



ORIGINAL ARTICLE

Spouses' Experiences of Rehabilitees' Burnout and Recovery

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The role of family members' support in the burnout recovery process has been recognized in several studies. The role of emotional support provided by the spouse has been found to be significant in reducing burnout levels. Although crossover of burnout and emotional support have been investigated, the partners' experiences of the individuals' burnout and recovery have remained largely unexplored. To fill this research gap the study aims to provide in-depth knowledge of the experiences of spouses of individuals who have a history of burnout and are recovering from it by participating in a rehabilitation course. Ten spouses of individuals who had previously suffered and had recovered or was recovering from burnout in a national rehabilitation course, were interviewed. Semi-structured interviews comprised the main research material and were subjected to Thematic Analysis. Results showed that spouses were vicariously affected by the individuals' burnout and recovery. While they were able to provide significant support, especially if interspousal communication was well-functioning, they also experienced significant distress. In the recovery phase, the positive changes in the individuals' well-being were transferred in the relationship, and were perceived by both spouses as an increased ease, shared activities and improvement in communication. Knowledge of the spouses' experiences will allow their possible inclusion in the rehabilitation programme and their training in recognizing the symptoms of burnout in their close ones. This will enable individuals and their spouses to be better equipped to prevent the full development of burnout and to initiate a timely search for professional help.

Keywords: burnout; recovery; spouses; rehabilitation; thematic analysis

Introduction

Burnout is a chronic job-related stress disorder characterized by three dimensions: exhaustion, cynicism, and reduced professional efficacy (Maslach, Jackson, & Leiter, 1996). Typically, burnout research has focused on unfavourable job characteristics (i.e., high job demands and low resources) known to be the primary reasons for burnout (see Mäkikangas, Leiter, Kinnunen, & Feldt, 2020) or on the efficacy of burnout rehabilitation programmes at the individual level (for a review, please see Maricuțoiu, Sava, & Butta, 2016). However, despite its working life origin, burnout and its rehabilitation should also be investigated by taking into account the milieu outside the working life context. Although burnout affects

family members to a large extent, it has traditionally been investigated from the perspective of burnt-out individuals, with a focus on the burnout process. Recovery from burnout has also remained underexplored despite calls for more work on this line of research (Hakanen & Bakker, 2017). Furthermore, even decades after the start of scientific research on burnout, studies on family members' experiences of another member's burnout are still scarce, and the present study aims to address this need to better understand their experiences.

The investigation of the spouses' experiences is justified for several reasons. First, burnout as an occupational disorder has been studied primarily in terms of its direct effects on employees. Thus, despite quantitative studies, little is known about how job strain experienced at the workplace affects the spouses of burnt-out individuals and how they subjectively go through burnout and recovery from it. Furthermore, the negative consequences of such a transfer of job strain may impact the spouses' working capability and thus, indirectly, have knock-on effects for their workplaces (see Bakker, 2009; Westman, 2006). Simultaneously, apart from absorbing the negative impact of job strain, spouses may play a variety of roles that provide additional resources and thus facilitate the

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preservation of working ability. Finally, spouses may also be instrumental in expediting burnt-out individuals' recovery and return to work after a period of sick leave. Next, the possible mechanisms via which spouses experience strain are discussed and earlier studies on the topic are presented.

The effect of an individual's mental state on significant others has been, in broad terms, studied from two distinct lines of inquiry. The *first* of these has been predominantly quantitative and has explored the phenomenon of transfer (also called contagion) of stress from individuals directly experiencing job stress to those with whom they interact on a regular basis. This phenomenon has been labelled *crossover* (Westman, 2001) and has been recognized and studied extensively in the literature (see e.g., Bakker, Demerouti, & Schaufeli, 2005; Bakker, Schaufeli, Sixma, & Bosveld, 2001; Westman & Etzion, 1995; Westman, Etzion, & Danon, 2001). More specifically, burnout is found to be among the major strains investigated in crossover research (Westman, 2006). In addition, Bakker (2009) found indirect effects of burnout; that is, an individual's burnout may affect the partner's physical and psychological health through partner burnout. Furthermore, individuals whose partner was burnt out were more likely to report higher scores on depression and lower scores on health, thus indicating indirect effects of burnout. Nasharudin and colleagues (Nasharudin, Idris, & Young, 2020) demonstrated in a recent study that husbands' burnout crossed over to the wives, but the opposite, from wives to husbands, was not observed.

The *second* perspective from which the effect of a mental health condition on caregivers has been investigated in research is that of *family burden*. The concept was introduced by Treudley as early as in 1946 and elaborated in 1981 by Platt, who asserted that family burden designates the hardship and unfavourable events affecting those closely connected to psychiatric patients. Almost a decade later, Schene (1990) proposed an integrative framework describing the objective and subjective dimensions of the burden, the former referring to the direct tasks of care and the latter to the emotional impact of caring for an ailing family member.

Traditionally, family burden with its related dimensions has been explored in the context of chronic physical disease (e.g., Alzheimer's disease; see Garity, 1997) or severe mental health disorders (e.g., schizophrenia, see Stengård, 2005), which place heavy physical and emotional demands on caregivers, and the majority of the literature has likewise focused specifically on these patients (see Kuhlman, 2013; Rautiainen, 2010; Sales, 2003; Stengård, 2005). What these illnesses have in common, namely the duration of the caregiving situations, the extent of care demands placed on caregivers, the degree to which normal behaviour is disrupted, and the patients' lack of competence and ability for self-maintenance, has led to the extensive study of family burden in that particular context. Burnout differs, however, from the above-mentioned illnesses in that burnt-out individuals normally retain their ability to take care of their own lives and basic daily needs. Thus, despite the existence of studies on family burden in the context of a chronic illness or a mental

disorder, these do not adequately describe the experiences of family members when a member of the family suffers burnout. In particular, it sets out to address this question in particular by exploring the diverse experiences in the context of burnout and subsequent recovery. Although it recognizes the theoretical assumptions and the ample empirical evidence in family burden research, it goes further by focusing on the spouses' experiences in the context of a job-related problem as opposed to a chronic disease. The theoretical postulations are subsequently used to reflect on the results in the discussion section, but the analysis of the data is neither guided by nor based on the theory of family burden *per se*.

Family support for burnt-out employees has been studied and its significance has been proven beneficial in several qualitative studies (Fjellman-Wiklund, Stenlund, Steinholtz, & Ahlgren, 2010; Hålstam, Stålnacke, Svensen, & Löfgren, 2015; Salminen, Mäkikangas, Hättinen, Kinnunen, & Pekkonen, 2015). However, the respective impact of burnout on spouses, in particular, has remained largely unexplored in the research so far. At present there is still paucity of qualitative studies examining partners' experiences of individuals' burnout and recovery. To the best of our knowledge, only a couple of studies with a specific focus on the family members' experiences have been presented. First, drawing upon Schene's framework, Eija Peiponen's doctoral dissertation (2015) explored burnt-out individuals' spouses' experiences from an action research perspective. The study with a dataset comprising 12 spouses was conducted as part of a development project in Finland, in which couples participated in a three-year programme designed to help the families of burnt-out employees. The results of the study were consistent with Schene's framework (1990) and showed that burnout had a broad impact on the families and the life structures, while also affecting the interspousal relationship and intrafamilial relations. The spouses reported that they carried responsibility for running the household, taking care of children and managing finances, as burnout, with the demands it placed on the spouses, changed social relations. The reduction in one's own free time and the increase of workload for the spouses taxed their personal resources and affected their own mental health, causing distress and aggravating pre-existing mental or physical conditions. Over time and with the help of peer support groups and weekend respite courses, the spouses were able to rebuild their own self-confidence and self-knowledge as well as gain knowledge about their partners. Positive outcomes of the lived hardship were also reported, and found expression in better interpersonal communication, higher self-respect and ability to take care of oneself.

Secondly, another study by Ericson-Lidman and Strandberg (2010) explored the experiences of people closely connected to health care providers working in psychiatric and geriatric care who were recovering from burnout. Their sample included five interviewees: three spouses, a best friend, and a child of burnt-out individuals. The researchers found that being close and providing support imposed a huge burden on the individuals connected to those in recovery. They identified

four themes and 14 subthemes reflecting an experience of *"putting one's life on hold"* to support the other. The authors concluded that the significant others were put into an exhausting situation, in which they had to provide encouragement, protect the other person from strain and take over additional responsibilities, which led to their becoming drained themselves, carrying guilt for not being able to help sufficiently, and eventually finding a path to recuperation and new self-knowledge.

Although the studies mentioned above provide valuable knowledge about the experiences of people closely connected with burnt-out individuals, they explore the topic in a particular context (Peiponen, 2015) or take into account a specific occupational group of burnt-out individuals and a diverse sample of closely connected people (Ericson-Lidman & Strandberg, 2010). The present study contributes further to this research domain by approaching the topic from a slightly different perspective. Its aim is to provide in-depth knowledge on the experiences of the spouses of individuals with a history of burnout beginning their recovery by participating in a rehabilitation programme. The study seeks to reveal how one of the spouses perceives the other spouse's (herein referred to as rehabilitee) burnout, the subsequent recovery process, as well as how the process of recovery affects the interspousal relationship as perceived and reported by the respondents. Consequently, the study will contribute to a better understanding of the links between work-related phenomena, family burden and spouses' well-being by adopting a more comprehensive perspective on the current work-life research and discussing its practical implications. The main research questions we seek to answer are: *First*, how do spouses experience the rehabilitees' burnout and recovery from it; and *second*, how does the rehabilitee's burnout affect the interspousal relationship?

Methods

Study design, participants, and data collection

The interviews with ten rehabilitees participating in national rehabilitation courses and their spouses constitute the main material for this study. These courses are subsidized by the Finnish Social Insurance Institution, which also provides income during participation in the course and covers possible additional travel and accommodation expenses. Applicants are referred to rehabilitation by occupational health care and are pre-selected by the local branch of the Finnish Social Insurance Institution. The rehabilitation courses are aimed at adults whose work capability is at risk due to a diagnosed mild or moderate depression and/or anxiety disorder as a result of burnout or a bipolar disorder in remission. The duration of the courses is 15 days divided into three periods of five days each, at equal intervals within a 12-month period. The content of rehabilitation courses must meet specific standards set by the Finnish Social Insurance Institution, which regulates the professional groups included and the content areas of the courses. Topics covered in rehabilitation include psychosocial guidance and counselling, enhancing participation in

everyday life, physical activation and guidance in health-related issues and education on nutrition. One of the central goals in rehabilitation is to strengthen coping strategies and a sense of agency (Järvikoski, Martin, Autti-Rämö, & Härkäpää, 2013). Prior to the start of the course participants receive an invitation and questionnaires eliciting preliminary data. During the first five-day period the participants' physical, social and mental conditions are assessed by a multidisciplinary team and specific goals for rehabilitation are set. The rehabilitation plans are evaluated and updated in the follow-up period and plans for further work are made after the final period. Between the rehabilitation periods participants complete individual tasks in accordance with their rehabilitation plans. A family member has the opportunity to participate in rehabilitation on the last day of the second five-day period.

The participants for this study were selected from eight different courses taking place between September and December 2017. Participants' eligibility was determined by the rehabilitation centre psychologist based on the diagnoses set by an occupational health care physician and the documents collected on participants prior to the start of rehabilitation including anamnesis, burnout scores evaluated on the basis of the Bergen Burnout Indicator (BBI-15, Näätänen, Aro, Matthiesen, & Salmela-Aro, 2003), and rehabilitation goals. As the rehabilitation courses are targeted at adults with differing medical histories, the psychologist pre-selected only those with history of job burnout. An important condition set was that both the rehabilitee and his/her spouse were willing to participate in the study. The invitation to participate in the study was sent after the first period of the rehabilitation course. The psychologist served as a liaison officer and was in charge of informing potential participants about the research, its goals, and its timetable. She answered questions related to data collection, coordinated the interview timetable with the rehabilitees and their spouses, and gave regular feedback to the research team. The data collection method was approved by the chief physician of the rehabilitation centre.

Although the primary focus of the study is on the experiences of spouses, the rehabilitees were also interviewed as they provided a valuable perspective and served to contextualize the experiences reported. The interviews with the rehabilitees and their spouses were conducted on separate occasions between September 2017 and February 2018. The thematic interviews covered questions related to the development of burnout and the recovery process: the onset of burnout, the actions the rehabilitees took to cope with it, how the spouses noticed the signs of burnout and experienced the period of burnout, the impact of burnout on the interspousal relationship, the spouses' experiences when recovery started, and the effect recovery had on the relationship. One couple was interviewed on the premises of the rehabilitation centre and the rest of the interviews were conducted by phone. Participants in the study were interviewed by students of psychology at the University of Jyväskylä, Finland. They received interview training

from the first author and conducted practice interviews prior to the interviews proper. Consent forms were given to participants. Participants were assured of the confidentiality of the study and their option to withdraw from the study at any time.

Demographic data elicited at the beginning of the interviews included: age, gender, education level and number of underage children living in the same household. All couples were heterosexual, and the gender distribution of the spouses included three females and seven males. Three of the couples had been together for a period of two to seven years; the duration of the rest of the relationships was longer than seven years. One of the rehabilitees was divorced and the new partner participated in the study. Spouses' mean age was 54.5 years (range 32–66 years), whereas the rehabilitees' age was 50.2 years (range 39–60 years). The interviews were recorded and transcribed verbatim by the interviewers. The duration of a single interview varied between thirty minutes and one and a half hours. The total amount of data comprised 19 hours of recorded interviews and 283 pages of transcribed material.

Data analysis

Data were subjected to thematic analysis by following the step-by-step guide proposed by Braun and Clarke (2006). This method of analysis was selected as it is a widely used, albeit not so clearly demarcated, qualitative method for identifying and analysing themes. Qualitative data analysis software Atlas.ti was used to allow for a more systematic analytical process. All interviews were first read to get a general grasp of the material in accordance with Phase 1 (familiarisation with the data) described by Braun and Clarke (2006). As our focus was on the spouses' experiences, our subsequent analysis focused primarily on the interviews with the spouses and those with the rehabilitees were used as a source of background information and for contextualization (i.e., information on when and how burnout began, what the job-related circumstances were, what actions were taken to address burnout symptoms). In the next steps (Phase 2, generating initial codes), the interviews with the spouses were read separately and coded. In the coding process the interviewer's question was occasionally included in the unit of analysis, as the answer on its own, i.e. in isolation from the question, could not be clearly understood. The codes attached to the extracts were reviewed and condensed. Throughout the coding process, the Atlas.ti software was utilized to run reports on codes, their groundedness and density, and to verify them against the quotations they were attached to. During this procedure of continuous reading and comparison codes with similar meaning were merged, grouped, or deleted.

In the following step, corresponding to Phase 3, searching for themes, as described by Braun and Clarke (2006), we continued reading the interviews and the codes reports and started sorting the codes into potential themes. By identifying these themes, we formed our initial theme map. Next, we moved to reviewing the themes that we had devised and refining them (Phase 4,

reviewing themes). As Braun and Clarke (2006) propose, we conducted the review on two levels. At the first level, the extracts to which codes from a potential theme were assigned were re-read to ensure that the code captured the content correctly and that it fitted the theme. We analysed whether the initial themes were internally coherent and if the sub-themes identified were sufficiently distinct. Sub-themes which were too similar in meaning were combined, whereas others which were too heterogeneous were separated. In this phase, the first three authors discussed the candidate themes, their internal homogeneity and external heterogeneity (see Patton, 1990; Patton 2015) until inter-researcher agreement could be reached. At the second level, the entire data set was re-read to confirm the fitness and accuracy of the individual themes and sub-themes. As Braun and Clarke (2006) report, this is the level which serves an additional purpose, namely to code any additional data within the themes that have been omitted earlier. As a result, we identified an additional theme (Validation) and re-named several themes. The categorization of individual and interspousal level themes was made at the end of the analysis to facilitate the reading of the themes, as the levels reflected most closely the structure of the interviews and the research questions and, hence, the content of the spouses' accounts.

Credibility and ethical considerations

The rehabilitees participating in the study were selected from different courses and the interviews with the rehabilitees and their spouses were conducted on separate occasions. This can be argued to reduce groupthink, which may develop as a result of group cohesion (see Denzin, 1970). To increase the reliability of the study, researcher triangulation was applied as the rehabilitation centre psychologist did the preliminary selection on the basis of the rehabilitation documents available, the interviews were conducted by three external neutral interviewers and the analysis was conducted by the first three authors, who were not involved in the rehabilitation programme in any way.

To preserve the anonymity of participants, pseudonyms were used in the excerpts and, where necessary, any details that might lead to recognition of their identity were either omitted or changed (e.g., replaced with more general expressions), without compromising the meaning of the experiences reported.

Results

Thematic analysis of the interview data from the spouses resulted in five main themes, with three of them on the individual level: Spouse as Safe Haven, Strain on the Spouse, and Validation; and two on the interspousal level: Commitment to the Relationship and Adverse Impact on the Relationship. The themes and the pertaining sub-themes are presented in **Figure 1**.

Spouse as Safe Haven

The theme refers to the extensive role of the spouse in the processes of burnout and recovery. The spouses embody a safe place and represent a source of stability,

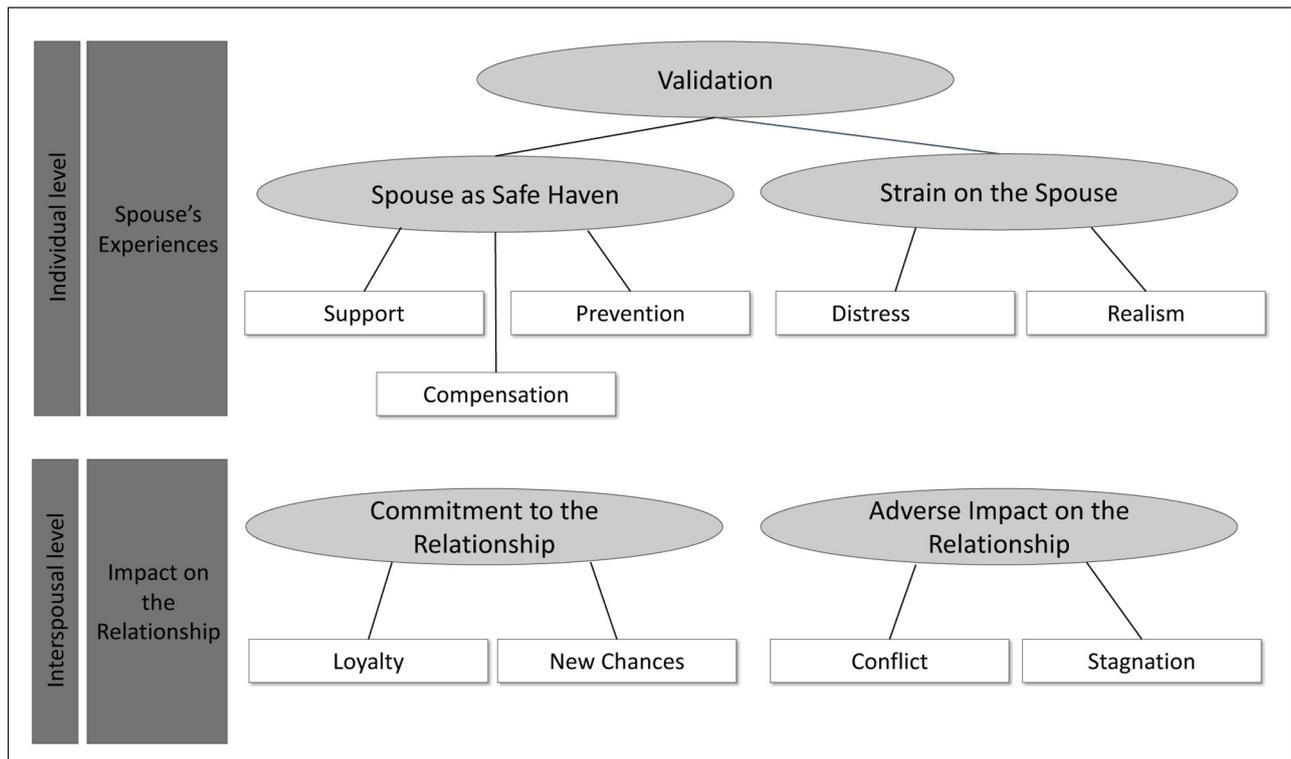


Figure 1: Main themes and subthemes.

security and robustness when the rehabilitees' own resources are depleted. It is to be noted that this theme is the researchers' construct and not a label used by the interviewees themselves. The theme encompasses three subthemes: Support, Compensation, and Prevention.

Support refers to the emotional nurturing and responsiveness which spouses provide in difficult times. It includes listening to the partner, validating his/her experience, providing words of consolation, or encouragement. Support also means being present and emotionally available, demonstrating empathy and compassion, even without an explicit verbal response.

I try to accept the fluctuations and give him peace, try by all means to make him feel better, and try to encourage him to go and be outdoors and so on, but it doesn't maybe work every time, if you don't have the energy, you don't have the energy. (Spouse, couple 7)

Sometimes, the spouses did not see a particularly strong effect of listening or comforting the rehabilitee, and in those cases, they resorted to encouraging the rehabilitees to pursue hobbies or engage in social activities which they saw as conducive to recovery. This role was more apparent in the stage of recovery when the rehabilitees' own physical and mental resources were beginning to be replenished.

Interviewer: What would you say, how has your spouse reacted to this, to your offers of help, when you've tried to say to take it easy or to do something refreshing together, has she reacted then in any way?

Spouse: Well, yeah, well...taking it easy and relaxing hasn't really worked...but then the other things, well...quite well, she has agreed to do them, has tried to do them. (Spouse, couple 3)

Compensation: Spouses reported taking over a number of daily chores or responsibilities, such as taking care of the children, maintaining the home, running various errands. Thus, they were able to take a burden off the rehabilitees' shoulders and provide the necessary conditions for rest and recovery. This role was particularly pronounced in the most severe phase of burnout, that is, when the burnout symptoms were particularly serious and when rehabilitees' exhaustion and need for rest were at their peak. In general, this did not pose any significant problem to the spouse and was reported as a normal part of their responsibilities.

Interviewer: ... so your shared time together decreased?

Spouse: Well, yeah, it decreased when you think that she did a very long day and was exhausted, of course it naturally decreases ...so what then happens at home late in the evening and then in the morning I have...I get up early and prepare breakfast, and I've tried to encourage her to leave for work and so...as I am retired already so I don't have any work...

Interviewer: So you've given support in practicalities?

Spouse: Yes, I've tried to as much as possible, have cleaned at home and ...cooked when she comes home, of course, sometimes she came home earlier, but then during the worst times the days were

a blur...and we have had a good team spirit the whole time. (Spouse, couple 10)

However, in cases of prolonged burnout, this was perceived as strenuous and led to fatigue in the spouse as well.

Interviewer: When your spouse mentioned that when her exhaustion was at its worst, you did the majority of household chores. How did you feel about that?

Spouse: I have always participated in household chores, so it wasn't something new to me, but yes, at a certain point I started feeling that I was getting exhausted, and I sort of lost sleep, I was just too tired. (Spouse, couple 9)

Prevention encompasses the spouses' actions related to monitoring and detecting burnout symptoms and alerting the rehabilitee to their presence. The spouses were instrumental in suggesting external help when they estimated, based on their own knowledge and experience of living with the rehabilitee, that the rehabilitees' condition was deteriorating. They also took the initiative to contact healthcare when the signs detected were severe and the rehabilitee lacked the energy to take care of practicalities.

Interviewer: How do you think you can help her in the future?

Spouse: Well, primarily by monitoring the signs, when the situation is changing and then encouraging her towards better life habits. Supporting, participating myself and trying myself to have a regular daily rhythm, eat healthily and do sports. (Spouse, couple 2)

Strain on the Spouse

The second theme captures the adverse impact of the rehabilitee's burnout on the spouse and includes two sub-themes: Distress and Realism. It encompasses, on the one hand, the whole spectrum of emotional reactions to the rehabilitee's suffering and altered behaviour, and, on the other hand, the coping mechanisms spouses have to resort to in order to alleviate the negative effects and preserve their own mental well-being.

Distress refers to the range of emotions aroused by living with and supporting an individual with burnout. These include but are not limited to: *guilt* for not being able to respond or help adequately, *bewilderment* at the inability to comprehend the situation, *frustration* when the help or advice offered is rejected, *helplessness* when the spouse feels he/she has no knowledge or resources to help, and continuous, pervasive *worry* about the other's well-being. These emotional reactions were present, to varying degrees, in all the spouses' accounts, but the emphasis in each was on a different reaction, depending on the duration of burnout, on the stage of recovery the rehabilitee had reached, on the couple's communication culture, and, ultimately, on the spouse's coping skills.

Frustration was expressed when the rehabilitee did not heed the spouse's advice or offered help. It left the spouse without any means to influence and alleviate the situation, thus nullifying all attempts to provide comfort, advice or consolation:

And although I said many times, don't pretend, just try to talk, swear even and talk about how hard it is and how pissed off you are and how everything is so difficult and it is not only because of the job but because of much bigger things, and life gets so tough. [...] And you can't do that by force, but instead it has to be that he asks for it, that he can't do anything about it, that he can't take it anymore. But then, then he declined everything. Why should I do this and pretend, when nobody can help me. So this attitude of his, it's quite frustrating. (Spouse, couple 1)

In certain cases, the rehabilitee's burnout aggravated the spouse's pre-existing mental health condition due to the accumulation of stressors and the need to be supportive to the rehabilitee:

I feel that I myself was drawn into it, especially when I myself am like this, we have in the end quite a lot in common, this depression and low mood, both of us have it, so his burnout somehow aggravated my state too, when I see that he is not well and I start being cautious so as not to annoy him or cause him to be in a bad mood. (Spouse, couple 5)

Realism comprises the concrete actions or mental shift occurring as a result of the emotional reactions to the rehabilitee's burnout. Under the pressure imposed by the burnt-out spouse, the spouses came to the realization that, despite their efforts and despite doing everything in their power to help the other, their own mental, physical, and professional capabilities were limited and they could not assume a role exceeding their own knowledge and skills.

But then sometimes he starts talking on his own initiative and then of course he knows that I can't help him, and I've said that the spouse cannot be a therapist to the other one...(Spouse, couple 5)

This distancing also took the form of "healthy selfishness": taking care of one's own needs and attending to the needs of other family members, resuming one's own leisure activities, or merely allowing oneself to be detached from the problems of the rehabilitee:

I have overcome it in that sense. I don't know if I have somehow become more cynical or if it's just becoming an adult and maturing, but I don't take this so personally, so hard anymore. 'Cos I have my own life and we have two adolescents, who also

have their own lives, so they shouldn't take on the burden of their father's depression, they have the right to lead a free and rich and interesting life... and to trust themselves. (Spouse, couple 1)

Validation

This category was found in only one account. However, due to its major significance, it was taken to constitute a separate main theme on the individual level. Validation refers to the spouse's own experience of the rehabilitation course and the beneficial effects it exerted on the spouse's well-being: recognition of the spouse's own distress, confirmation that the support given is sufficient, and a sense of belonging as opposed to being alone in this experience. Highlighting the theme is due to the fact that the rehabilitation course envisages a day dedicated to a family member, although very few members currently seem to utilize it.

Interviewer: M. mentioned that you were in the rehabilitation centre, too. How did you feel about this?

Spouse: I was there on the last day when there was a day for the family members, and I think it was very nice. I was myself a bit surprised that there was programme organised for us, and we went there and it wasn't too full, and in the end it was pretty free...we got to talk about those things and noticed that somehow it became more concrete, that many others were in more or less the same situation ...so it brought to me, at least a bit, like tranquillity and security, confirmed that I was on the right path, had been on the right path the whole time, that I hadn't gone into it and hadn't worried too much, and had just done what I could and then took care of myself as before. (Spouse, couple 9)

Commitment to the relationship

A deep, genuine feeling of commitment to the relationship with their partners pervaded the majority of the interviews with the spouses. Their responses conveyed a sense of profound appreciation of the other spouse, of total approval and a spirit of permanence. Two sub-themes which captured the essence of the commitment could be distinguished.

Loyalty embodies the attitude of the constancy of the relationship regardless of burnout. It refers to the resolute belief that the marriage or the relationship is sacred, and no hardship can change the status quo. The statements by the spouses conveyed a sense of stability, appreciation and serenity that, come what may, the spouses will stick together. The air of constancy was even more emphasized in long-term relationships where interspousal communication functioned well.

The relationship appears quite good so it hasn't in that sense affected us, it is on quite solid ground and we talk about everything and we have always talked about everything and we have similar inter-

ests and so it has felt quite natural from the beginning and continues to do so. (Spouse, couple 8)

Interviewer: Do you feel that your attitude towards her has changed along the way?

Spouse: Changed how?

Interviewer: Have you found new sides or...?

Spouse: Well, I don't think I have. My attitude towards her, it has always been the same, I have this belief that you always have to respect the other person, I've had this attitude the whole time we've been together, I try to respect her...and then, in my opinion, if you're married, then the central part is to respect the other, the other's opinions. (Spouse, couple 10)

New chances. This theme embodies the beneficial impact that living through and overcoming burnout has had on the interspousal relationship. The spouses and the rehabilitees alike agreed that burnout and the steps taken to overcome it had been instrumental in increasing interspousal communication and enhancing the quality of the relationship. It was pointed out that the foundations of a functioning communication had already been laid, but the hardship lived through together strengthened the bond between the spouses.

We have experienced all sorts of hardship, but such that it has made our relationship stronger, so, it has affected us so that we have fought on together. (Spouse, couple 5)

The role of rehabilitation was also recognized as a beneficial factor contributing to improving the relationship:

Yes, it feels that after those [the rehabilitation periods] her mind is brighter and more open and she is more active and vigorous. So yes, I'd say that it has had a positive effect. (Spouse, couple 9)

Adverse impact on the relationship

Despite commitment to the relationship, burnout did have a negative impact, though to a lesser extent. This was manifest in two distinct ways which constitute the two sub-themes: Conflict and Stagnation.

Conflict. Exhaustion, irritability and lack of energy or capacity to talk through problems led to fights, quarrels and misunderstandings.

When he comes home it's there, along with us, that sense of withdrawal and anger, and resentment. So, of course, it has driven us apart, there isn't a desire to share things, because if you say something, you know the response is downgrading and nullifying or you see immediately what is wrong there. So he doesn't want to share things. And then quarrels break out very easily, the threshold for quarrels is so low. And he is often so angry, so yes, we have very concretely experienced that. (Spouse, couple 1)

Stagnation designates the negative effect of burnout that was more common than conflicts in the relationship. Quite many of the respondents referred to a general lack of energy or initiative in the rehabilitees and to a scarcity of shared time and activities. Activities that spouses used to have together had dwindled to a minimum and an air of stagnation pervaded the accounts. Stagnation was clearly perceived as more detrimental by the spouses, even though many tried to downplay the negative effects of burnout on the relationship.

But of course the interaction, well it has certainly, it has been quite little in that we haven't been able to go anywhere to relax, and she has had no energy for anything and of course I saw that she didn't have the energy, but well I sometimes suggested going somewhere, but she said that she didn't have the energy. Such an impact. (Spouse, couple 10)

Discussion

The aim of the present study was to explore spouses' experiences of rehabilitees' burnout and recovery, and the impact of these processes on spouses' well-being and on the interspousal relationship. The results revealed that the negative effect of burnout is not confined to the burnt-out individuals, but extends to their significant others, who experience the process indirectly. At the same time, the study also revealed the various strategies that spouses adopt in order to make sense of an adversity and find novel ways to overcome it. Altogether, five main themes were identified. Three themes – Spouse as a Safe Haven, Strain on the Spouse, and Validation – were situated on the individual level, which comprised the spouses' subjective experiences and their own role in the process of burnout and recovery. The interspousal level themes – Commitment to the Relationship and Adverse Effect on the Relationship, on the other hand, captured the effect of the aforementioned processes on the relationship between spouse and rehabilitee.

Individual level themes

The first theme, *Spouse as a Safe Haven*, with the three subthemes of *Support*, *Prevention*, and *Compensation*, comprised the various, very concrete roles that the spouses played throughout the processes of burnout and incipient recovery. A major role of the spouses was to *support* the rehabilitee by providing “talk therapy”, being present, encouraging or admonishing the rehabilitee to relax. Spouses were buffers, guardians of “normalcy” in the moments when the rehabilitee lacked initiative or was under severe pressure. The role of family members' support in the recovery process has been recognized in several studies (Fjellman-Wiklund et al., 2010; Hålstam et al., 2015; Salminen et al., 2015). Muscroft and Bowl (2000) conclude that families are the most significant factor of success of recovery, and participation of the spouse in the process is found to be very helpful in therapy (Rautiainen, 2010). Family support has been established to mitigate burnout and secondary traumatic stress (Galek, Flannelly, Greene, & Kudler, 2011) and the role of emotional

support provided by the spouse has been found to be significant in reducing burnout levels, especially for men (Livingston, 2014). The activities grouped under *Support* closely resemble those described in Ericson-Lidman and Strandberg's (2010) subtheme *Striving to be there for the persons affected*, which entailed prioritizing the affected person's needs, being protective and emotionally available.

Furthermore, spouses were instrumental in *preventing* further development of burnout. This was due to the fact that spouses were external observers or co-participants in the processes of burnout and recovery, and they could adopt a relatively neutral position with regard to the symptoms of burnout. Thus, they could recognize early symptoms of exhaustion and alert the rehabilitees to the detrimental effects of excessive self-investment in work. This role, however, could only be performed once the spouses had acquired the necessary knowledge of burnout and its symptoms, which, at least initially, was difficult. Difficulties in performing this task were also reported in the study by Ericson-Lidman and Strandberg (2010) as the significant others failed to understand what was happening. In the present sample, the spouses' awareness increased over time, thus enabling them to serve as monitors and counsel for the rehabilitee and to encourage them to seek timely help, a role of particular significance with respect to a possible future recurrence of burnout.

The third subtheme, *Compensation*, included the various activities the spouses had to become more involved in, especially in the most acute phases of burnout: taking care of the household, looking after children, attending to administrative tasks. This subtheme finds extensive support in earlier studies: Ericson-Lidman & Strandberg (2010) named this role *Shouldering responsibility for the household*, whereas Schene (1990) referred to it as *Household routine*. It appears that this is a fairly common manifestation of objective burden, which is proportional to the number of different responsibilities and the degree of severity of the physical or mental condition of the affected individuals. Even though burnout may not be as debilitating as Alzheimer's disease or cancer, it typically manifests in a severe decrease of energy levels and working capacity, thus leaving the burnt-out individuals incapable of taking care of tasks that have previously been regarded as routine. On the other hand, by assuming the lion's share of household responsibilities and giving space and time, spouses may in fact inadvertently perpetuate a vicious cycle of over-commitment to work, which in turn aggravates the rehabilitee's occupational stress and burnout symptoms. Such a behaviour of “enabling” addictive behaviours has been seen, for example, in studies on workaholism (Robinson, 1998).

The second theme, *Strain on the Spouse*, included two subthemes: *Distress* and *Realism*. *Distress* encompassed various emotional reactions from worry to frustration, depending on the severity of co-occurring diseases. The negative valence of these emotions in the spouses correlated with the duration of the rehabilitee's

burnout symptoms and the lack of motivation to seek help. The multitude of emotional reactions reflects the multidimensionality of burnout and the various effects it exerts on the spouses, as also reported in the study by Peiponen (2015). These reactions correspond closely to the subjective dimensions of family burden, namely *Subjective Distress* and *Health* (Schene, 1990), and have been found extensively in earlier research (e.g., Fadden, Bebbington, & Kuipers, 1987; Tsang, Tam, Chan, 2003). Spouses in this sample also reported that their own mental well-being was jeopardized as a consequence of caring for the rehabilitee or taking over the majority of obligations carried out by the rehabilitee, a result consistent with prior research (Peiponen, 2015; Ericson-Lidman & Strandberg, 2010). The feelings of frustration reported in the present sample corresponded to the themes of *Being resented and not listened to* and *Failing to help* reported in Ericson-Lidman & Strandberg (2010). These circumstances produced a pronounced straining and draining situation for the spouses and exacerbated their suffering.

Realism, on the other hand, comprised the actions taken when the spouse had limited or no control of the burnout and recovery processes. Spouses resorted to different coping mechanisms: distancing themselves from the problem or focusing on their own well-being and accepting that not everything can be rectified or repaired, especially in the absence of the rehabilitee's internal motivation. Such reactions could be interpreted as actions to find a way out of the wearing situation in which the spouses were put and to seek to replenish their own resources. In this respect, realism has certain features in common with the fourth theme identified by Ericson-Lidman & Strandberg (2010), namely *Re-energizing and finding strength*, which entailed spending time on one's own hobbies or alone.

A particularly meaningful theme which could be distinguished in the spouses' accounts was *Validation*. Although present in one account only, it was perceived as a very important phase in the experiences of spouses and demarcated as a separate theme. This is consistent with Braun and Clarke's assertion in relation to the question of the prevalence of a theme: namely that the significance of a theme is not necessarily measurable in quantifiable terms, but instead reveals something essential about the research question (Braun & Clarke, 2006, p. 82). Validation closely resembles rehabilitees' experiences of the rehabilitation course as discerned in earlier studies (Salminen et al., 2015; Fjellman-Wiklund et al., 2010). The validation of experiences and the realization that the spouses are not alone in their experience finds robust support in prior research (Botha, Kaunonen, & Aho, 2014; Ericson-Lidman & Strandberg, 2010; Peiponen, 2015; Tsang et al., 2003). The extensive need for support for those closely connected to the affected person was particularly emphasized in Ericson-Lidman & Strandberg (2010), as often occupational health care, counselling and sick leave are provided to the burnt-out individual, but family members "are left alone with the burden of suffering". The need for and the importance of having peers who have experienced the same process of burnout

was remarkable, as reported in Peiponen's study (2015). On the other hand, Peiponen pointed out that having to empathise with other burnt-out people's spouses' experiences, particularly in group workshops, led to an increase in anxiety, an effect not identified in the present sample, presumably due to the small number of spouses who attended the day reserved for them in rehabilitation.

Interspousal level themes

Commitment to the Relationship and Adverse Impact on the Relationship were the two main themes identified on the interspousal level. Overall, rehabilitees' burnout had a negative impact on the spouses' well-being and taxed the interspousal relationship. However, the spouses did not seem to perceive the interspousal relationship as imperilled. Their profound respect for and appreciation of the other spouse were expressed as unflinching *Loyalty*. This sub-theme is consonant with Sales' (2003) assertion that burden is not an appropriate label for when taking care or helping a loved one. Similarly, the majority of the spouses of depressed patients were committed to staying with the patient (Fadden et al., 1987). Thus, loyalty should not necessarily come as a surprise as burnout spans most likely a limited period of time in a much longer and more extensive relationship. Furthermore, supporting a member who is temporarily affected by a stress disorder or an illness is associated with positive aspects, too, and recognizing the rewards of this process, for example having the companionship of the affected partner, conveys a more rounded picture of what is involved. Loyalty may also be a theme which is more discernible after the most acute stages of burnout have been overcome and additional psychological resources have been freed. On the other hand, caution is called for in interpreting the causes and outcomes of loyalty, as the duration of the relationship of three of the couples ranged from one to seven years, and two of those relationships started *after* the onset of burnout in the rehabilitee.

Discussing the quality of the relationship in retrospect, the spouses were able to point out positive outcomes of the hardship shared and overcome. This particular perception of a positive outcome emerged in the subtheme *New chances*: the strain imposed by burnout was duly acknowledged, yet positive aspects were pointed out and burnout was interpreted as hardship whose overcoming made the spouses stronger. Such a mechanism of re-evaluation is associated with meaning-focused coping mechanisms (Folkman & Moskowitz, 2000). In circumstances where individuals cannot change the situation or have insufficient control over their environment, they can attempt to find advantages or benefits that help them overcome the adversity. Positive outcomes of burnout for the spouses have been found in earlier studies (Peiponen, 2015), especially referring to gaining more self-confidence, looking for a new job or study opportunities, building greater self-respect and learning to say no. Beneficial consequences were reported in Ericson-Lidman & Strandberg (2010), although on a slightly more individual (as opposed to interpersonal) level, where the subtheme *Learning something new about*

oneself represented the positive effect of looking for recuperation and ascribing meaning to the lived hardship.

Conversely, *Conflict* and *Stagnation* were discerned as the subthemes of the theme *Adverse effect on the relationship*. Marital conflict is a common consequence caused by prolonged stress (Randall & Bodenmann, 2009; Timmons, Arbel, & Margolin, 2017). Conflicts arising from exhaustion and lack of shared time to negotiate each spouse's role in the household were also reported by Peiponen (2015). Schene (1990) refers to conflict in discussing the dimension of leisure time and career, which are relegated to the background when the spouse has to take over a lot of previously shared obligations. However, despite being present in the spouses' accounts, conflict was shared in a matter-of-fact manner and was not attributed an excessively big emotional value.

In contrast, *Stagnation* in the relationship expressed as lack of shared time and activities was imbued with a much stronger sense of loss of something valuable and conveyed a feeling of nostalgia and longing. Peiponen (2015, p. 101) reported that burnout led to distancing oneself from family and social activities as both the burnt-out members and the spouses lacked the energy to initiate or participate in these. Ericson-Lidman & Strandberg (2010) labelled these experiences *Being constrained concerning everyday life*, which implied having to forego one's own leisure activities, hobbies, and social encounters in order to be physically and emotionally available for the burnt-out individual. The sacrifice of one's own social life and the loss of the feeling of companionship appear to be the most detrimental effects of burnout on both individual and interspousal level. It could also be inferred that, especially in the most acute phases of burnout, the rehabilitee's withdrawal from social life and the decrease of shared activities in fact contributes to sustaining burnout rather than to overcoming it. Thus, it is not until some slight improvement in the rehabilitee's state has taken place that the spouse can start to actively counteract the atmosphere of stagnation and lack of social or marital engagement.

In discussing the results, the temporal dimension of the themes emerging merits consideration as these reflect different phases of the process of burnout and subsequent recovery. Sales (2003) concedes that the individual illness paths as well as the patients' needs change over time and thus stage-specific problems are experienced by caregivers. This matter was also addressed in Peiponen's study (2015) when reflecting the timepoint at which the spouses participated in the development project. She analysed the experiences of social support received at three different stages: at the onset of the study, in the middle phase and in the final stage. The spouses' experiences of social support in the different phases varied depending on the phase of burnout and recovery which the families were going through. Even though many of the experiences received a negative interpretation and were consistent with the dimensions of family burden, positive experiences were also derived from burnout and manifested in more effective, open, and sincere interspousal communication and better knowledge of the other spouse as well as

more profound self-knowledge. However, these positive outcomes were possible only after the most acute phases of burnout were over and some distance could be taken from the negative experiences (Peiponen, 2015). In the present study, although cross-sectional and thus including accounts gathered at a single time point, the themes manifest such temporal contingency, too. *Support* and *Distress* describe experiences pertaining to the acute phases of burnout as it develops, whereas *Prevention*, *Realism* and *New chances* contain an element of post-factual processing and analysis. This may be attributed to the fact that participants related their story at a particular point of time after the most intense burnout phases and at the onset of recovery, which allowed the development of reflection and re-evaluation of the past events. Cross-sectional studies may indeed overlook some of the complex dynamics of burden and emotional repercussions, as Sales (2003) poignantly highlights, yet it appears possible, to some extent, to discern temporal layers in a single-time-point account, as the results of this study demonstrate.

Methodological considerations

Questions related to validity and reliability in qualitative studies are relevant and discussed in terms of the trustworthiness of the study. Trustworthiness comprises five elements: credibility (i.e., accurate identification and description of participants), dependability (i.e., interpretations are supported by the data), confirmability (i.e., objectivity and inter-researcher congruence), transferability (i.e., potential for extrapolation), and authenticity (i.e., reflecting a wide spectrum of realities) (Guba & Lincoln, 2005; Lincoln & Guba, 1985). The selection of the participants in the present study was based on the Bergen Burnout Indicator (BBI-15, Näätänen et al., 2003). In addition to using a structured survey method and its cut-off values, the expertise of the psychologist and chief physician were utilized to ensure that the study participants met the eligibility criteria (i.e., decrease of burnout symptoms). Dependability was increased by a systematic record of the interviews and the process of analysis and also by constant comparison of the interpretations by the authors of the study. Confirmability was ensured by the first three authors being engaged in the analysis and able to independently conduct checks on the accuracy, relevance, and meaning of data. Generalization to larger populations is not a concern in qualitative analysis. However, it is justifiable to posit that the findings are highly likely to be transferrable to groups in the rehabilitation context in Finland. We made every effort to explore the depth of experiences and to approach the topic from both the perspective of burnout and recovery and also from the individual and interspousal angle, and thus the study, to the best of our knowledge, meets the criteria for authenticity.

Limitations of the study

The present study revealed the subjective experiences of burnt-out individuals' spouses and increased our knowledge of the multiple effects these processes have

on family members. Despite its contribution, it has several limitations that should be acknowledged. The rehabilitation context provided an arena for recovery where the process was organized in a structured and systematic sequence offering a well-balanced set of activities designed to meet the needs of individuals suffering from burnout. It was also a protected environment and financial security for the duration of rehabilitation was guaranteed through the mechanisms of state-subsidized funding. Thus, the results are relevant primarily for burnt-out individuals and spouses already receiving support or included in a rehabilitation programme. However, spouses' experiences may differ significantly in cases where individuals suffering from burnout have to overcome organizational, emotional, physical, and financial hurdles unaided, without a structured, systematic course attending to the specific requirements of burnt-out employees.

Second, the lack of a markedly negative impact of burnout on the interspousal relationship may likely be due to *selection bias*, that is, couples whose interspousal relationship was stable and functional opted to participate in the present study. Supposedly, a well-functioning relationship may have had a protective effect on both spouses and, in turn, facilitated recovery. Thus, the findings of this study should be viewed as one possible outcome, but caution should be exercised when making generalizations regarding spouses' experiences where burnout had clearly a negative effect and led to disruptions.

Third, rehabilitees had comorbid conditions, and, on certain occasions, it was not clear whether the spouse talked solely about the rehabilitee's burnout or about the effect of co-occurring diseases, which rendered the overall experience more complex, more intense and strenuous for the spouse. Undoubtedly, this demonstrates the challenges related to diagnosing burnout and the fact that burnout is often associated with other mental health conditions, for example, depression (Bianchi, Schonfeld, & Laurent, 2015) and anxiety (Koutsimani, Montgomery, & Georganta, 2019). Although every effort was made to ensure that the selected rehabilitees were participating in the course due to job burnout, it is not possible to determine exactly what factors led to burnout and if burnout was accompanied by other symptoms.

Finally, it is worth noting that occasionally the respondents' utterances contained references to several themes or sub-themes all at once, for example when describing a situation in which the spouse intervened to help the rehabilitee going on to include a statement on the physical and mental state and ending with a personal, intimate statement on how the spouse felt in that situation. In addition, it has to be mentioned that the theme labels, although based on the interviewees' accounts, were researchers' constructs, that is, a deliberate and conscious outcome of the process of analysis and interpretation conducted by the researchers. This concurs with Braun and Clarke's (2006) assertion related to the advantages of thematic analysis in that participants are seen as collaborators and the analysis may be data-driven, yet researchers are not completely free of "their

theoretical and epistemological commitments" (Braun & Clarke, 2006, p. 84).

Practical implications

The study established that occupational health problems are not confined to the individual but exert effects above and beyond the burnt-out individual. Burnout indirectly affects the spouses, and eventually their working ability. Studies on crossover have confirmed the transfer of strain from one spouse to another (Bakker, 2009; Westman, Etzion, & Danon, 2001), but the present study approached the phenomenon from an experiential perspective and demonstrated the wide array of experiences spouses undergo in both burnout and recovery stages. A more systemic approach should be adopted in occupational healthcare to include the wider context surrounding the burnt-out individual, as this may, on the one hand, ensure better outcome of interventions, and on the other, offset accumulation of stressors by protecting the spouses against exacerbation of pre-existing mental health conditions.

Return-to-work policies have been researched (Kärkkäinen, 2019), and recommendations include concerted efforts by HR professionals, return-to-work coordinators, and occupational health care. These policies may also extend their scope of activities to include people close to the burnt-out individual. As demonstrated, spouses can play a monitoring role and serve as early detectors of burnout symptoms, especially after becoming acquainted with the antecedents of burnout. Thus, HR professionals and occupational health care may avail themselves of the potential for change and recovery that spouses provide.

Regarding the rehabilitation context, it is evident that the participation of spouses on the rehabilitation course had beneficial effects for spouse and rehabilitee alike. The rehabilitation scene in Finland is continuously evolving and occasionally changes in national policies lead to the discontinuation of intervention courses for the working population, including courses targeted at burnt-out individuals. As the study demonstrated, spouses play an essential role both in the burnout phase and in the recovery process, albeit while paying a price for their involvement. In the light of this finding, it is advisable that the role of spouses should be recognized more broadly in the planning stages of rehabilitation as their support has direct effects on the rehabilitees and vicariously affects organizations planning and implementing return-to-work activities. Spouses can and should be included in the process of recovery by highlighting their key role and encouraging them to participate more actively in the rehabilitation courses along with their burnt-out partners.

Avenues for further research and conclusions

All in all, the study contributed to a better understanding of the subjective experiences of spouses of burnt-out individuals and demonstrates that the process affects not only rehabilitees but also people closely related to those suffering from burnout. Thus, it is advisable that burnout research should take into consideration the wider milieu in which individuals function. Recovery from burnout

has been a little investigated topic and the spouses' experiential perspective has remained largely unexplored. For work and organizational research this implies that the process of recovery can be investigated from a systemic perspective and include, in addition to job and personal resources, support from the family domain.

Future research needs to examine more closely the dynamics of the processes focusing on the correspondence or discrepancy in rehabilitees' and spouses' accounts and possibly on the impact burnout has on the family and on dependents. The effect of burnout on children emerged spontaneously in the interviews, which demonstrates the significance of their inclusion in any rehabilitative measures. Different interventions aimed at providing mental health support for the children of parents with a chronic somatic or mental health illness have only recently been implemented (for an overview of studies on interventions, see Diareme et al., 2007). However, our knowledge of the support needed when a parent suffers from a less debilitating, yet serious condition, remains limited and deserves further attention. As already mentioned, studies of burnt-out individuals and their spouses and/or families outside the rehabilitation context are to be recommended as these groups tend to be the most vulnerable and might report different experiences from those presented in this study. Furthermore, longitudinal studies are also warranted as recovery from burnout is not linear and relapses may be evident after a certain period (see Salminen, Andreou, Holma, Pekkonen, & Mäkikangas, 2017).

In conclusion, it is reasonable to claim that the effects of burnout and ongoing recovery deserve further scholarly attention and spouses should be encouraged to share these experiences in a peer support group in order to validate them and maintain their own well-being. The beneficial consequences of this are threefold: first, spouses adopt a healthy distance and look after their well-being by setting boundaries; second, spouses can offer the practical and emotional support needed, especially in the most acute phases of burnout, which provides the necessary space and time for recovery; and third, the enhanced individual well-being has a protective effect on the interspousal relationship, which in turn benefits both spouses and the dependants in the family. At the same time, it is crucial to recognize that by adopting a broader approach to the spouses' experiences of burnout above and beyond the burden perspective, we obtained valuable knowledge about the positive aspects associated with supporting one's partner during hardship, learning to communicate more effectively and ultimately consolidating the interspousal relationship. Hence, we recommend that this essential new line of research focusing on the people closely related to burnt-out individuals be continued in future studies exploring burnout and recovery.

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Competing Interests

The authors have no competing interests to declare.

Author Contributions

Dr. Stela Salminen planned the data collection and provided interview training to the master's students of psychology. The first three authors (Ms. Stela Salminen, Dr. Anne Mäkikangas and Dr. Virpi-Liisa Kykyri) were involved in writing the theoretical exposé and analyzing the dataset. The fourth author, Ms. Eeva-Liisa Saari, was involved in the selection of participants in the study. She served as a liaison officer between the rehabilitation centre and the researchers. The fifth author, Dr. Mika Pekkonen, provided the insider perspective during the acquisition of data and made valuable contributions to the text in the revision of the draft.

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