of a bit of an ‘up yours’ too, it was kind of like it was a deliberate effort to concentrate on something else, and be productive in something else and draw some happiness from something else because I don’t need my job to be happy, it’s just a job.

65. That’s still my attitude largely, it’s kind of still there; I don’t have to do this, I mean it’s a job … and I’ll do it and be professional and do it the stand that I think it needs to be, but I don’t have to do it cause I can do a whole heap of other things.

66. It reminds me a little bit of… you’re going to think I’m a bit silly, you know those really large plastic doors that you get through, usually they’re in ED’s or operating theatres … really heavy doors; I used to work in an operating theatre; I was there for about eighteen months and so these plastic doors were my bugbear because you’d have all your tray full of instruments that you’d just cleaned and sterilised and you’d have to go backwards through these doors to get these sterile instruments into the theatre to get them all bagged up to put in the big steriliser, so you’d have two lots of doors to go through backwards and, and that was okay but I could never get through these doors properly without bumping, dropping, I used to have scraped elbows, so that transcending thing is like constantly pushing through these bloody doors which were really horrible; cause I remember them distinctly because it was this hospital in Sydney and they were really hard to open doors, and having a try of instruments and I was only kind of nineteen-twenty at the time and I didn’t have… a bit gawky and clumsy, and I always had… I could never ever master these doors, and I used to watch other people go through these doors and they would go through the doors really easily, and I’d watch them and I’d think okay that’s how I’m going to do it, and I’d go through and I’d always get stuck , I’d either, they’d open up partially so I’d kinda be stuck trying to get through when they’d be stuck, or I’d think okay I’ll just go through this one side cause it’ll open but I’d always end up it’d flick back on me and then I’d have another set of door and it wasn’t the same set so I’d have to go over to the other side, it was also messy .. you know it took me six months to get through those doors and actually do it properly, and by the end of the six months … if you want an analogy it’s kinda similar, it’s like pushing through these bloody doors, and you are getting through the doors, it’s not like you don’t get through the doors, but you just don’t seem to be doing it as comfortably as everybody else.
67. It’s life changing, it’s a learning thing, that … to me … it’s about increasing your coping strategies, increasing how you cope with stress because if you look back on a period of time where you’ve had to do that transcending form a very, very burnt out stressful kind of thing, and coming through the other end … it’s something that you realise you get to and it does get better.

68. It’s about how they cope with that, it’s about realising that it’s not the end of the world that life goes on.

**Participant B Significant Statements**

1. My thoughts are that most people who work in psychiatry for a long enough period will experience burn out at one time or another, and especially if you work in the acute setting, such as CATT or ECATT, its more likely to happen because of the stress that you place yourself under.

2. I think if you continue to work in this job you will experience it [burnout], and you will work through it.

3. There’s a lot of people that don’t recognise they’re experiencing burnout at the time … and … struggle with why they’re still in their profession, or change jobs.

4. I did not enjoy my job, I was struggling as far as going to work was concerned, um, I wasn’t enjoying sending time with the people I was working with … I continually questioned actually why I was doing the job that I was doing, um… in some respects I may even have been slightly depressed, because what was happening in my life at the time… I wasn’t sleeping; I’d lost a little bit of weight … I wasn’t spend as much time with my friends, I was isolating more from family, and it was all round work …at the start I didn’t really recognise what was happening; it was just ‘I don’t like this anymore, why am I doing this, why am I putting myself through this stress ever day?’

5. I made a decision to utilise my long service leave and take six months’ time-out … I needed that six months to refocus, reassess really, was I going to continue to be a nurse or not, cause at the time I had no intentions of continuing in the profession.

6. At that time I would have been happy to and work at Subway making sandwiches.

7. I suppose it just overall unhappiness… but that was more expressed in the fact that I was more slightly more irritable and angry.
8. As time went on it was much easier to work as an individual clinician in a different setting than what it was to work as part of the CAT Team on the road.
9. I really couldn’t be bothered, participating with everything else that everybody thought at the time was important.

10. I can’t be bothered, I’ll just go and work in the other department [ECATT] where none of this happens; yes they have their own politics, yes they have their own way of doing things but I’m not a major player in that so I can just do my job, which I wasn’t enjoying, but I was doing it more effectively.

11. I’ve never taken a great deal of sick leave, but I was taking some sick leave from work just because I was … it would depend … I probably took more sick leave in twelve months that I had in the previous eight years combined.

12. But it [burnout] did sort of flow over at times into my personal life, I stopped playing hockey on a regular basis … I visited my parents a lot less because it was too much effort to drive the three hours to see them … and I probably socialised a little bit less with my friends… but it was harder to participate in everyday life.

13. It was only after working in TAFE for a while … teaching SEN students mental health, that I actually rediscovered my passion for working in psychiatry.

14. It’s about teaching other people, I suppose, your passion and in that respect I rediscovered that [passion].

15. There was a distinct point where I had no intent of coming back to nursing, it was only … I suppose it was only me teaching other people what I do that actually made me stay in it.

16. It’s a different experience because you’ve moved on, you’ve grown, things have changed in your life so therefore you do look at previous experiences differently down the track … so I suppose it was about reviewing what it was that I liked about my job as opposed to the negative bits.

17. Personalities, and politics, which unfortunately in any job plays a role, but if you can remove yourself from those then you actually discover what it is you like about the job, not the things that you don’t like about the job.

18. A part of my burnout at least; was, it was all about the negatives, there was nothing positive and teaching what it is that I like to do, was actually positive.
19. During that time I also did work with Casey CATT, as a casual staff member; worked here in the ED and did some stuff on the CAT Team, and actually found that that was really positive experience as well, cause it actually gave me the opportunity to do the job I liked without any of that underlying stuff that was happening at my previous job.

20. I don’t know if there was an actually specific moment [where she had transcended burnout], but it was that fact that I actually had passion for doing what I was doing.

21. I suppose that understanding, that there are great aspects in this job, that made me realise that I could work through this, or that I had worked through it realistically because I wanted to go back to work.

22. [Describing returning to CATT work after the break on LSL] For a start it was a little apprehensive, do I really want to be doing this?

23. I was the fact that I’ve seen people, in those first two or three weeks that were really unwell, and [I] could make some impact by providing treatment.

24. At that stage it was like ‘I actually really like my job’ and I had some thoughts of maybe I wasn’t too bad at it, where three or four months previously all I thought about was ‘I hate this job and I’m crap at it’, and that’s the difference.

25. Stepping away from it for a little while, doing something different even though it become related, in respect that it was just a different aspect of my job, made me appreciate what it was that I had…and the abilities that I had!

26. I suppose, teaching in that respect, you have to understand what it is that you’re try to teach … and I suppose it’s that clarity of thinking, having to put that into a process that other people can understand that made me realise that when you’re teaching somebody, they don’t understand it and you’ve got to teach it in five different ways to get to understand, then you think well actually ‘I do know what I’m talking about, I do know how to do this’.

27. I think that discovery of teaching others makes you have a better understanding of what it is that you know yourself, and that gave me that confidence I suppose to go back to work.

28. The actual [CATT] team itself… it gave me that ability to sort of think, ‘well you know I can do this, I will go back and try again’.
29. I think I would recognise it a lot better ... I have put in those safeguards that some people just don’t do, so I do get supervision now, I do have time out from my job, I’ve changed my hours.

30. I think it’s about putting in those self-protections, knowing when to step back, knowing when to say ‘I can’t do this at the moment’, not taking on too much, being able to say ‘no’.

31. With the whole process [of transcending burnout] you need to put in ... you need to concentrate on yourself at times, cause otherwise you fall in a hole.

32. I had no plans of returning to psychiatry, full stop ... it gave me the opportunity to think outside my career-path and what I was going to do, and where I was going to go, was I going to go back to school, was I going to go and do something totally different... and it was in that reflection of what it was that I had any interest in, that come back to where I’d started in the first place.

33. It was that whole process of I suppose, sitting down and re; re-looking at your; your choices in life, and that fact that I had multiple choices at the time, and didn’t have anything to do ... it didn’t have to have anything to do with the healthcare system, that I suppose redirected me back into it.

34. At the time it gave me the freedom to make those choices [referring to the fact that she did not have to work as an RPN].

35. In the six months I had LSL it was just an opportunity to make that...in hindsight if I hadn’t had my long service leave due I probably would have resigned ... I probably would have gone in a different direction and been in a different place now, but I had that six months leeway that I could; that I could actually make that decision, and make a positive decision in the direction that I wanted to go, as opposed to making a snap decision.

36. I think I had an easier path, because I had the ability to take time off, and I had the support to do it.

37. I think it was essential to actually have that space; to actually be by myself, not be at work, not be responsible for other people ...other people constantly asking you questions, or wanting things from you; it was about spending time with me; rediscovering who I was, in my own time... it was about spending quality time with me, and then that moved onto spending quality time with my family and friends.
38. The pressure’s still the same there’s still multiple people asking you for things all the time, but it’s about I suppose now, my knowing when to say no, me knowing what it is I need to protect myself… from burnout; whether that be supervision, or whether that be spending weekends down the beach with my dog.

39. I suppose part of the experience is knowing that it has happened; there is the potential for it to happen again in the, in the job that we do, and it’s about I suppose being aware of the cues and the signs that things are maybe leading in that direction, and stopping them before they happen by … following through on some of the things that we’ve passed on.

40. I suppose it’d be the beach; the waves, having time to myself, sitting there reading a book reading a book; now it’s still the same thing realistically; if I need some space I’ll go and sit on rocks at the bottom of our block and read a book … no one around.

41. I think I was that space; that time out that … you can sit there for hours, things change, different things happen, the waves come in, they go away again, so there’s consistencies but there’s changes … and I think that’s life realistically, there’s consistencies and there’s changes.

42. I have a much better, I suppose, life verses work mix than previously, that wasn’t there.

43. You need to have a balance in your like; I can’t just be one thing or another cause it just doesn’t work; you need time for different aspects of different things; whether that’s a social life, whether that’s your partner, whether that’s doing things you need to do around the house, whether that’s exercise or just having five minutes to yourself, but you actually need to take those cues from what’s happening and work through them, and do that; not ignore it, cause once you ignore it that’s when things do happen, you do become burnt out.

44. It was the way I looked at things that had to change for me to progress and move on.

45. It’s possible for it [burnout] to happen to anybody and at the time I didn’t think that, I thought it was just something that I experienced, and didn’t particularly want to talk about that at the time, whereas now it doesn’t particularly bother me.

46. When I was working in the ED … I seen a client that I’d looked after, I don’t know, four years earlier, and did an assessment on that person and they remembered me, and remembered what I … what I’d done for them in that past, and that was a really positive experience to think, ‘well look I can actually have an
impact on somebodies life, and I am actually not too bad at what I do’, and that kind of thing reinforced that fact that I, maybe was in the right job, and maybe should continue in it.

47. That’s definitely what it was for me, it was about re-finding what it was that I liked in the position to begin with … what I liked in that chosen career path and focusing on that as opposed to the negatives, and they’ll always bubble along in the background because that the nature of … of working in a large organisation, or working for the health system as such, but, they don’t have to be the main focus.

48. It would probably be happiness; that would probably be it [describing burnout in a single word].

**Participant C Significant Statements**

1. I had time out away from the CAT team, which I needed ... looked at me not doing certain things like working a late shift or working too many shifts so it was a very slow transition back into full time work again … once I sort of got back onto that sort of stepping stone it sort of just went from there, things got better and better.

2. I looked at the CAT Team differently because I was coping better, but at the time it was, it was pretty tough, it was pretty hard going.

3. I sort of lost confidence … um, I sort of felt my colleagues … I wasn’t performing and my colleagues were maybe commenting about that, or that people could see that I wasn’t functioning at a hundred per cent… that distressed me on top of the other stuff.

4. I’m sure I didn’t think straight, I wonder what my documentation; if I looked back at my documentation I wonder what it would have been like.

5. I was probably, you know, a bit thought disordered, um because my mind was elsewhere… so I was distracted, I was … you know, sensitive, extremely sensitive… I wasn’t able to accept any criticism, whether it was constructive or not, it was sort of, it was very personal and I saw things in a negative light.

6. It was a very depressing time, that’s what it was like … personally… thank god I’ve never experienced it again, that was really hard, hard going.
7. There was even time when I thought it would be better if life ended, not that I would have done anything, but at that time it was really hard to live.

8. For me, for me really … I knew that my thinking boundaries were just out of whack, I needed someone to take control, I needed someone to tell me what to do.

9. My GP really was the key for me … she took control, ‘this is what we’re going to do’ because I wasn’t thinking straight okay, so she just said well you’re gonna rest … she took control and I gave her the control, I said to her ‘you tell me what you need me to do’, um, ‘tell me what to do and I will do that’; that was really important for me, that was really helpful, cause I sort of felt that I didn’t have to think about what do I need to do to fix this, how do I manage this, how do I interpret this, what’s the right thing to do, am I, am I over reacting, am I taking sick leave for no good reason, my colleagues have got to work to cover my shifts whereas she just remover that; you’re not going, I’ll let you know when you’re ready.

10. I think at some point I was a bit reluctant to take it back [control] cause it’s such a safe place to be when someone else is controlling … that gave me comfort, that gave me a lot of comfort because she was a professional, she was my GP, she um, she had control, she had authority … she was really empowered, she was really in control, she had a plan, she was really clear about it and I felt taken care of … which is very different for me, because I’ve always been the carer, I’ve always been the control one, so that was really different, but it was very relieving, I think she played a very key role.

11. My colleagues also would ring and pop to visit; they almost gave me permission to be away from work, which was important because we all get that guilt when we’re not at work on sick leave… that was very helpful as well.

12. It was interesting though, the more people were nicer to me the more I would cry; at that stage people were nice so I’d cry, but that was part of; part of being in that stage.

13. It moved, it was a moving stage, it moved; I sort of had lots good; initially had very bad days and a couple of good days and it sort of slowly balanced out and then it became more good days than bad days, but that took some time.

14. I didn’t really want to take the control back, cause I felt quite, felt quite safe, but I knew that I could …I knew that I; something had to change and I was not crying so much and I was sleeping better … I didn’t want to get into that permanent sick role … I like work, I need to work, I liked being functional.
15. I was very frightened about going back and falling in a heap on the first home visit … that was really, that was a fine line, like I needed to get back there, but I wanted to get back there and function, I didn’t want to get back there and be a burden, … um, you know, going back on sick leave, crying at work.

16. It was hard, it was hard; I needed to have a really good chat to myself to work it through, and for me that took several days. … you know, what do I need to do, what’s a good middle ground safe area.

17. I used to volunteer all the time, I really liked the curly complex ones; ‘yeah I’ll go’; ‘you might need to take the police… yeah that’s fine, I’ll go, I’ll go’, and I remember, and I remember [the team manager] saying ‘you know, that’s okay’; part of me was really offended.

18. It was about a balance … it was about the GP saying to me ‘two days a week, I think it was for a couple of weeks, and then I just did it [returning to work] gradually … it released the control from her back to me slowly.

19. Slow effective progression, there’s no point going forward if you’re just going to fall … slow and steady.

20. I saw myself in one place, and knew I had to get to that place [gestures in a forward direction], and it’s about how do I get there, um; I had to really think it through.

21. The picture was, back at work, functioning; no one worrying about me, me just doing my job …not crying at work, being okay and feeling okay about the work I was doing and not being sort of sensitive and negative about what people might say or think, and half of it was in my head I’m sure … that’s where I wanted to be, but that was a very big jump.

22. Gaining power, and gaining control and gaining confidence… (describing the experience of transcending).

23. I did feel really dis-empowered … it was a strange place to be when you’ve sort of, when you’ve always sort of… you know what you’re doing, you know where you need to go, you just get on with it, part of me wanted that power back, part of me wanted to be empowered, was frightened about whether I’d cope with it or not, but I needed, needed that back.

24. There was a couple of times where things were going okay, and then it just; it was a bad day … I sort of see that as the first stage … but the next day would come good, and it did in a couple of days, it did come good.
25. I sort of knew things, and I was starting to cry very easily, I knew then I had to; okay you need to slow down.

26. That was another stage for me, that I started to recognise what, what was happening, do you know what I mean?

27. I saw the world so differently; saw myself a bit better after, after all of that, and um, felt like I was a better nurse after that.

28. I felt hopeful; I felt … it’s going to be okay … that was in that first stage.

29. During that process I guess there was a lot of baggage that came out … to deal with that, that’s, that’s opening a Pandora’s box.

30. I’ve definitely changed for the better, I can see things in a different light, I can … I see the world very differently.

31. I’m a much better person for it [transcending burnout].

32. Mentally I could handle, you know, I got past that sort of; the anxiety and the fear and the tearfulness, so I got physically better, and in a better space mentally.

33. The stuff about work and the stuff about my mood sort of was left behind, after about two months, it was, and then for the next year it was about how I see the world, how I manage the world, how I see myself, how I fit into the world, how I think about things, what was acceptable.

34. I felt like I was able to compartmentalise… I’m doing okay, I’m functioning, no one’s worried about my work, um, I keep an eye on myself, just take it easy… I felt like I was in control, and I was empowered at that point … I knew that there was still stuff that needed to be sorted, so definitely, I definitely felt, okay, I am, I’m out of the woods, I felt out of the woods.

35. In retrospect I probably wasn’t completely recovered from a burnout at that stage, but I was in a safe zone, it felt like I was in a safe zone; I wasn’t on the radar for anyone to be worried about me, or I didn’t need medical input, or I didn’t need, um, time off work, so, so I was functioning but I think … for me it was separate, work was containable, and then the other stuff was being; was a learning curve; I was still learning, you know sorting out issues and stuff like that, but looking back I think, I don’t think I completely recovered until I had completed my stuff.
36. Yeah, I had this expectation that, this [burnout] shouldn’t be happening to; to a CATT clinician … I was embarrassed.

37. There was a bit of anger at the CATT role … I couldn’t just leave the CAT Team, I could not leave in that situation, I couldn’t just leave because for me then it would be ‘well they’ve just beat it out of me and I’ve had to go’.

38. My whole concept of being a CATT clinician changed completely …at the end of the day I felt, as I came out of the woods … then I needed to decide do I stay, or do I go? …what do I want on a long term basis?

39. I needed to win … I don’t know who against … but I needed to win, um, it gave me the motivation, it gave me the strength, it gave me the drive, um, I could not give into this, I could not leave under these circumstances … I don’t want to be remembered like this, I don’t want to be seen like this, I just have to get back there and sort it out.

40. I knew I wasn’t clear headed to make a big decision, like do I leave, do I just resign.

41. The stress and anxiety came first, and then anger came.

42. It [anger] was at the beginning of the transcending … it was consistent for a little while.

43. I don’t think I ever went in there and said ‘this is a problem, we’ve got to address it, let’s take it to the powers above’, because at that point I didn’t trust myself, I didn’t know; I didn’t know what was anger and what was my, my stuff … I didn’t know if my stuff was colouring how I was seeing things, so I didn’t trust myself.

44. As I could let the anger go I could manage the stress in a different way, and be a bit more accepting of, okay well that’s how it is and these are my options.

45. I had to feel I could trust my own judgement; it got better as I got better.

46. I needed that outside voice [referring to her GP’s influence].
Participant D Significant Statements

1. I haven’t looked at it as burnout, I’ve looked at it as, a … overwhelming sense of frustration I suppose, kind of at times in a physical sense it feels like heaviness, like this heaviness that I carry around sometimes, but I guess I’m not as bothered by it now, which is probably why I’m able to still do this job, because I now have family of my own, I work part-time, so I’m not totally there all the time, so when I feel heaviness about my job I know that I’ve got a like outside.

2. Socialising in between shifts which is, say doing a morning shift, going out on a Saturday night, then doing a morning shift the next morning, it never really feels like that social like has any impact on your, on you … so you kind of just fit social life in and then you go back to work and then you, it’s more of that, more of that heaviness.

3. Having a decent life outside work, where I have days where I’m not there … and it’s easier to forget what’s going on at work so when you attend work any of that sort of heaviness feeling that sort of comes with, I feel, the burnout feeling where you, you can’t give anymore; it’s fine because it’s sort of not there before you’re off again, and that’s how I feel I’ve managed to move through it.

4. I’m certainly not to the point where I was many years ago where I was just so upset about it; felt trapped, I don’t feel trapped anymore.

5. Over four years I’d had periods; six to eight months where I was actually away from that environment and had a good decent break … when you go back to work, and you’re so looking forward to coming home to see your kids, your focus is different, it changes, and if you’re frustrated with work you don’t … I no longer feel I have to fight the good fight, oh well, that’s it, and I’m moving on and I’m going home.

6. I try to ignore problems with the politics and things like that at work; you can’t always ignore it, it’s always there, but I don’t feel like … if things aren’t going to change the rest of my week’s going to have more of the same.

7. I think also having my colleagues share, share their feelings, probably because I force them into discussions about it all the time, but it’s just nice also to know that other people, but other people that are in my position, who are part time now as well.

8. I look at it more now, at least I’ve got the experience … I’m looking at the years that have gone past as experience, and sometimes that helps.
9. How could I have gone through a period thinking I’m burnt out, thinking I’ve been there too long, and now sometimes I still feel like a rookie, and I don’t know why I’ve gone through that now.

10. Going part time and moving through that and … having a focus outside work has helped me stay in this job.

11. I don’t not like the job, I actually love the job, I like the … everybody likes the … when you’ve been able to help somebody who isn’t there too wrought the system, it’s always nice to help people like that.

12. I don’t think the word burnout, in my experience in recently, certainly over the years, I don’t think it gets used at all; people aren’t acknowledging it happens, I don’t know what it is.

13. I do think that I would like not to be in this job for ever; but I’d like to be able to leave it and come back to it, cause essentially I like it a lot.

14. For the moment I’ve moved through that burnout and I’m stay where I’m at now because it’s; well it pays well, my job pays well … and I’m not in a position to, to look at an alternative career, so I still hang on to what I like about the job.

15. Liking aspects of it has definitely kept me in the job as well as financially, but if there was nothing I liked about this job I would seriously have to consider doing something other than nursing just to get away from the whole health-care profession.

16. My experience was feeling control, or overwhelmed I should say by burnout, then releasing it because it was not an issue for me even while I was having children.

17. Taking a long time off from the place that makes you feel burnt-out was helpful for me … I felt like I had fixed the problem at the time, and I don’t feel like I’m burnt-out now, I just feel that there’s still frustrations, but that’s with this job and I think … I don’t feel; I feel bothered but it but just don’t feel like I’m like I’ve lost control; I would cry and things previously where I really don’t do that now. .. it’s not that I don’t care; of course I care I just don’t think I let it affect me the way I did before.

18. I didn’t plan on how to fix the burnout.
19. Even though I was, I felt completely burnt-out I was still excited to learn new ways to do things (commenting on moving to a different CATT service).

20. It was definitely change for me, and that’s certainly how I moved through that burnout.

21. I am now seeing myself as … being now in the job where there’s no more long time, long periods away from the job; this is, this is it, so now I can see myself maybe falling back into a place of burnout, I don’t know.

22. I can refresh myself again by moving again … it would be a temporary fix but I know that for me in the short term, it’s helpful … helpful to move.

23. For me the burnout was about being, feeling frustrated about things I couldn’t control.

24. I think working part time and having a family … and doing something with those reduced hours that is, I think emotionally very important and very satisfying, has been a good thing, really important.

25. I don’t think you can enter people’s lives as a clinician, go into their homes, hear the ins and outs of all of them and then not have, and not have your own life to be embracing as well.

26. Now I’m able to pace myself; being part time at work is important I think in terms of hours; I don’t see how people can survive for long periods of time in a job like this.

27. My home life is healthy, and the work we do with clients, obviously we’re dealing with people who, we’re dealing with unhealthy situations and unhealthy minds, so it’s nice just to have reality, reality checks, and every time I go home it’s a reality check … I’ve got a good life.

28. He (the participant’s husband) very much understands when I’m frustrated with my job, so I think debriefing to him at times has been a very big help.

29. My husband over the years has learnt a lot about this job just through me and so he does understand and if he doesn’t understand he’ll actively listen … and validate my feelings … and once I’ve sort of off loaded it I feel good.
30. If I hadn’t moved away from the service, if nothing had changed at that time in my life, nothing, and I was still slogging away the way I was before there’s no way (she would have transcended her burnout), I don’t know where I’d be right now, I would be a ‘head-case’, I’d be really, really, really unhappy, and I think everybody around me would know it.

31. From that point on it’s always been a though in my head that I’ve done it once before (moved CAT Teams), I’ll do it again, not I will, I’m not threatening myself, I can do it again … if I need to I’ll take leave again and go somewhere else to freshen things up again for myself …. I grew as a person I felt.

32. Whenever I’m frustrated by my job I always have that conversation with myself; I don’t have to stay here really, there are other things out there, and that’s what I didn’t have before for sure, I did feel like there was nowhere else for me to go, I don’t know why I thought that.

33. I don’t feel trapped now, I’m always in my mind thinking if I get to the point where I feel trapped like I did before I have to be the one to physically change, I can’t expect that something within my work environment is going to change to make it better for me, that I will have to be the one to either move away or be active about it but I don’t want to feel like a victim anymore.

34. I think it’s important to have a voice, to feel you have a voice so you don’t feel like … so you don’t feel like you’re being dictated to and taken advantage of I suppose.

35. There are a lot of things I let slide as well, I don’t let, I don’t try and let every single annoyance be an issue of discussion, I just let things go too; so important things I speak up about, things that are not so important I no longer feel I have to make an issue of.

36. The less you sweat the small things, the less you are going to be overwhelmed by feeling trapped or controlled or whatever.

37. Now I really feel there are a lot of people on the team that are the same place together, so I feel like I’m; I share the burden more that way.

38. When I returned back as a working mum … I now work fixed days, so I have some predictability about my week.

39. All those years I worked full time … I’ve pulled the reins in right now, I feel like I’m taking some of that control back.
40. I don’t feel like it’s a big cloud hanging over my head anymore and I’m going to run, I’m not going to run anymore; that’s not necessarily true, there are times when I could just … drop everything and leave, but I don’t feel like that’s a constant, I don’t feel like I wake up every morning to it.

41. Because I work part time; it’s been a really bad weekend, I’ve got, you know, several days up my sleeve to recover and then I’ll get back in it again, but if I had to do that at full-time level, I’d be back to feeling on hundred per cent burnt-out again and I’d call it that, and I’d label it and I’d acknowledge it and try and run from it.

42. The job that I do for me, it’s an interesting job … I have a career, I’m proud of that … now I see myself as a mum that works as a nurse in a job that is important and interesting, and that makes me proud of the job again, I’m proud of being that again, whereas I wasn’t.

43. I think just through the natural progression of life, I don’t think burnout was, thankfully, not permanent state of burnout was not on the cards for me.

44. I now look at; this job still has its problems, but I’m no longer it’s number one victim, I’m just one many, just one of many numbers that feel frustrated by the service and system, but I’m not dictated by that.

**Participant E Significant Statements**

1. I’ve always had a lot of interests outside, outside of work that have sort of kept me going, families been important, hobbies catching up with friends has always been important.

2. The ability early on to develop empathy rather than sympathy for the patients, so you know, keeping things out there, I guess probably helped me a lot.

3. For me it’s about keeping work interesting really, and not falling into the same rut … so although it’s been on CATT for many, many years that’s been a changing playing field.

4. It was about having that good balance outside of work but also having that good balance inside of work as well.

5. On top of that is about knowing when things are getting a bit too much really, … for me the early warning signs really, earlier on in my career was about going home
and stewing about work, you know thinking, waking up in the middle of the night and 'I forgot to do something, and this case is really bothering me’, you know, you start to get those intrusive thoughts I guess, and it’s certainly happened to me.

6. When work has become intrusive, and I know at that point, I recognise in myself um, it’s time to, time have a break or time to book a holiday, or time to really do something about that … it’s about trying to resolve whatever the issue is, I guess I’m fairly pro-active in that sense, seeking supervision, or seeking some sort of resolution to whatever the current problem is, but then planning to have a bit of a break as well.

7. The thing that got me through that (burnout experiences related to a difficult clinical situation) was the support of colleagues and the support of; yeah people were just willing to, to assist) … to relieve that stress was really about knowing that people were there to help out, people were there to support.

8. The support in the sense that there was a good system in place at the clinic, if you’d ask for someone to come out with you that they would; they wouldn’t hesitate, aah, and um yeah, you could always have someone to talk to or debrief about to.

9. That (potentially dangerous situations) starts the stress levels going up, but how high the stress levels get I guess is; I know for me when they got to, got to high levels that’s when I’d start stewing about work, ruminating and; I always had this thing, when work was affecting my sleep it was time to have a break and take a step back from things.

10. For me it’s about … moving through that (burnout) is about, is about the practical tackling of the issue is the first step, so … it’s really, it’s really about having a good idea of what the problem is and how to move through that, um, I’m not one that gets a bit stuck on the issue, you know I need to; I problem solve quite well.

11. Those things that aren’t in my control, is, is where the stress comes from, you can move through, I can move through a stressful situation by problem solving, by, you know, by, trying to fix what the issue is and looking outside the box.

12. The only way to relieve that stress at the time was doing the things that had to happen.

13. That sounds fairly logical and fairly easy, um, sometimes, I guess what I’m trying to say, those plans don’t often; it’s not that simple as well, which just adds more stress to the, the whole situation.
14. To move through that stress it was about just smaller problem solving things, ... my best way to describe it was just, just cap the stress for the time being, it’s a juggling act, you were just juggling all the time, and you were aware at any point that those balls could fall ... the answer was about, the answer was about the main problem solving thing, that’s where the answer was in, but there was also all these little things ... I guess that just capped it, didn’t sort of make it overwhelming in that sense.

15. Coming into work, the feelings for me were that, um, it would be very stressful and be worrying and be you know, can I do this form right; the pressures, did I have the right training to do these things ... for me it was the stress and the worry of am I going to stuff this up, am I doing this right.

16. You’d really feel that pressure I guess ... feeling pressure, feeling of not being able to relax, yeah just the worry, waiting for something else to go wrong, so this sort of feeling of impending doom, you know, anxiety and a bit of ‘what’s next’, um, but a big sense of relief when things worked as well, when things go okay... the huge sense of relief was the biggest thing.

17. The experience is about not having that sense of doom, coming to work more positive as opposed to a very negative mindset, so rather than coming to work thinking ‘what’s today going to bring?’ or you know ‘how am I going to get through today?’ or ‘what, what problems are going to happen?’. um, it’s actually about coming into work looking forward to getting rid of some of the back, backlog of stuff, um, it’s actually; and working on some of the things that are really, really exciting.

18. For me it’s um, it’s the new stuff that’s coming into SH. that keeps me excited, that keeps me fresh.

19. A lot happier (describing the emotions associated with transcending burnout), is the main thing, um, a lot happier and happier in a lot of different ways not just at work, but also at home, and more relaxed and probably, probably a nicer person to be around I think; somebody who usually takes things fairly lightly, and um, enjoys a joke and enjoys a bit of fun, um but when things are stressful ,you know that side of, that side of me sort of is put on hold really, so yeah, sleep a lot easier, enjoy things outside of work a lot more, enjoy work a lot more ... less angry, less irritable, less demanding.

20. Ebbs and flows (the experience of transcending burnout), you know today; um, it’s so much dependant on what’s going on around you.

21. There’s a lot of stress at home you know; if you don’t, if you don’t manage the good balance, that’s real important, I mean, so certainly seeking out the things I
enjoy doing is very important you know, across the board, if you just get stuck in the, in the rut, that’s what I struggle against so I’m often looking at whatever, different committees, or meetings of things that interest me, the workshops … the learning I guess is really important.

22. For me, part of it comes down to bettering myself, but also feeling useful, feeling that um; feeling that I contribute, and I guess it comes down to your own personal; what drives and motivations I guess, but for me I always had it instilled by my father and my parents, you work hard and you have a good work ethic, and you show up and you’re there to do a job, and you’re there to do it by the best of your ability, and um and that’s what I’ve always tried to do … things that push me and interest me … I’ll certainly throw myself into those things, and try and do them to the best of my ability, and um I guess being challenged and learning new things is good; I’d hate to go stale.

23. I was lucky early on to have some pretty good teachers who taught me about, about balance.

24. I’m quite an analytical person in the sense that I’m very aware of where I’m at in here (gestures to heart) and in here (gestures to head) and like I said I’m very aware that, when I start to get the cycling thoughts and that are intrusive and are not something that I choose to think about, that I know I’ve got an issue there so; I know that if I don’t start to work on this things that they will start to affect my sleep and will start to affect my moods and what not … at a very early age I was very , I was able to learn to be keyed into that; it’s something I’ve maintained over the years.

25. I see it (burnout) and I recognise it in other people, and I guess that’s a bit of a protective mechanism for me, you know.

**Participant F Significant Statements**

1. My experience of burnout has been … increased resistance to going to work due to fatigue, my own kind of decreased capacity to listen to peoples stories, to problem solve what needs to happen, to tolerate my own anxiety around the shit that happens at work … increased interpersonal conflict within the team, wherever, the tireder the more burnt-out I get … my increased inability to discharge clients due to: I start to second guess what could potentially happen.

2. I’ve noticed that happen two, three, possibly four times over the last: I think I started CATT nursing in Ninety-six / Ninety-seven; it’s happened at least three; probably three times; probably more so where it’s been really quite prominent in our practice and function and my response has been quite different.
3. When I first started working as a CATT nurse it would be a lot about the bravado and the façade; it didn’t matter where my anxiety was at you just had to put on a brave face and keep going because that’s what you did as a CATT nurse.

4. I think for me the most effective way I kind of dealt with my burnout was; as wankey as it sounds, through supervision; though taking my experience to an external, objective source and having an environment that was purely there to support me; I’ve always had external supervision, I’ve never had internal supervision.

5. I first started to get external supervision when I was working at Casey CATT in the late nineties cause I was really struggling with how I operated, how I saw myself as a CATT nurse within that particular CAT Team; difficult dynamics at the time, lots of interpersonal conflict between the team members … how it work for me was I could separate my emotive response, and transferential or counter transferential experience within that kind of context and look at it objectively, as opposed to ‘this is just not my shit; this is not me being bad at what I do, or causing a ruckus … this is the experience between the two of us, so what is my part in this … how do I deal with it’.

6. So for me supervision was fortnightly, or maybe even weekly at times depending on how much I was carrying and how able I was to carry it … at times that felt more like therapy than supervision, yeah that happened.

7. I have drunk a lot; when I have felt particularly burnt-out alcohol has been there as well, and chocolate; it’s true, very much comfort things.

8. Stepping into comfort is doing the things that make me feel immediately better; for me it’s how do I distract from my immediate experience, sometimes it is to separate from my immediate experience after significantly traumatic events.

9. Alcohol, it has been a comfort thing, and the comfort is for me is its self-soothing; I can hang out with friends, use alcohol; I can sit on the couch, eating ice cream and chocolate; focus on another sensation as opposed to fear or anxiety or pain or embarrassment or the immediate distress of what happened or what is happening; and it doesn’t kind of add to my control, but it distracts from my lack of control.

10. As a CATT nurse control is something I’m very much aware of cause if I feel out of control it makes me question a lot more frequently what am I doing, how am I doing it, why am I out of control? Am I out of control in my personal and then is that transferring it to my professional life or vice versa, because the two for me are so closely correlated.
11. It’s something that supervision does for me; it’s like ‘what’s my personal shit and what’s my professional shit?’; the two meet and where are the boundaries in between them, if I’ve spilt from one area to another.

12. I’ve transcended burnout by taking a large chunk of time off work, and a lot of that was about self-care; I could no longer care for myself effectively and separate effectively from my work environment.

13. I took a year of leave without pay … I thought I was going to go travelling, but essentially it was about how do I get out of this environment before it destroys me … and that was a big thing.

14. I could recognise that work had impacted on my sleep; it had impacted on how I socialised and who I socialised with.

15. [Burnout had affected] my capacity to see people as people as opposed to the PD or the drug-pig or the violent anti-social plonker; all of the story that we have around our clients, that are just the people who pissed me off as opposed to people who were in distress or has stuff going on.

16. I think for me CATT nurses tend to socialise with CATT nurses in my experience; most of my friends are psych nurses now … so if you hang out with CATT nurses it’s not only your own story; you’re hearing theirs as well, constantly, so separating for me; taking time out.

17. In recent times just doing the Gestalt [therapist training] has just helped … step back into my own kind of phenomenology, ‘what is mine and what is the story of the people around me?’, and how do I kind of, put a boundary in.

18. We all have trauma; we all have traumatic stories that; it’s like a pissing contest really … it’s a really weird way to socialise, when you’re socialising around your trauma cause you all know the trauma that happens, but it gives you a different kind of frame of reference; you can’t go out and chat about normal things … yeah.

19. Systemically I don’t feel supported; for me it’s how do I actually say ‘yes I need to my supervision, and I will do it in work time’, as opposed to using my days off or I’ll do my extra study today and enhance my practice and pay for it myself in do it in my own time’, cause the organisation has never supported me doing that, ummm fuck, I know it sounds like whinging but it’s not.
20. The whole notion of burnout, it’s very hard to work out, for me, where my own burnout currently is, cause I don’t think you’re ever not burnt-out or completely burnt-out; for me it’s a spectrum of how do I sit in the feeling of burnout, how prominent is it, how managed is it.

21. There are certain aspects of burnout that are always present for me … and it’s my sense of support by my assistant constructions, my capacity to sit and tolerate the crap; to work for me is to work constructively or objectively with other aspects of my own service as opposed to kind of hoarding my own resources or my teams resources until I have to give it back, which is tempting.

22. So moving from the burnt-out space of a client with a predominant borderline personality disorder is a client who is an ‘oxygen thief’; he’s wasting my time and all theirs to this person; for me I notice the shift [transcending burnout] very clearly in my head; goes from ‘I can’t deal with them, get them off the board, give them seventy-two hours and there-there-there’ and move along to ‘this person doesn’t choose this behaviour, they’ve been organised and socialised into these behaviours … due to their historical experience; they didn’t wake up one day and deciding they were going to take an overdose or cut themselves; this was learnt behaviour because it sooths them … how can I support them to make healthier, better, different choices; can’t do it for them, can’t do it with the, can only model the behaviour, or better behaviour. That shift is not subtle for me; I can feel it.

23. When I’m kind of burning out, burnt out or just really tired I can’t make that separation; I can’t make the separation from ‘this person’s giving me the shits and they trigger all my previous really bad experiences with borderlines’ to ‘this is a separate individual with needs, to some degree I’m here to service, how can I them in a way that’s going to support and contain them’.

24. For me, how do I take the path of least resistance when I’m burnt-out, what is the easier for me as opposed to what is in the client’s best interests.

25. The tireder I am the more kind of fucked-off with the system I am. The path of least resistance is invariably what I’m more likely to take as opposed to; open to longitudinal planning, what may be harder, what may be more emotionally taxing for me and the client which may in the long term have better outcomes for my relationship therapeutically with the client and for the client’s outcomes.

26. I don’t go to work for me, I go to work for my clients and the tireder I get the harder it is to hold that, because at the end of the day when I’m burnt-out I go to work for my paycheque as opposed to I go to work in the service of the people I’m seeing; that’s a really powerful distinction for me. The system doesn’t employ me for me; the system employs me I in the service of the clients on the CATT board or clients that rock up to ED.
27. For me looking at the whole relation of transcending burnout is being aware of my own internal process and where I sit, within that … the language around that being very overt and I hear myself talking about the ‘oxygen thief’ or the ‘anti-social drug pig’ or the ‘chronic schitz who’s non-compliant’ as opposed to Fred Nirk at the Bree who needs blah … for me it’s been about building awareness around my own language, or my response, and my tolerance to the language of my colleagues, and looking for myself support.

28. The increased disinterest, where it’s easy for me to call them an ‘oxygen thief’, and to do little … when that stuff is starting to build; it’s like, okay, what else is going on; am I working too much, am I not getting supervision, am I not doing the things that support me, so for me it’s how do I change that process, so I can actually take that step back and look at; I’m tired, I’m grumpy, I’m feral, the clients are suffering, I’m suffering because of how, how do I change the context of it.

29. It’s not a subtle shift, it’s not something that is there one day and gone the next, it’s a conscious, considered ‘all right fuck, I’m fucked off’, when I’m talking my language changes, I can hear it now as I’m talking about it, I swear more, document less, I either arrive late or leave early my attention and presence is not … and transcending that is looking at all of those, in the context of what’s happening and whether my work environment, and my emotional response to my work environment is happening externally that contributes; and what has to change in order for my overall presence to change … sometimes it’s about increasing the frequency of my supervision, it’s about … for me it’s about just stopping being present and looking for what; I know the whole notion of transference and counter transference can sometime be wankey, but sometimes it’s as much as which client is driving this for me … which client is really hitting my on buttons and really revving me up and why, and what do I need to do.

30. For me it’s how do I separate, how do I get back to objective view; sometimes it is maybe withdrawing from contact with that person if it's not therapeutic, or limiting, or bracketing my own stuff.

31. For me part of being a ‘good’ CATT clinician is being attentive, that’s what we do; we attend, we listen, we’re present; how can we do that for people we see if we can’t do it for our self … my own personal stance is if I can’t look after my own internal world how can I then go out and look after somebody else’s; how can I be authentic and real when I am with somebody?

32. It is that self-attention; I know I have my own internal dialogue … how do you manage your own internal dialogue so it doesn’t impact on the therapeutic encounter … supervision therapy, studying the Gestalt contributes to that.

33. As a CATT nurse you are told you are the master, you are the expert, you are the one with the experience and the knowledge. As a very young CATT nurse … it sets
up a false expectation, it sets you up with the thought or the idea that you have the answers, and if you don’t go and bloody well find them; that these people’s destiny is in your hands … the dynamic and the pressure it puts on you is almost at times insurmountable, separating for me involves recognising I don’t have all the answers, I do not have all the knowledge’.

34. When I believed as a CATT clinician that I am ultimately responsible for outcomes of how many people we’re looking after it’s a daunting place to sit and for me it ramped up my anxiety to the point where I was overly vigilant … when I look at how the shift in my own perspective has transcended my burnout it’s: I am not ultimately responsible for the twenty five people who are currently on the CATT board; I share their journey with them, I contribute to them but at the end of the day my dimensions are clear.

35. We talk about burnout with clients. I’m not responsible for my colleagues; that for me that has been a big part of my burnout; how does interpersonal stuff relate; I am not responsible for how they function, I am not responsible for them.

36. For me it [transcending] takes a lot of the ‘I’ out of it; it makes it more about the ‘we’ thing; we do this, we as a team do this, ‘we’ as a multi-disciplinary team involving everybody provide you with care … for me that shifts the sense of power.

37. You asked for an image of what for me typifies my sense of burnout, and it’s one I’ve used with clients for years and it’s one that sits in my head for me when I get burnt-out; I have a pot on the stove on constant boil and when I burn out it boils over; it’s uncontained and spilling over … and for me the analogy is how do I turn the heat down, what things do I take out, how do I turn the heat down to manage what’s on constant simmer.

38. My significant period of burnout was of sadness and despondency … for me it was ‘I can’ I can’t feel; I can’t contact my feelings’ cause they’re that kind of protected… I did feel anxious, I feel the agitation, the internal kind of restlessness of ‘have I done everything, is everything okay’, my anxiety manifests in my hyper-vigilance, double checking, I manage my anxiety, and it’s that self-flagellation.

39. I feel sad, I feel really unable to manage my own negative emotions, and I feel sad and I feel hopeless … worthless … cause I can’t do what’s expected of me, more to the point I can’t do what I expect of myself.

40. You squash down the rising sense of panic, so I’ll eat it down, or I’ll stay in bed and hide under the doona and get up five minutes before I have to go to work, or I’ll isolate more at work.
41. It’s lighter [transcending]; there is a lightness; I can get to work on time it feels easier; the whole burnout feels like a burden; everything is a burden, listening to someone’s experience is a burden; transcending that I lose that sense of burden; it doesn’t feel like I am being put upon, or I’m being asked to give more than I’m capable of; I don’t feel depleted … and I don’t feel like my clients are sucking the life out of me, I’m better able to; to regulate.

42. I feel; when I’m burnt out I lose that sense of separateness; this is my stuff, this is the clients stuff, this is where the boundary is; when I’m kind of burnt-out I lose what’s my stuff and what’s their stuff, when I’m not burnt out I know where I end and I know where they start; there is a clear distinct boundary that is very, very evident for me … my sense of objectivity is back so I know what is mine, what is the transference stuff that is happening between us and what is theirs and so I can look objectively and hold my stuff and work objectively with theirs.

43. It’s easier, it’s so much easier; I don’t feel like I need to come home and sleep after a morning shift, I don’t feel like I need to sleep till midday to go to an afternoon shift, and my life is not about work and sleep, my life is about the other things except work and I can give more headspace to socialising and school work and family as opposed to my life is work, sleep, work, sleep, work, sleep.

44. It’s a bit like the chicken and the egg; I don’t know, I don’t know whether I’ve had chunks of school work that I’ve had to hand in and whether physically doing the schoolwork energises me more which separates me from the work stuff, I don’t know whether; it’s a hard one to actually … not it’s actually; I think it’s doing the social stuff, forcing myself to do it; getting out of hermit land back into life … as part of transcending burnout; the more burnt-out I get the more isolative I get, recognising I haven’t rung anybody, and haven’t gone anywhere, cause he [husband] goes out all the time and I won’t go.

45. Transcending is actually making the conscious steps to get up, get dressed and go out as opposed to sitting on the couch watching shit TV … bitching and moaning that I haven’t gone out when he’s rung me; part of that is accepting my part of that and making those conscious forward steps to go out.

46. I don’t think it is such a directed directive process of I feel like shit, I haven’t rung anybody, I’m going to work and sleeping and that’s about it … it’s hard to articulate …it’s an awareness around am I burnt-out, what are my indicators of burnout; procrastinating for a prolong period of time thinking about the shit I’m in and how to change it, and it’s like sticking my toe in the water, what do I feel ready to do, what do I need to do to shift my headspace, as opposed to A-B-C-D, o it’s that kind of gentle stepping out again, to shift; to shift my current headspace.

47. As opposed to jumping in the deep end I will go out with the friends who understand that I might be feeling a bit alike, so instead of sitting on my couch watching shit TV
I’ll go an sit on somebody else’s couch watching TV and drink wine and eat chocolate. I might go and hang out with low maintenance friends who don’t have kids; go and sit at the park and drink wine and eat chocolate … cause I might go from sitting on a couch to socialising to working to everything; it’s overwhelming.

48. As I think about it I generally re-establish self-support; talking to people who get what I do for a living and the time that it takes … not the full-on stepping back out … it’s like what you do with your patients, just do a couple of things and then do a couple more and then do a couple more … and regulating around that; I’m absolutely knackered, great I’ll go back to bed with a trashy mag, and it’s also ‘okay I’m absolutely exhausted, I won’t do the extra shifts, I will say no to the overtime’.

49. I know I use the word self-support, but it is; making sure I sleep; making sure I eat; making sure I get to hang out with, or see my friends, having a little bit of contact with my family, that kind of stuff … looking at what I’m doing at work and how that’s impacting on me … looking at it from an external perspective and going ‘okay, what’s going on’.

50. It’s not euphoria, it’s light, it feels light [feelings associated with transcending], it feels … I feel emotion as opposed to; I feel a broader emotional range as opposed to the darker side of my emotional spectrum; I feel like I can tap into some of the joy; it’s easier to access laughter or happiness … not everything is grey.

51. You would say the picture with the person carrying the world on their shoulder; when I am burnt-out it feels like I am carrying everything; all the clients on the CATT board, to all my colleagues, to all my family shit, to all my shit; becomes evident … and as I transcend I lose continent by continent and it becomes a lot lighter.

52. So that for me is something that is significant; I don’t think my experience of burnout would be so profound … if my colleagues didn’t have such a large part to play in it … yeah.

53. People [CATT nurses] don’t know how to ask for support; absolutely, it’s a sign of weakness and failure. If you say you need support, then clearly you’re not managing so therefore you’re not able or capable of doing what you’re meant to be doing; there’s a lot of kind of stigma attached to that.

54. So doing the work, not feeling pissed off and sitting with myself becomes easier; that sense of fraudulence, that sense of façade diminishes and I’m better able to access both the light and the dark side.
55. I can get happy, I can go out and laugh, I don’t need to self soothe as much with the drugs and the alcohol, or the food and the alcohol these days.

**Participant G Significant Statements**

1. I’ve learnt to put it in that context of this [burnout] is part of the job; that it just is as it is.

2. For me burnout is when there is this expectancy I suppose from community, from management to do more than you are actually able to do… and I find it; that’s probably what causes me the most burnout.

3. Staffing levels fluctuate, but it’s the support you get from your ‘managers’; there’s fifty of them around and I’ve met probably about two, and I don’t think they even know my name, and it’s just so impersonal… it’s almost like they forgot what was like to be an actual clinician, and I burnout when I just tell them things and we’re just head butting the wall.

4. It’s hard not to get shitty with your patients, because that extra demand on you, and they shouldn’t be, cause you’re there for them, but they become the demanding people, they you just fight, cause you can’t yell at management, and it’s these people who are going to suffer the consequence of your foul mood.

5. What I try and look at is that, okay this is part of the job, this is not going to be something new, then you need to get a grip, you need to deal with it and just do your job because it’s not going to change, so there’s this kind of acceptance.

6. It peaks and waves because some days it’ll be really busy and we’re not coping and things are rough and then there’s; you just think okay, there’s going to be a lull, cause there’s always a lull, you think it’s a weekend, it’ll be a weekend shift so it should be alright.

7. It has go to the point where I’ve had to take time off cause I was just really frustrated where everything was going and I wanted to change careers, and the only thing that keeps bringing me back was I think, ‘do I really want to go back to general?’ … that’s a really hostile environment to work in… so I take the good with the bad and I keep staying back in psychiatry.

8. I take time off. There’s probably been twice that I would actually say that I actually got really, really upset that I went to the GP in tears saying I need to get away, I need time out.
9. It’s more about having this sense of; it almost becomes fear evoking, I felt fearful to go into work, that just because of the pressure I thought I’m not coping, I’m going to fuck up really; and I didn’t want to fuck up because I could identify that my care-factor was going down, I wasn’t completing paperwork as well as I could have been.

10. When you’ve got tyrants who are within your own team causing some problems as well, you just can’t manage it [burnout].

11. The transcendence for me is; I’m really lucky I’ve got a lot of clinician; all my friends are actually in psych in some way shape or form, so it’s always good to have a few days out with them drinking red wine [laughs] and just bitching and moaning and that seems to work for me.

12. Currently my partner, who also works in psychiatry, is considering leaving the profession, so it’s also good to, what I’ve learnt is to look at other clinicians and see what their breaking point is and where they’re at and see if any of my behaviour is related to that.

13. I think I’m working with some people at the moment who suffer continual burnout … I bitch and moan on shift, but it was never that chronic, constant bitch and moan about how bad you are, how bad that is, and name calling around handover and stuff; that is not acceptable and again it comes back because that puts extra pressure on you as a clinician, as a whole team, but no one in management will step up to that and fix that.

14. For me I accept that it’s [burnout] going to happen for periods, when things get worse, and just I drink; I wouldn’t say I’m an alcoholic, not at all, but I have my drinks with my friends and I vent it out, take some time out, do things I like to do, and then come back to it.

15. One of the things that I like, when it comes to taking time doing things I like, is actually art. I’m not very talented, and there’s this thing that the borderlines do, and it’s kinda like glass stuff and instead of using leadlight it’s like a paint in a squeezy tube thing … it’s really simple stuff and you just, because you’re so focused on having to get your lines straight, your mind just vacate; you’re not participating in anything else in the world apart from getting these lines straight, and for me that just gives me the complete time away, so I really like doing that.

16. The drinking, well, I suppose we grow up in a culture where alcohol is acceptable and you get to laugh and have fun which I think in:- in our job, we’re always so serious; it doesn’t have to be but it’s a pretty serious job, and sometimes it’s just nice to sit back with other people who know your clients or know what: the sort of
stuff you do and just laugh about it … it’s just nice to have a laugh because I don’t think we get to laugh much.

17. You go out and, because most of my friends are psych nurses we start off talking about our separate lives, but our lives are work the majority if the time; we spend eight hours a day there, so effectively my life is psych nursing and everything else comes second cause this is what I spend the majority of my life doing, and this is where I’m focused.

18. Even though you go out with your friends and try and talk about other things but it always comes back to psych nursing; which is probably good that my partner’s leaving; hopefully [crossed fingers gesture] in the job, so we can maybe have some kind of different discussion, like rebuild the relationship based upon something else apart from our role, our career.

19. And the other thing is this sense of need for people to, to push us to step up to the plate. I think what we do is good enough; we do the best we can … I spend more time doing paperwork than I do spend with clients; you have to put that into your time; that’s something that burns you out because if you do three assessments on a CATT shift, you know you’re got to spend the next four to five hours on the paperwork.

20. It’s hard, it’s still really hard to make that time for myself, because there is this expectation that you have to, see other people, it’s really hard to get that alone time… it generally ends up being time away from me when I could be doing my art.

21. There’s no time for me on my days off, cause you have to try and split your time and I find I really struggle with that and I, and the art I like to do is not something I can do, say before a shift or after a shift, it’s something I have to plan for on my day off; cause it’s a complete day.

22. I get up, quite early … do all the stuff you need to do and by eleven I’m sitting down there with a glass of champagne to start; do all my stuff, putting my music on; it goes for about four hours but that’s what I need on that time.

23. It’s a sense of achievement I think, cause even though its childish people love it; I give it away to people and you know I’ve made beautiful floral designs you stick in a window … it’s just the pleasure that it gives people when you can see they’re actually think ‘wow that’s really nice and I really like it’, so it’s that sense of achievement that you’ve done something as well… and you can look at it and think ‘yeah, that’s really good’.
24. You don’t get that sense of achievement really on CATT sometimes, you usually hand them back to the case manager cause the acute crisis is over, but you never see ‘really well’, you never see a successful completion to anything you do, whereas this [art], I can plan it, it’s all sorted; it takes, generally for one article to come out it can take me, probably about, at least twenty hours… it’s that sense of achievement, and it’s long term, and you’re working towards a goal and when it’s complete; ‘wow, there it is’, it’s done and it’s beautiful and it’s perfect, and we don’t get beautiful and perfect in our job, not really.

25. I think it’s because … I get to work towards something and have it complete and it’s done, but it’s also that period of time where it’s just me, and my art, me, and my art, no one’s involved, it’s never made for anyone in particular, it’s just something I really like, it’s something I think is beautiful.

26. I get to focus on it so completely when I do, cause I make sure no one is in the house… it’s just that complete me, me and my own thoughts which is nice and I don’t have to worry about anyone else, it’s just all about me, and it’s nice to be all about you sometimes, so yeah I think that’s probably what it is.

27. I think I know that I’m stressed and this is what I really want to do and I don’t want to be around people so it more comes down to me identifying I don’t want to be around people cause I just get an: - I just did it then, I got angry [laughs], I don’t want to be around anyone, everyone just go away. I think that’s more what I identify with initially, that I want to be by myself, and it’s about how do I get to that place; how do I get to be by myself.

28. I identify that I need that time alone, but it’s hard you know, I don’t know whether, when you look at burnout what that actually means even, cause it would mean something different, cause when I look at it I’m probably constantly at this perpetual state of potentially being really burnt-out, cause I need this time so badly, so frequently.

29. I wouldn’t say I’m generally shitty … I’d say I generally like coming to work and enjoying people and I know when I start not enjoying people I work with that’s another thing that I might be I; identify burnout.

30. The last time I had to take time off was two to three years ago, we were having this restructuring kind of thing going on in the CAT Team … there was that pressure; so we lived in this place of constant anxiety… so for me it was the, partly politics, partly different personalities, cause the job really hadn’t changed that much except they took out our triage work, and it was just this constant daily battle with that anxiety, and it wears you down, and you get tired and you get frightened about coming into work cause you don’t know what to expect or how it’s gonna be … and that’s when I took all that time off … but I just couldn’t face coming back, it was
just the anxiety was too great and it wasn’t about the patients, it was about my fellow clinicians, and how I just could not cope with them.

31. I spent a lot of time crying, cause I love my job, but thought ‘I can’t go back, I can’t do this anymore’ and I spent most of it plastered, um, and yeah just talking with you know, Deb … just by talking with her about all the problems that we were having in our team and having someone sit there and just listen to you and support you and hear the stuff that you were saying and turn it into, cause sometimes you can’t do it yourself; she would say look ‘it’s only a job, it’s gonna happen, there’s nothing you can do to change it’, and she would always say ‘come work over here.’ It was about identifying what options were available to me, and but you almost get nihilistic about your career future at that point in time, and think I’ve got nowhere to go, I don’t want to go back to the wards, I can’t go to triage, I’m not going to ED, I don’t have the skills there, I can’t go into education cause I’m not registered so I; you just look at everything so nihilistically; there is nothing left, and she was really good just being there to listen.

32. Even if you have a mentor; although … supervision, it’s not worth a fuckin’ cracker, really, you know. Because they want to talk about cases, well fuck, we’ve got handover twice a day, I’ll talk about my cases there; what I need to talk about is how these people piss me off and I want someone to fix it; that’s what I want my supervision to be that’s not appropriate, so there is no outlet for me there … that’s what causes me burnout and I need to talk about it, I need to speak to other people about it to get some help. It’s never resolved, it’s never resolved.

33. For me it’s about needing to vent and people just to hear me cause I don’t feel heard …as much as you talk no one actually hears you, but your best mate will always hear you, and particularly because she knew what was going on here; it was great to have someone who actually supported you and listened; I mean your other colleagues do but they’re all in the same boat; it’s nice to speak to an outsider who can just say ‘yeah that’s really tough, but I don’t know how you cope with this sort of stuff and you know, what can you do.’ And you go through the options which are all null and void but it was just having someone there to listen and to understand it was almost; because she’d lived it before she left as well so she could understand a fair bit.

34. So I go to Deb and I talk to her, and I say ‘Deb this is what’s happening and this really upsets me’, and it’s just that venting, it’s just getting it off my chest, because I just feel I’ll go on shift and I’m tense and I’m angry and I want to say something, but I’m not:- I’m the one the one who’s gonna cope a pizziling for it, and even more recently when I spoke to a couple of other clinicians to see me with the manager one agreed and the other one sais ‘nah, it’s not worth my trouble.’, and it’s not really… again we’re back to Deb looked at what options I have to stay or to leave; so it’s really about, yeah, it is identifying what options are available to me, and also just you know, just having that time to just bitch and moan and get it off my chest helps a lot to; to have someone to validate I think my experience you know.
35. If I went to say, mum to talk about this she just wouldn’t get it; she doesn’t grasp psychiatry at all, she doesn’t understand the difficulties within our job … I think you do need to be part of a team; or within psychiatry; you need to have that psychiatric experience I think, that would go a long way.

36. If you don’t feel that you’re validated it just puts more pressure on you when you think ‘maybe I’m just overreacting, maybe I’m a bad person, maybe I’m not a nice person’, all that sort of stuff. That would just make it that much harder to get on with the job, you know it you started to not believe in yourself; and I think getting that validation makes you feel ‘no, no, I’m okay, I’m right and I’m okay’, and I can plod on, but if, you know if I was coping a constant pizziling and no one was there to say ‘no, that’s not right’, I don’t think you could move on from it.

37. Even when you do go to the GP in tears they just stare at you; ‘oh okay you look stressed, you got a hard job’ that’s it, there’s no talking, not that I think that would really help anyway … you don’t get anything.

38. It’s distraction, cause when I drink I generally do art or I sing; I can’t sing either but I love singing and dancing. I think I’m a little Britney Spears; I do little groovy things [dancing gesture], and it’s because again it’s that not thinking of psych at all; I’m focused on doing whatever I’m doing.

39. People would say well why don’t you set yourself up to go to do something regularly; with shift work you can’t do anything regularly … you can’t do that consistently, that’s not the reality; so when I do get a couple of hours … have a few reds, pop in the ear; iTunes and stuff like that and start boogying along; that’s completely; again it’s all about me, but it’s that smaller time frame that I’ve got and then I can just sleep it off and get up to do the shift the next day.

40. It’s about that distraction, it’s about you know not; just having a laugh I think it’s laughing too; cause I laugh at myself a lot, you know; when I’m doing it[drinking] and having fun that’s again, it’s alone though; it’s very much about being alone.

41. Everyone wants a piece of you; and it’s not always bad you know, it’s not because that want to be vindictive or anything; they want you because they want to spend time with you because they like you so I never view it negatively, but I do view it as not me being allowed to be alone with my own thoughts; and do you know you always:- you don’t have to keep a guard, that’s not … you have to… you have to participate when you’re with other people whereas when I’m by myself I don’t have to participate; I don’t have to listen you know, I don’t have to do anything I don’t want to do, it can be all about me.

42. Sometimes you have to actively participate, you do, and sometimes I can’t face that, and that’s when I know I really need to organise that time [alone].
43. I can judge I suppose where I’m at too; when I needed complete time alone, and you know it’s also hard because I have external activities that bring me a lot of pleasure that I have to try and fit in as well as well … it’s about trying to fit everything in but it’s also about needing to not have to participate and interact.

44. That’s fantastic [not having to participate], but then I get shitty when someone intrudes on it … I’m shitty cause I don’t feel I’ve had enough time yet and I have to go back to participating and listening you know, and having to just go back to what I perceive as life … I want more time to myself, go away, but you can’t get that so you just have to appreciate that you’ve had that time and now it’s back to life, so it’s like that little bit of escape, and I just have to tell myself ‘you’ve had enough time now’, now be nice, yeah and go back to doing what you’re doing.

45. I think that’s partly why; the picture I have it’s about compromising on everything; it’s the mundane but it’s also compromising, because the, the … it was in Morocco I got this pic; in Morocco; he’s got people walking through the Moroccan streets, it’s just a painting, it’s a very simple painting and it just shows the people going around their normal business, this the mundane, this is just what you do daily, every ones the same out doing their own thing and the reason I talk about compromising and needing to, to be there for other people is because, in Muslim law you’re not allowed to draw people but he has, but he’s got away with it by shadowing their faces, so it’s not against the law, so it’s about compromises and trying to adapt, so he needs to make money, people aren’t just going to buy a building, they want interaction or something, so he goes against what he has to do, he has to compromise and stuff, and that’s why I like it so much, because you know you bend the rules consistently, you know, to make things bend for you, depending on what your needs are.

46. The period of transcending I don’t actually identify with any emotions, I just know it’s done and it’s over … it’s almost like I have burnout and now I don’t have burnout [laughs], it’s not something that I can actually see that I’m recovering from as such maybe it would be acceptance, maybe as a feeling; I just feel a sense of acceptance; well this is how it is and just move on, you know just accept …

47. I don’t really identify anything going on, you know even when I look back to that time I had to take sick … one day it was really bad and the next it was just get on with it.

48. There’s a sense of contentment and peace and a fair bit of joy, and achievement, a sense of achievement, um, feeling warmth; I feel warm, I feel cosy and happy with myself and just this sense of overall contentment; I feel happy, I feel nice; everything’s good and I have a talent and I’m really quite comfortable where I am at the moment, and that’s why I think I really struggle with the intrusions [laughs]
because I like myself when I’m doing this sort of stuff, and I feel comfortable with everything I’m doing.

49. I feel in control; and I think that’s another big thing. I feel in control, um, in a job, in a place where you cannot have that kind of control, apart from you know, you have to be with other people and you kind of; have that little merry waltz with different people all the time you know; I don’t have to do that when I’m doing my art; so I cannot have to worry about how will this person respond to me … that’s what I like about that, and then it’s just back to having your usual insecurities, and your worries and anxiety an stuff.

50. It’s that break, it’s that feeling good for that period of time and just liking yourself I think as well, that’s really important, cause let’s face it we’ve got to do a lot of things that aren’t nice to people and that can make you feel really, really bad and it can make you feel really frustrated, and I think frustrations another big thing … you get frustrated because we have no answer to what’s happening [clinically difficult clients].

51. I get to go away to my art and I have to think, sometimes I do, sometimes when I do it I’ll think back to of my clients who has passed away who I really felt strongly for; I think about them occasionally but it’s not … again it’s with love and with contentment and with that peace; it’s not like when you’re at work and you think of your clients you can sometimes:- it’s more about oh my god I don’t want to make the same mistake that happened there [laughs] … when I’m doing that time by myself I can reflect, and it’s reflecting nicely with peace and contentment, yeah, it’s completely different.

52. When I’m at work I get angry, really angry that we’re not doing enough and then when I’m at home by myself can I sit down and say ‘okay, as a person you’ve done the best that you can, you know, and surely god will understand that you’re doing what you can, and you can’t fight powers that, that you just can’t fight’, so I try and look at it that way, but it’s only when I have that that I can do that.

53. Doing this with you today, I’m now worried I’m in a perpetual state of burnout [laughs], that just has periods of relief; I’m thinking ‘fuck, this is a really bad place to be’ … maybe we’re all a little bit more on edge that I realised …but I’m back to that again, I’ve got to speak to Deb [laughs], and look at what are my options here, cause I don’t want to be here now [laughs].

**Participant H Significant Statements**

1. I think um, probably I can think of probably a couple of times where I have transcended burnout, whilst I was working on a CAT Team … probably the thing
I can remember most is sort of looking back and noticing that life was a lot better, and that I was a lot happier and that work was a lot more enjoyable, and that I was more motivated, and then realising at that point that probably I had … that things were a lot better.

2. I guess it um, probably started for me; it started with realising that you know I was burning out, or burnt-out, and that I wasn’t enjoying my job, that I was; for me it was that I was dreaming about work, that I was thinking about work when I was at home; that I was not feeling confident with anything that I was doing, and that I was sort of getting all blurred about what I was doing:- realising that something wasn’t right, realising that I was um; that there was way too much in my life being spent on work … just thinking about work all the time.

3. At that point either I or somebody else would point out that perhaps things weren’t great, and: I’ve always been big on supervision; would make sure I was getting a lot of supervision, would … take a holiday if I could, and would just try and change things at work a bit so that I: maybe I had a break from a client that I’d been dealing with or … tried to do something different, tried to find a focus that was gonna re-spark interest and get rid of all that angst and hatred sometimes that happens.

4. Slowly I guess things start to improve; I found I don’t actually notice the period as much as when you look back and go well that was bad this is good.

5. I think I have been good at sort of figuring out that things are not right, and doing something but not actually: the actual period of time I could never work out how long it took for things to get better.

6. I guess my biggest regret is that the last time I actually left the CAT Team; which I think looking back, cause hindsight’s a beautiful thing; if I had of stuck it out life would have improved, but I was in a; I was really struggling and just kept thinking life’s gotta be better than this, this can’t be my career, this can’t be what life’s like and then I left … and still being burnt out went to a different job which was equally as stressful and frustrating, in fact worse and then I left the service; I left psychiatry altogether for a little while.

7. I guess I did transcend burnout in that way, but I did it in the wrong way, and it wasn’t til I wasn’t working in psychiatry and I started to miss it that I thought ‘Oh, I was burnt-out back then’, and I really missed the CAT Team and I really missed what I was doing but at the time couldn’t see any of that because I was struggling.

8. There was another time earlier on where I was, I was just really struggling with how much to be involved and what to do; wanting to change the world and not
being able to and getting frustrated and I did; I got lots of supervision and lots of people generally expressed their concern.

9. For me, I’m a talker, and I need to be able to express: I need to be able to express what’s happening for me in a safe environment … often you don’t feel comfortable talking to your work colleagues about it because you don’t want to sound: you don’t want to seem weak, you don’t wanna seem like you haven’t got it sorted; so supervision just gave me that opportunity to be able to say ‘look his is a real struggle for me or parts of this are a real struggle for me, and I’m feeling this towards the clients and I’m generally just not coping’, and it allowed stuff to be presented to me in a different way and the suggestion that I might have been burnt-out, raised in a safe place, whereas if your colleagues raise it, you sort of, think you’re having a go.

10. It was really valuable to me, having a good supervisor; at one stage I was seeing her weekly I think … was invaluable … it really helped… I guess it also, for me, when I was sort of burnt-out I was losing co:- like I lost a lot of confidence, and felt I couldn’t do what I had to do to do my job which was where I sort of … always trying to cover my tracks all the time; checking and rechecking and make sure I: ringing someone the next day just to make sure I that they were okay and just felt like it was all getting out of control, and I think the supervision validated that I was actually doing a good job and … that it’s okay to go through these periods of time.

11. A couple of times I have taken a big break; a one month break as opposed to a two week break; like it probably does help but I’ve just always found if you’re in that mindset where you just constantly; and I mean everyone’s different but like I said before for me there’s the constant thinking about it; you know waking up in the middle of the night going I wonder what happened with that person, that didn’t stop when I was on holiday and it was only, it was more frustrating cause I wasn’t there, being able to check what happened with that person so … probably when I was at the height of my anxiety I guess about work it wasn’t an incredibly valuable experience, but it does mean that you don’t get to add to it, you don’t get all the; you know you get a month off or three weeks off.

12. I used to find I’d think a lot about work; I’d think about what had happened; I’d be really worried that people had got; that I’d done something wrong at work and that people were gonna be: that I wasn’t there to control the situation.

13. The lead up to work I’d be; the lead up to going back I’d start getting really stressed, and start waking up really anxious and worried about it, and then by the time I got back to work I’d be an absolute mess again, so I wouldn’t say it’s the solution; cause I don’t think that it’s only part of it.
14. I think it’s a mindset that; removing yourself from work as evidenced by my leaving the CAT Team to get away from it is not the solution …. I don’t think for me; I think for me it’s about recognising it, and um, just trying to make some small changes in the method of working and putting limits too for me.

15. It was about putting limits on myself, about how much I was gonna do; the work /life balance, because that’s what I found when I [was] burning out, that the work/life balance goes pear shaped.

16. I would find myself staying back at work till six-thirty, getting a bit earlier to catch up; ringing work if I knew someone was on that I wasn’t going to be embarrassed about, ringing work to find out what happened with someone; I really was just constantly thinking about it, dreaming about clients and I suppose it was about trying to put some limits on that which is not easy when you just wanna keep on checking.

17. Trying to make sure that I got out of work on time; that I didn’t take on too much … that I had a break from the rather intense clientele that we were dealing with … if I felt myself getting too over involved with someone that I would just sit back rather than trying to fix them, but that was really difficult to do when you just wanna be getting it right.

18. At home I was lucky, cause I had someone at home who was going ‘you’re spending too much time at work’, and ‘when are you coming home, what are you doing’, so that helped having a supportive; very supportive relationship.

19. But I think too, the other thing is, the experiences of burnout very much depended for me on what was happening at home too, like different times of my life … affected the burnout at work, if that makes sense.

20. When I was, … in previous relationships I was very unhappy, and I was, life was feeling out of control for me, and I was gambling as an escape and I was: looking back work was; I was loving going to work … I was immersing myself in work, and in gambling, to sort of you know, escape; not escape; obviously life just wasn’t great, but that of course then leads onto burnout; because you’re doing too much; the balance is not right so then that lead on to probably more escaping behaviours, indulging in escaping behaviours.

21. When all of that sort of ended and I started another relationship that was good the focus shifted and I: the focus on work and that fact that I was just out of control at work and I was ringing up at ten o’clock every night going I’m going to be home at midnight … highlighted that for me and that fact that I was overdoing it and needed to do something about that and then I guess the supportive relationship that
said ‘how about you spend some time at home’ helped to get through that period and start fixing the balance.

22. I did start to burnout again, which was when I left, but at that point I was try to: I was questioning whether I was ever going to start to really enjoy work again, I was ever going to sort of enjoy the CAT Team again, and I guess I needed to test that out, which is why I left, and hindsight says I probably shouldn’t have.

23. Back then everything I did was about psychiatry; I was in a relationship with a psychiatric nurse, all my friends were psychiatric nurses and that wasn’t a healthy way to be … I like to think that I wouldn’t be that immersed any more … but I don’t know.

24. Just basically looking after yourself as well; I was smoking like a chimney, I was spending hours on the internet, I was not looking after myself; I was like a wired being [laughs]; I was getting three hours sleep and coming to work and you know, so that didn’t help the situation.

25. Transcending it was about getting happy again in all aspects of life, cause it’s just all clouded, everything just; it all leads into … when every aspect of your life is going badly it just all … turns into one big ball really.

26. Trying to find another, something more; something interesting: when I started on the CAT Team it was just so exciting, it was fantastic, you’re like this blooming’ hero going out and saving people, and after a while it was ‘Oh yeah, gotta get in the car, got to go to Berwick, whatever…’ and I can remember getting to that point where you’re just like; ‘I can’t be arsed, I can’t be arsed going out again, I can’t be bothered talking to that person’; and I just remember being sad; and I still think it’s sad … because it’s such a good job and really fun.

27. For me it was trying to find, like trying to get interest; it’s like we always joke about, you know, I’m dying for a first onset … getting something else to put your teeth into, or getting a project … something to re-spark the interest and to make it; get that excitement back.

28. I do remember getting to that point where I just though I don’t wanna go to work … I just don’t wanna; can’t be bothered; yeah I can, I can distinctly remember that, so that’s what it; it’s just about getting something to change the focus, cause it you’re wanting to stay in the same job; which is: it’s never a good idea to leave at that point anyway.

29. Well to start with it was about making a decision it was going to be exciting today, like for me … look what we get to do every day, just trying to sort of highlight the
good stuff and I guess making a decision to put what you can into seeing this person … making a decision that it was going to be interesting; that each person was going to be interesting.

30. I think it was about reassessing it and thinking why am I hating this so much, why am I: I used to love going out to people’s houses, I used to love doing this and what am I going to do to make it different, it was just really reassessing it and highlighting it … I just remember making a decision.

31. I always realised when I was getting to that point where: I never ever wanted to be a cynical old psych nurse, never … when you realise that you’ve just gone through two or three weeks of ‘bloody bastard, bloody can’t stand the guy, whatever, who cares if he goes and kills himself’; when you realise that every single person you’re talking to is like that; … often it’s a parallel; like often you can hear someone else; one of your colleagues doing the same, cause there’s always at least one or two having the same experience, you just think ‘hang on a minute that’s me … I’ve been talking like that for three weeks’; and at that point it’s like ‘no this is not what I’m about; I’m not about this and I’m going to change this’, that’s when I’d kick in the supervision … I’d just go ‘right, I’m gonna walk in with the smile and I’m going to be happy and I’m going to leave at five o’clock ’.

32. It’s almost like you get to a point where you’re looking in a mirror, and you’re going ‘this is not how I want to be doing this’ … that’s where I would usually get to that decision.

33. To me that was like getting to a point where you’re getting close to burnout, and then warding it off at the pass … I see that as transcending cause you’re sort of kinda going down a bit, but you go up before you hit the bottom, and that only came out of realising; that probably happens; would happen every few months even, that was a fairly regular occurrence.

34. I suppose it was just about making a decision that I wasn’t going to be one of those burnt-out, grumpy, cynical, psych nurses.

35. It was control, and it was reflection … this is not who I am, and this is not how I practice, this is not what I’m about, and I really have always been about making sure I do the best job that I can do, and when I got to the point where I didn’t give a shit about that that was always a real concern; cause that is me, I’ve always been about reflective practice, and ‘could I have done this better, and could I have done this differently … is the client happy’.

36. I don’t think the clients ever actually saw what was going on in my head, but … I could feel it all the time.
37. Probably it was about control, I’d say it was more about reflection, which probably is control to some degree as well.

38. With burnout you’re probably less reflective than normal, for me, so probably the fact that I started to reflect … I think reflection is what would get you to start transcending burnout … you have to reflect on your practice, and you have to reflect on how you’re feeling in order to get to that point.

39. It is a lot like looking in a mirror, and going: or hearing yourself; hearing yourself talking to someone and getting frustrated and angry and thinking this is not what I’m about.

40. Reflection’s a huge part of this job, or should be a huge part of this job for me I think for everyone; and if you use reflection on a regular basis you get to the point where you realise you're; you need to get yourself out of it.

41. The times when I’ve really realised; probably the times when I’ve become more burnt-out, where I’ve really realised I’m in a bit of a hole, it’s quite confronting, cause it’s ‘shit, no, I don’t want to be like this, it’s not me’.

42. When you get to that point when you realise that your colleagues, clients and everyone have been suffering because of your behaviour, which I have been there a couple of times, it’s not a great place, but it’s the only way to get out of it so…

43. The ability to be able to go home and then realise that you haven’t thought about work for twenty-four hours is quite extraordinary for me … and that’s when you know you’ve kind of made it, waking up from a good night’s sleep … not actually giving a rats arse what happened after you left work, is just a lovely feeling.

44. Enjoying life and wanting to go back to work, wanting to: having a couple of days off and actually looking forward to getting back, but not from that desperation point of what happened with that client, what happened with that client, just wanting to go back and thinking ‘I wonder what’s happening today’; an absolute, it’s a real casual feeling of this is where it all should be really, it’s just a really, really nice feeling.

45. It took me a number of years on the CAT Team to experience that, I think it was a; for me the first time round was a fairly decent spiral downhill, to get to the point where I realised it wasn’t okay and it wasn’t normal, and it wasn’t right to be immersed this much in your job.
46. It’s a lightness and it’s just a complete freedom; it’s a freedom; it’s a feeling of freedom I think is probably the best defining image for that, freedom [transcending burnout].

47. You have people [CATT nurses] that are like Teflon; everything just slides off them, and I’ve always been embarrassed that I’m not one of those people and I can’t just leave it all at work, and that I do think about it, and I’ve always wanted to be like that, but I just thought oh that’s not me, that’s not who I am; but when I actually did get to that point it was quite lovely, and I thought ‘Oh I can do that’.

48. It’s just a lovely feeling to get through the other side and the enjoyment; the enjoyment of your team and of your work, and getting into the car and going out and having a nice time and chatting to people.

49. I guess now I know what it is that you’re striving for too, so whereas the first time I just didn’t; I don’t think I even really thought about it until I was getting to over involved with something or someone, just wanting to save the world; I don’t think I even thought about what was normal and what wasn’t I just thought that I was inadequate in some way for not being able to leave it behind, whereas then I realised that there was actually more to life than thinking about work, dreaming about work…

50. It is something, something to strive for, but it’s hard to get back there, cause you feel like you’re sort of, in some ways; I used to feel like I was letting it go, like I wasn’t on top of it as much [tearful] …

51. I had to get to point where it was like ‘no, it’s okay. I’ve done everything I can do, I’m not responsible for that anymore and its okay and whatever happens will happen, and you can’t control the whole universe’; yes it is about control, but then at the same time feeling like I haven’t done as good a job as I could have done because I haven’t been as on top of it, so it’s all about balance really, the whole things all about balance and trying to find the balance and just losing that.

52. I’m all about guilt; feeling guilty for something, so losing that guilt, going ‘it’s okay, you’re still considered a good clinician if you go home on time and you don’t think about it all the time and if you … you’re still good at what you do, you don’t have to be completely out there, and it doesn’t have to consume your whole universe cause you really are only getting paid to be there eight hours a day.

53. I’m a control freak, so it [stepping back] was incredibly anxiety provoking, but at the same time it was necessary; you know you can’t go on like that; it’s like when am I gonna; when’s it going to end.
54. Me and another girl on the team used to work late, and again it gets back to that reflective thing, I used to look at her, and I used to think ‘god’s he’s burnt-out, she needs to get more to her life’, and then I’d go hang on a minute [laughs], something rather familiar about this.

55. It was incredibly anxiety provoking because I didn’t want to lose that control and that ability to feel on top of everything but as time went on it was getting more and more complicated to get on top of things and feel like you had it under control, cause you never did feel like you had it under control, cause it’s a CAT Team, it’s a fluid thing that changes all the time, you can never get to the end of it … I was never going to be completely in control because there was always something else that came up, so it was the ability to be able to … leave it, that I found really difficult.

56. I just think that age is a good think, getting older and wiser and not having to save the world is, having more to outside life…

57. I guess I can recognise the signs in myself, and in other people and I guess it gives me another point of insight; insight I suppose; reflection, whatever another way to reflect on my practice really, and it’s something to be aware of ; there’s a name for it and like, I know what I have to do if I feel a certain way … it’s experience; if I’d known before, if I’d known ten years ago what it was all about I probably would have: life would probably been a bit better, but I don’t think I’d ever get, ever get burnt-out again … I don’t think that I would ever become extremely immersed in work again, but that’s because I’ve got a lot more outside work than I used to have as well.

58. I think that the culture of CAT Teams has changed quite considerably … when we were on a CAT Team it was a lot more okay to be immersed, and to be working like a Trojan and to be: there was no such thing as over time, there was no such thing as; like it was whatever …and we all used to struggle to get out on time … we all used to struggle and it was all: it was just expected, it was just the way it was, whereas now it’s not like that; it’s a completely different mindset I think …I think the culture is changing which means that people are less inclined to have to be allowed to get to a point; that’s what I like to think anyway, because it’s not as socially acceptable: culturally acceptable to do that anymore.

**Participant I Significant Statements**

1. When I first went into CATT was I think, then I found it very … quite challenging, and quite sort of difficult to grasp the role initially, but that was a time when I was sort of, wandering whether should I be in that role, and uh, and gradually moved through that and felt more comfortable with that role, and you know starting to understand how it worked.
2. When I’m working I carry a lot of stuff in the back of my head about, you know, things that I’ve gotta do, that I’ve gotta complete, the tasks of, you know, if you’ve seen someone you’ve got to complete the err, sort of documentation, assessments, stuff like that, liaise with the people.

3. The documentation was the most stressful part, it still is really… I complete it and do it but it is something that always, is, is a thing that I, I avoid.

4. The other things, which is a thing in CATT, particularly is making decisions about people’s risk, um, that’s another sort of thing and I suppose, you know in the early stages, there was that, maybe, unconscious incompetence, really about you know making these decisions based on probably less information than was probably, err, you know … safe, in terms of; but being sort of macho with it at the time, thinking ‘yeah, okay, that’ll be fine, they’ll be alright, yes, send ‘em off to the GP’s, do this, do that, do the other’, and um, having done that on several occasions and then felt dear, I don’t comfortable about that at all, being very concerned about that, being very worried, um, about certain things until I got to the level of thinking about, you know, thinking it through a bit more, and being more sensible with it, thinking well; I suppose, weighing up the options.

5. If you talk about transcending, that’s how I transcended; by you know, balancing up, err… things and balancing up err I guess that… you know the consequences for those actions and how I reassured myself that yeah that was the, certainly the less of two evils to do that.

6. I suppose if you look at it generally; balancing … I could be very pragmatic about it; I think that’s how I am; a pragmatist generally; and I’m an optimist as well … a personality characteristic sort of thing; that helps as well.

7. It certainly has been a naïve sort of pragmatism … in its way it helped; not sometimes … thinking too much about the consequences, about what might happen, and just doing it, cause that sort of naivety, even though it was not good in some ways; it sort of helped me cope in other ways because thinking about all the consequences of all those priorities and actions would be overwhelming… I think sometimes that superficial approach; that pragmatic approach helped me deal with that.

8. I suppose it was pragmatism; yeah; pragmatism … I left idealism along the way a bit and focused on the practical as a way of coping, sometimes feeling guilty a bit about not being the ideal sort of clinician … there was a little downside to the pragmatism, the idealism got lost there a bit.
9. If you tried to do all those things that would be overwhelming, so you picked out the things you could achieve and prioritised them … prioritised what I could achieve and made some sense of it that way.

10. That really was quite crucial to that sort of role is that you had that sense of control, because the people that you were dealing with often weren’t in control at all; you there in control would be a way of reassuring yourself and reassuring them.

11. Containing myself was really important, cause I knew if I lost that confidence and that control I knew then it wouldn’t work at all.

12. You start to get that idea of patterns and then you can build some predictability, and that predictability gives you some confidence and some feeling of maybe safety.

13. A whole gamut of them [feelings associated with burnout] really, from initial anxiety, feeling overwhelmed, I think that was the chief ones.

14. I don’t feel as depressed as much; I don’t feel an actual feeling of depression, I don’t get chance enough to do that [laughs]; it ‘usually sort of anxiety or fear and sort of overwhelming: sometimes … anticipatory sort of dread about ‘god, don’t know how I’m gonna deal with that don’t know what I’m gonna do, just don’t know’, but I suppose I do know deep down that I do cope with these things, I do find a way through … somehow, and I won’t die, but there’s always that feeling you might not cope, you might not be able to do it.

15. It sort of mitigates it, I guess; that feeling in the back of your head you’ve got this: I’ve got this … this part of me I can bring out; this part that says ‘yeah, look, you know … chill, [laughs] get over yourself and focus on what you need to do’ … that bit sort of helps my anxiety, and I just; sometimes I forget about that bit and I go into high anxiety and I get … ‘I’m gonna get in trouble and I’m gonna get found out I’m really crap, I’m gonna get sacked’, and then that part of me sort of starts to assert itself, that says ‘come on, don’t be so dramatic, these are the things you can deal with if you just chunk them down into bits’, I think that part of me fortunately I have that helps me do that; I don’t know how much it will take to sort of over rule that cause I’m that at some part: some time it will say ‘well yeah, you’re right [laughs], forget it, you’ve had it mate, go, it’s true’, I think I’m nearly there sometimes, when that part of me, I guess that reassuring sort of … I suppose like a nurturing parent part of me that sort of says ‘go on, look you’ll be okay’.

16. It’s having developed that sort of I think; that coping ability which I’ve had but I think it’s strengthened with being in CATT, because I’ve had to have something there that sort of helps me to; I’ve had it cause I’ve done a lot of psychotherapy years ago … that’s helped me understand some of my processes.
17. Developing that part of yourself, that strong part that can reassure you, give you that self-talk; ability to support yourself in those dire situations when you feel shaky, when you feel it’s all caving in on you … then you have to sort of: I developed that thing that comes to my rescue, if I remember; it might take me a while to think ‘aah shit, you know … you’re not going to die here’.

18. Sometimes it is [needs to be ‘activated’], sometimes it’s self-activating, so it could be both … I think in some situations I have to remind myself ‘aah, yeah, I’ve got that supportive part of me, let’s get into that, let’s go into that’, and other times I go into that.

19. I self-supervise, self-talk, and that’s what helps me in many ways.

20. I’m always doing that self-supervision, all the time; it’s an ongoing process, I’m always sort of reflecting; I suppose trying to put things in perspective all the time, cause that’s how I function really; always looking at how things are, what consequences are and things like that; how, how I can … it’s part of control; if I can sort of exert that control then I feel more comfortable, I can be: do more things: be more effective; as soon as I feel out of control then my: everything sort of close in and … you’re trying to sort of crawl, find a way out [crawling gesture].

21. I think the contrast between that [CATT] and going home with the different focus at home; I’m pretty good … generally … at switching the focus, so when I go home I tend not to take very much with me: occasionally I do sometimes it does affect me, but generally I don’t, like I switch focus to another aspect of my life which is the family life, other things going on and that’s it; I leave the door, leave work; and it’s gone; I don’t tend to dwell on it unless there’s something particular… that’s probably very healthy for me to do that.

22. I know people who have trouble switching it off, of turning the focus; they maybe ruminate about things for a long time; I know if I did that then I don’t think I would survive very well in the job; I don’t know if I consciously do it; it’s like I don’t care when I go out the door; I don’t care about what happens. It’s like I’m a psychopath, I don’t give a stuff and walk out of there, and then I’ll walk back in and I will give a stuff and want to do it.

23. I suppose by all my whole life, fortunately, other experiences aren’t always being a psych nurse; before that I was in lots of other roles being lots of other things and I think all those things I can draw on now, sometimes I think ‘well yeah you done that, so you can do this, this is nothing’. I’ve done lots of things from living in the desert, the Nullarbor Plain, working on the railways, living in Alice Springs working there in the hospital as an orderly/ambulance driver seeing all sorts of horrible things, having a lease on a taxi in Alice Springs and running booze out to
aboriginal missions; I shouldn’t say that sorry, being in the army reserve, could have died for a while, living in Brisbane, going back to the UK, doing nurses training there, going back into a traditional bin of a psychiatric hospital, going through that ringer of experience there.

24. Not being a fully social person, I’d like to be; but I know I’m not … I can be social but it’s not natural, I’m typically avoidant really, but I suppose I’d like to be more social but the things I have learnt is that I can function very well in some very, very extreme environments.

25. More recently I suppose, I took up diving again and had a few close encounters there, and more recently I could have died there very easily … those are the sort of things I thought that help me draw on if I’m really sort of disparate, I think ‘look, you been in there, you got out of that, you did that’; and those are the things that help me transcend things because I can think of things worse than what I’m in at the moment, and that perspective and the comparison with that, that are the things I can draw upon, and I think ‘Christ, you’ ve done; if you got out of that, if you survived that hang-glider crash, if you’ve been underwater in a submarine and banged your head on the ceiling and nearly knocked yourself out, nearly been trapped in there and you’ve survived that and countless other things’, but it’s just sort of perspectives and things looking back saying if you can do these things because you’ve survived much worse, that’s how I deal with it.

26. I have to sometimes drag it up, I don’t always remember it but when I get really dire straits, there’s no way I’m here, it’s so overwhelming then I have to think ‘well fuckin’ hell, what about that, how did you cope with that’, and then you think ‘oh yeah, Christ, this is nothing really’.

27. It’s not always immediately available, but I know it’s there and I’ve got that sort of … kicking reassurance part of me which is there but I can always draw on those experiences to compare with what’s going on there; I think ‘well you know okay, I compare that sort of helps to take the sting out of something that’s happening now’.

28. Its [participating in the interview] like trying to articulate those things that I: what I do … put them in some transmissible form there. It’s interesting to sort of think through what I do … more consciously; that sense of I know what I do again now; I refreshed my: you know I do it, I don’t think about what I do I just do it.

29. It depends on the; maybe where I’m at generally at that time; whether I’m generally stressed, and also the severity of the stressors that are there at that time: whether I feel, how I’m coping with it; so there’ll be times where that reassuring part will come in and it will be quite sort of available and some times where it’s so sort of extreme that I have to step back and invoke it.
**Participant J Significant Statements**

1. For me it was going part time; I was ready to stop and have a family because I’d had enough.

2. It’s more about the political stuff, and the way management handle issues is what burns you out as opposed to the job itself … burnout for me is largely resolved around incompetent management or inadequate management, and the changing of the goal posts from what we originally trained under.

3. The supervision process which is really … hasn’t really worked for me; formal supervision I kinda found a bit of a waste of time for me, informal supervision, catching up with girlfriends (fellow nurses) … has been a bigger support mechanism for me, not that you kind of mention names or whatever, but just the specifics of it … I find that reflective practice, about it, and I also find that my mother is one of my greatest informal supports because she has a nursing background as well, so she kinda has greater empathy and understanding.

4. Having a break, not doing it full-time; just allows you to not buy into the politics as much, you still enjoy it when you’re there, but probably going part time has really minimised ongoing burnout.

5. I actually found giving supervision probably more beneficial because it made me think of solutions for other people, but when I was receiving it I just did it because my seniors told me I had to do it.

6. The informal stuff (supervision) … when you catch up with nursing girlfriends they always end up to a conversation and if there’s anything stressful; and at the time if I’m worried about anything clinically at the time there’s always someone to talk to.

7. Knowing that I have two beautiful kids to come home to and a great husband I just kinda think … ‘screw it’, my job is to look after these people not to fight the processes.

8. I know I can be direct, up front and um … assertive, which you know, I think most people who work in a CAT Team have to be (to cope with/transcend burnout).

9. If you don’t have those internal resources to be confident in your own clinical judgement and skills, you know even if it is a political thing or a process thing, if you don’t have the confidence to challenge people on that … you’ve got to be able
to carry that off and if you can’t… then you are going to burnout because you’ll get a mouthful from clients, from the families, from colleagues.

10. You have to have your own qualities, internal qualities, you gotta have a support network that can help you, you know, debrief, or whatever way you want to look at it.

11. You’ve always got to keep your sense of humour; if you don’t laugh about it you’d cry (regarding coping with the general mental health care environment).

12. I have that good support network that you can talk about things that bother you; be it professional, be it personal, but obviously everything interacts and interplays with each other so it’s having people that can keep you grounded that you know, you don’t get too grandiose cause you think you’re the best clinician in the world, or whatever, the worst clinician; people that will tell you; you know if you’re beating yourself up about something people remind you, kind of where you stand normally, … they keep you grounded, they keep you sensible, they also remind me that there is hope.

13. There’s things I can do to improve my personal life which will reflect upon my professional life, and there’s things in my professional life that reflect upon my personal life.

14. If I’m happier at home it’s easier to deal with stressful difficult people and vice versa, and you know, if there’s stresses at home I’m so much more intolerant of difficult, hard people.

15. The times that I’ve personally got really distressed; something that I probably, when I you get home you let it out type thing; a good cry is very therapeutic, it’s not a sign of weakness, you know, it’s a steam release for me.

16. You get great pleasure out of some poor blunted person with a first onset psychosis that can smile at you like, you know, … that sort of stuff still is a buzz.

17. I have come home and had a drink … it goes back to the support networks, and depending, depending on what answer, what response you want; if you want someone to fix not you talk to Adam (husband), not that he can … if you just want an ear you talk to mum sort of thing … depending on what you need you contact those friends that can support you the way you feel you need to.
18. It’s always about checking your internal processes, it’s about being comfortable with it, and it’s about if you’ve had a clinical flaw that you avoid that happening again, you make support.

19. Sometimes you do just need to have a drink, and you need to switch off, and it’s, you know, it’s not just a drink, it’s having dinner out, it’s just doing something different from your normal routine to mix it up, to change it… you just change it, you change the processes of it I think it helps you kind of work through it.

20. You kinda gotta let stuff go do, change what you can change, and accept that you can’t change everything and just work with the parameters that you have.

21. Well it just changes perspective you know, if you are really in despair and I came home to the same routine, or you know, it’s the same, if something happened at work … you have to change to get a different outcome, so it’s mixing it up.

22. It probably is about taking control …it’s about being assertive, it’s about being confidant, it’s about being happy in your clinical practice, it’s about being happy in your, um, work environment sort of thing and you know, I guess it is taking the bull by the horns.

23. So I only achieve what I achieve in my work hours and I’m happy; I am happy with that, at times I think I’d like to do more but then I think I’m probably not prepared to sacrifice time with my kids … is that about taking control?; probably.

24. It’s a balance, everything’s a balance, yes you take control, yes you’re assertive, yes, … um, you’re comfortable with all about it, but I think ultimately you have to have a really good balance of professional, personal, um … it’s very closely interrelated, if you’re having a good time at home it’s good, it’s better at work, if you’re having a better time at work, you’re having to do those extra shifts, but you certainly know they, they interface, abs-absolutely.

25. It’s about keeping in check, keeping grounded, keeping balanced, and … checking yourself … it’s all those resources around you that allow you to understand and hear.

**Participant K Significant Statements**

1. I’m wondering where to start and I’m not quite sure what it [burnout] means to me; what I do know is I have days when I’ve sorts got a shorted fuse, I’m a bit more cranky … I feel odd … sensitive perhaps, I feel a bit more sensitive to
what’s going on around me; whether that’s aggro, or hype or elation … I get caught up in that; it’s not as easy for me to bracket.

2. I’m quite good at self-care so I wonder if; the word burnout to me is so loaded. I’m not sure, to me it’s quite loaded; it conjures up for me at this point in time crotchety old bin nurses sort of thing, which I could fit into that category, but I don’t believe that definition, I, that definition, I don’t believe I am.

3. Just looking after myself; and changing jobs fairly regularly, changing roles might be a better; I’ve been at St Vincent’s for twelve years but I’ve worked in various areas, just about all of them, so that has given me; a change is as good as a holiday; different staff, different clientele sometimes.

4. Coming home and really; I take good time out, I’ve got a group of girlfriends, a couple of groups actually, really close friends who I’ve known for a lot of years who can be honest with me, I’m honest with them, so they give me feedback [laughs], have a few drinks.

5. I like to cook, I like to lie on the couch, I get a bit of exercise, I eat well; sleep, I’m a good sleeper, so those sorts of things I think really support me physically and mentally … well really.

6. I was talking to someone [colleague] about meeting you here tonight, and she said ‘Oh yeah, I’m an old burnt out nurse’, and I said I don’t see her like that, I see her still as a fresh, meeting each individual client on their own … terms if you like.

7. Being irritable and crotchety, I think that plays a big part with me and with nurses around me.

8. I’m thinking it [burnout] is a passing through experience; after I’ve had a couple of days off I come to that first handover which is often a late shift; feel refreshed, I come a few minutes early, I might get myself a cup of tea I feel a lot fresher, open to what the handover might bring … on the days if I’ve done late/early, late/early, late/early and had a few combative sort of situations I feel; my body is just a bit more tense, more reactive; maybe more inclined to come to conclusions quicker rather than just sitting with things for a little while; I have a belief that nothing is so urgent that we need to fix it right in this minute … most often we can just sit with things for a little while, sit with their families… I think I lose my ability to sit with things.

9. It’s interesting isn’t it, because I’ve never actually really put words to this stuff and you can tell by the way my mind’s thinking about it [chuckles] … yeah I don’t think I have, or not like this anyway.
10. That acute initial assessment, I like to go slow, especially if you’ve just met someone for the first time … there’s a whole lot going on and you can get hyped up; the police can hype you up, the family are concerned, the GP might be concerned … there is that potential to wanna get in to ‘fix it right now mode’, and I think perhaps when I’m a bit more ratty and irritable, tired I can get sucked into that rather than saying ‘alright people let’s just slow down here and take a minute to find out what’s going on and what the best options are, cause we don’t have to race you off to hospital, we can actually care for you in your home’.

11. It’s that: just getting drawn into that ‘quick-fix, quick solution which of course nurses are very good at’; a lot of us are older children; a lot of us are bossy and organised and controlling; but in the face of this episode, let’s just slow down and really have a think about what we’re doing.

12. I lose my slow and thoughtful edge.

13. Days off; as I say I feel fresher when I come back to the first handover after two or three days off; even one day off … having downtime.

14. Perhaps having supervision if I’ve had a … there’s been a particular incident that’s been difficult; having supervision which I have every fortnight, helps to unpack it and tease it out and think about what I could do better next time, or what I did do well at that time; that helps.

15. Being acknowledged … I wanna say appreciated but I’m not sure that’s the right word; cause that’s not what I’m in the business for … be acknowledged …

16. Having some peace at home … making sure I’m not too busy on my days off, things come out of left field with teenage daughters, so managing that a bit; stuff that I can actually slow down, sometine isn’t my responsibility.

17. It’s taken a lot of yours to work out I can … not taking responsibility where I don’t need to.

18. The contemporary way of working is different too; there’s three or four of us on the [CAT] team who need to talk and reflect and take a bit of time out and; we are old bin nurses that for all the badness of the bins you had a slow process and you got well before you went home; now you’re lucky to get three days in the inpatient units, and there’s this push to get ‘em out of the ED … it’s sort of hurt up, hurry up, and mental health isn’t like that, so that is a huge frustration for me and my
similar styled colleagues, so managing that, embracing change and the way things are in the health system now … I have to manage change.

19. Really, really difficult [managing change], though I’m up for it, because I’ve learnt to be up for it rather than butt up against it; I’ve wasted years trying to change the system … or not change the system perhaps, and that’s not going to happen, and so to look after me I’ve had to learn, and thus the supervision and the small group in my CAT Team.

20. I have to look after me; no one else is going to, at work or …

21. I know when I; when that irritable crabbly stuff came up that I really have to take time out; I’ve got a fantastic manager who, if I say ‘I need to go early today, I’m a bit crabbly’, he knows Margaret wouldn’t say that unless she really needed to get out of here, he knows I work really hard when I’m there.

22. So lightening up on myself; giving myself permission to go; leave things to someone else so give up some of the responsibility, not having to do everything myself … I’m just wondering if these are experiences that are good across life anyway, not just in the work place, because they’re things that I’ve: that try and do at home too.

23. But I guess it’s about really getting to know yourself, having people in your life; friends or supervisors or managers who you can have an honest dialogue with about how can we do it better; how can I as a clinician do it better … I really value people’s honest feedback, as I would give others honest feedback, cause that’s really helpful; cause sometimes you get so caught up; often you get so caught up in it you don’t actually see … or feel the … whatever it happens to be … damage was the first word that come to my mind, sort of erosion, as well as some of the good stuff; like you can do a really good days work and not really realise it.

24. It’s about just having your spirit or yourself or your professional person be chipped away at by the ebb and flow of a day’s work, a week’s work, a month’s work and then; and I’ve been nursing and I’ve been nursing for twenty-five; twenty-seven years something ridiculous, so a lot of water under the bridge, a lot of conflict, a lot of good times as well, but lots of difficult…

25. Any erosion you need protection from, to use the metaphor, so bolstering myself, steeling myself, which is about, I think about things of self-care, talking about it, yeah just putting things in place to not let that … it will happen, but just packing it up …
26. In my mind I can see a cliff face and some waves, and now I’ve come along with some wet clay-sand and I’m just putting that bit of cliff face back where it’s been, where the waves have taken it out sea … so that cliff’s still there protecting the people who have got their little houses, and the sea’s still there, cause we need the sea; we actually need I think to be broken down and: that’s about change isn’t it… this is my subjective experience in the context of everyone else, the clients, the relatives, so we need the ocean pushing us around.

27. I’ve had to learn to really bracket things off, and to not … sure listen to it, but also not get hooked up in that.

28. So transcending burnout; my feelings as I’m in there, or coming up to it are , the more negative ones, that ones that make my skin a bit more irrit[able]; I’m a bit more irritable, I’m a bit more churned up, short tempered, more bossy than usual, more controlling … and then; and I’m getting better at this, and I know I keep saying this but I’ve really working on it, because then I might have a run in with someone or get; raise my voice … and then when I realise this isn’t good for Margaret … I go ‘oh yeah, okay’, I’ll go and have a bath, or I’ll decide to go and see a movie or just go to bed early with a book; something to just look after me …

29. Sleeping’s really important … I’m a really good sleeper so I organise and sort all that stuff while I’m unconscious and in bed … so then I’m well rested too; and if I have a bath before I go to bed I’m out for the count for a good eight, nine hours, and I think that’s really important.

30. The transcending burnout to me; there’s a picture for me about little episodes; I’m not sure it could be one long episode over your career, or maybe you just get to a certain: if that’s an episode your career might finish here and still be in the thick of it, and retire feeling crabby, and crotchety and irritable.

31. I feel more like I do now [having transcended]; all the polar feelings, calm, more cognitive, like I’m more able to think, take things in, I’d certainly be more susceptible to change.

Participant L Significant Statements

1. Well I think, I don’t know if you ever really transcend burnout while you’re still working in the system; you make attempts, um it’s really hard to identify it as well, because it wasn’t really something that was pointed out right at the start.

2. There was a sense of excitement, and really wanting to create a difference … not really: going in innocently, not really understanding the true impact of that work long term, that was never really highlighted.
3. It was two years of, the halcyon days we called it, and then of course it amalgamated into another CAT Team and it was one big team, and that from then on that’s when I noticed the effects of burnout; the high … expectations … there’s a huge catchment area, the travel, the amount of people that are seen, constantly; there’s always huge numbers of referrals on a daily basis … really just sort of in survival mode, and many years of working in this way took its toll; exhaustion and not being able to protect yourself properly, by having time to really assess the situation before you go out there, so therefore some very dangerous things happened … over the years a few homicides, a few suicides, and seeing staff terribly affected by those things.

4. CAT Team members come to that sort of work from their own issues anyway; they’ve managed crisis well over the years I think in their own development so you sort of gravitate to that area of work, so naturally there’re a little burned out before they even get there.

5. So I guess transcending that; I must have realised the impact it was having on me, witnessing these incidents … the shift work was incredible; not getting off until two in the morning and then starting at eight in the morning in those days … noticing the effects on my family, that you’re just not available to them emotionally, you become very cut-off; you notice that the joking, and the fun, and the laughter it’s all: you become very hardened to things, so that worried me.

6. I started off going to a holistic therapy centre in Belgrave up in the hills … I found a ‘mother-earth’ type woman who used to be a psychiatric nurse and she’d transcended her own burnout by setting up her own holistic centre and getting out of the psychiatric system altogether.

7. I started having some supervision with her and I really got to see what if felt like to slow down, and just to have some time and space to talk about yourself; I had her for supervision which I paid for myself … within the service supervision wasn’t a high priority.

8. So I started supervision with her, I started to realise, just having that time and space, how affected I really was, because I broke away from the camaraderie [within the CAT Team]; I had to break away from that just to start; to start healing a bit.

9. I realised it was unhealthy and it just wasn’t working for me anymore, because that was the only way to survive; was to get into that camaraderie, and get into the culture.

10. I think it’s my own … I think I have more maturity on my side and also I have … my own work ethic which is to be an advocate for the client and really that was
going against my own work ethic, to advocate for the client and I didn’t like who I was becoming.

11. I didn’t like the way I felt when I was at home; my children would be talking and I couldn’t hear what they were saying; it wasn’t going in; they’d start cracking jokes and clicking their figures and trying to get me to repeat what had been said and I couldn’t tell them what they said… I guess I was probably disassociating a lot and that sort of worried me.

12. I started to feel like a robot and I just felt empty inside … I thought I can’t keep working in this area but the money was keeping me there, which is what everybody says, but I thought at what cost: it’s very hard to pull away.

13. I did supervision … for probably a year every fortnight, and then I started getting interested in some of the work she was doing there … I sat in and was co-therapist with her. And, that really gave me a different view of how you can work with people; there was a lot of creativity involved in that, so that was almost healing for me as well; there was drawing and music … that really helped me in developing a part of me that had been suppressed or killed off to have to work in that area [CATT].

14. It [CATT] became more medically orientated too, over the years … that was the thing that kept me there; I could use my own: I’d done family therapy I could utilise those skills, and that was really supported, but all those things got killed off in time, and I was more or less popping in that pill and helping the Police to nab them, get them into hospital, as you know.

15. After about six, seven years I got out and worked in case management for a while and I tried other areas of work; I’d always end up back there [CATT] … I went to St Vincent’s for six months and tried that hospital and that was so quiet … it was too quiet, I couldn’t cope with that, and then I went back to Maroondah.

16. It [doing family therapy training] really tapped into my intellectual need; I was really craving for some intellectual stimulation and that; I was able to feed that need whilst I was at work cause I would see different dynamics… at handovers I’d get interested … that really giving more of an intellectual stimulation I suppose, kept me interested.

17. I really noticed how traumatised staff were; I was acutely aware of it … I kept thinking I don’t want to be like that, I don’t want to end up like that; we’d had a couple of CATT clinicians from other teams on the board, couple of colleagues we’d looked after … I really started to recognise burnout, and I felt it [gestures to herself] and I knew what it felt like, and it worried me.
18. How can you try and transcend your burnout? I guess I’d never really had any supervision within the organisation, because I had a lack of trust because that’s part of the burnout, is you don’t trust anybody, you get paranoid.

19. I went back again [to CATT], just because it was closer to home (or so I told myself), I’d really noticed the, cause I’d been away from that group, and so I was already detached from that group phenomenon of camaraderie, the culture; I was totally detached from it and I was able to keep myself separate from it while I worked there for the last two years.

20. Because I wasn’t in that culture [CATT camaraderie], and I’d done so much work on myself I was really transparent and so they could see when I was traumatised; it was really clear if I’d had a difficult day, I was really traumatised, they could see it, it was written all over my face, whereas backing the old days I would have been hidden, I would have been laughing, joking and all of that; nobody would have a clue … when they saw it, that’s when they got angry … because they knew that’s what was inside them, hidden deep down and they don’t want to know about that vulnerability.

21. I’ve done Gestalt therapy, and part of that you have to do a lot of therapy, and I’ve done a lot of personal therapy … through that my brick wall has basically been stripped away … it’s made me a much healthier person, and it’s made me realise what my needs are, and I’m not suppressing them as much; you need to slow down, have some space, not to see this person if it’s not safe, unless all the requirements are around it, not have the bravado, speak out, say ‘no way, not unless these things happen’.

22. You have to be a bloke, it’s like being a bloke; all the women on CAT Teams become blokes, so I had to sort of ‘de-bloify’ myself, and try and become a woman again.

23. How did I do it? Having different breaks from the different CAT Teams, working in different CAT Teams, different areas; having times where I’ve worked a normal life, had weekends off, had routine in my life.

24. Having routines in my life, that’s the number one thing, is have some routine, and some space and time to think about what’s happened, what’s happening to you; what’s happening to you in that process, I that the sort of person you want to be; asking yourself ‘do I really want to be that person?’.

25. It really made me question how I want to be at the end of my life. I don’t want to be a sour, burnt-out, dried out prune, one of these crabby old women who can’t even relate to people; that was my biggest fear, so I think that’s really motivated to me to stand my ground and keep on the pathway that I’m going.
26. Getting lots of support for myself; doing study, I think that keeping your mind updated on different things is the way to go … cause you really start thinking you’re dumb; you’re lost all your confidence, you don’t think you’re capable of anything … you just think you’re a burnt-out human being … your brain’s all burnt-out, it doesn’t function … I’ve discovered that it’s not true, so I think it’s about getting confidence back, through studying, realising that you are capable and you have got something contribute and you have got something to offer.

27. The work comes so naturally when you’re working with people you don’t understand the strength of what you’ve got, you don’t understand your skills; it happens by osmosis over the years, you acquire all these skills, and you have got no value on them; you place no value on them, and you totally lose your confidence, and I think that’s from the trauma … you can’t take in anything that’s good news, you can hear bad stuff.

28. Twenty five years’ experience; that is a long time, why haven’t I ever said that to myself? Words like that have made me feel surprised, shocked, validated, validation has been great, just having that validation … it gives you hope that you are … you’re still capable, more than capable, you’ve got a lot to offer.

29. I’ve started getting supervision internally and that’s been a life changing experience for me … talking about the traumas, the accumulative trauma, for the first time in my whole career at work, that was life changing because I spoke about things I have never even spoken about before …

30. Having that, I would say has been life changing for me, this year, is talking about work traumas for the first time in twenty-five years … that’s been really significant; I’ve had eleven sessions with that person and that’s all it’s taken to get to the point.

31. The experience [local supervision] was one of … that guilt, thinking ‘oh, I’m taking the time, his time, and I should be talking about clients, I should be helping them, it shouldn’t be about me.; cause I’d go ‘hang on, this is about me, I’d rather do this’, and not feeling like I was entitled to have that time to myself and then he assured me supervision is about you, and if you’re feeling okay and doing okay well that’ll happen … reassuring me about that.

32. I didn’t realise the impact of certain clients I’d seen, certain experiences , and just really taking the time … it freed me up, it was like a weight lifted off my shoulders, it was like this cement taken out of my soul or something, it made me feel lighter.

33. I said I deserve two hundred thousand dollars compensation … I should be on work cover, and I just got a chance to talk about my anger … but after that experience of
being able to talk, after a couple of times, I said ‘I feel like I’ve had that compensation, because . the most powerful thing was I’d had it from the organisation; the ‘tower’, the ‘evil tower’ I used to call it, I’d had it form that; from the tower, from that same organisation; that was to me that was the key, that was my compensation, that was amazing, I thought ‘I don’t need that now, I’ve had it’, and it didn’t take that much really.

34. It was just the support and the compassion that he showed [her supervision provider], the understanding and the sharing … he’s a psych nurse; he goes ‘I know about work trauma’ so there was power in that for me; cause I really thought he can speak my language, he can understand my language, and he saw through, having the ability to see through my cover-ups; my wanting to get away from those things, but also knowing and trusting; knowing how far I could go into it … it was about having that space to talk about myself.

35. When I did some of the original therapy I did a lot of breathing as well … I even went to a ‘breath-work’ workshop … it’s almost a re-birthing thing … you do really deep breathing for half an hour; a lot of people have really amazing experiences out of that; I didn’t … my brick wall was really attached, but there was something healing about that.

36. I did quite a few alternative, creative things there, I had Reiki, and I started having massages about that time; I’ve had a lot of massages over the years, I notice I’ve got a lot of pain in my body from a lot of burnout I think.

37. One thing I’ve transcended is probably drinking alcohol; I don’t drink as much alcohol as I used to. I think that was a huge coping mechanism and since I’ve done all these other things, like the course and the Gestalt and my own work and the supervision and everything I don’t see that as; it doesn’t really do anything for me … two glasses and that’s all I need; just like the taste, I’m deadening myself out with it like I would after a hard shift, or try and get to sleep.

38. To try and get to sleep after a late shift I’d have about two glasses just to get to sleep, or after a hard day you’d go out with your mates to the pub and you’d get blotto; it’d be nothing to get through two bottles of red or whatever just talking to people … especially cause that’s all they’d talk about because you’re all burnt-out, and then you’d get more stressed, cause you’d be talking about re-living it.

39. The alcohol, the disconnection were the big things and the self-neglect, and the poor eating, really bad eating habits, fast food, stuff you can get in a hurry.