Best Hopes to Preferred Futures: Translating Burnout with Nursing Orientated Solution Focused Conversations

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Article

Best Hopes to Preferred Futures: Translating Burnout with Nursing Orientated Solution Focused Conversations

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Abstract: The authors are trained nurses who have worked with, researched and taught vulnerable groups in mental health and learning disabilities in a variety of settings, and like many health and social care professionals, also experienced the effects of burnout. In this article, they explore solution focused (SF) conversations and their use in the issue of burnout in nursing. First, the authors consider the current literature on nursing burnout to set a scene for appreciating how SF offers a different conversational approach for nurses. Second, particularly, concepts of 'best hopes', 'preferred futures' and other useful techniques of 'difference' aim to help nurses re-evaluate burnout. Once practitioners begin to translate some of the SF theory into conversational practice, they can build a different relationship with what it means to be burnt out. And third, the authors offer a few figures and infographics on how to translate SF conversations to nurses who, given the chance, are more than capable of 'ferrying themselves' and others through the murky waters of burnout.

Keywords: nursing burnout; solution focused practice; mental health; learning disability; CAMHS

The English word "translation" stems from the Latin
'ferre' which means to carry or bring across… [of a text
from one language to another]
Christopher Kasparek (1983) [41]

1. Introduction

1.1.Aims of this article

This article has 3 aims concerning the nature solution focused (SF) conversations and their use with the issue of burnout in nursing. In a genuine attempt to offer something different we hope it advances something new by considering the following:

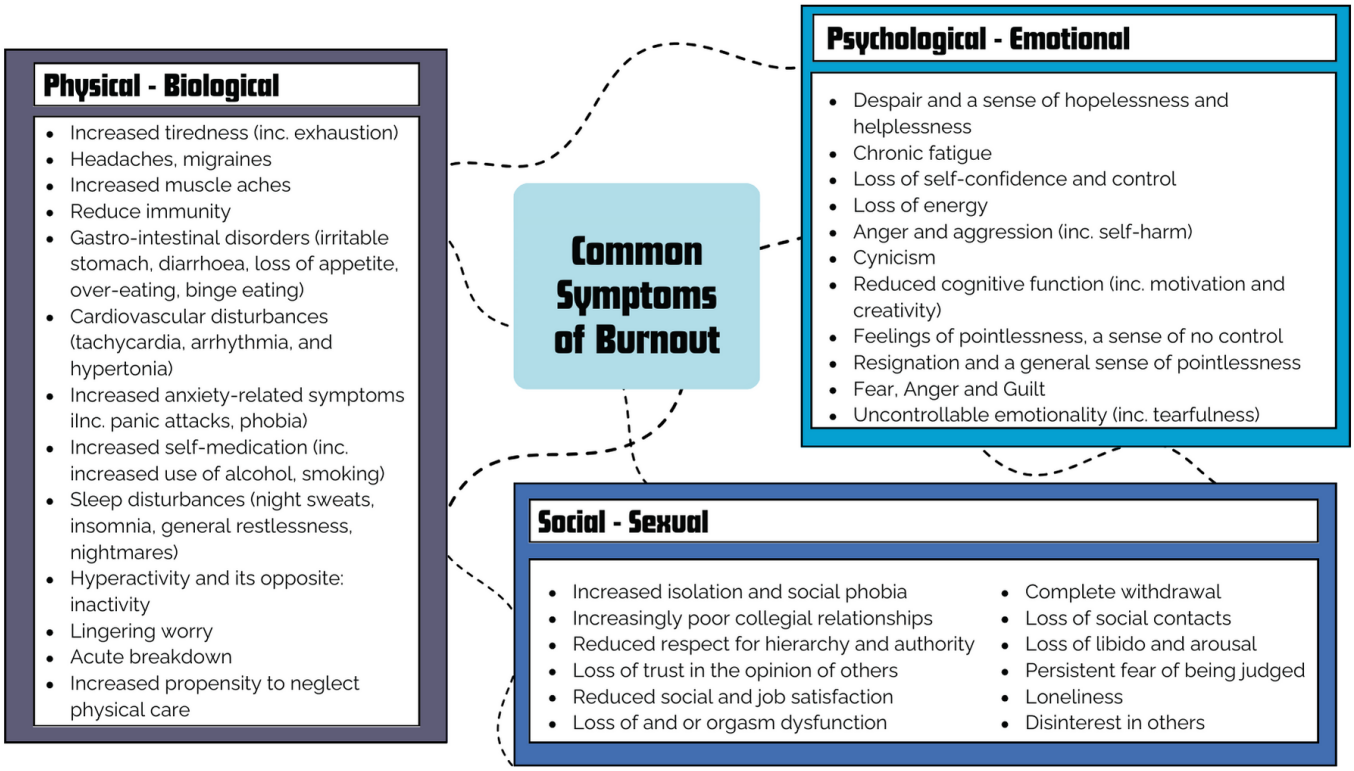
1. A brief consideration of the current literature on burnout in nursing to help set a scene for our appreciation of having SF conversations.
2. As such, introduce SF by way of vignettes the key ideas of 'focusing on hope', 'preferred futures' and other useful ferrying techniques of 'difference' for helping nurses considering their relationship with burnout.
3. To offer a few figures and infographics translating how our SF conversations help clients start ferrying themselves.

1.2.Conversations Ferrying Change: Background to Our Work

The authors are trained nurses who have worked with vulnerable groups in mental health and learning disabilities. Over the years we have practiced in a variety of settings including Tier 4 child and adolescent services and community posts. Between us we have also taught and researched phenomena related to anxiety, obsessive compulsive disorders and solution focused recovery and like many health care professionals, also experienced the effects of burnout. The exhaustion and mental effects that are a real blight in nurse's lives and a real thing with its own ICD-10 code relating to both the acute and chronic personal suffering it causes. In addition, the fact burnout also presents in a manner of 'non-coping' makes it awkward and distressing to diagnose in professionals who pride themselves as coping by professionals who are mostly sympathetic, but likely to consider the condition using a growing lexicon of terminology that for some is unsatisfactory for their recovery. Therefore, the use of SF offers a different conversational approach and suggests that nurses, if given the chance are more than capable of 'ferrying themselves' and others through the murky waters of burnout. Once each of us begin to translate some of the strange SF theory into conversational practice we can build a different relationship with what it means to be burnt-out. Whether suffering full blown symptoms replicating those of Post Traumatic Stress Disorder or less debilitating occasional flutters of anxiety SF offers a sidestepping and ferrying translation which doesn't deny or trivialise symptoms but instead, and 'despite', invites the sufferer to start paddling some of their own. We have interjected this article with infographics for those who are short of time and disguised case studies to suggest that everybody can learn some SF language and start something different about burnout.

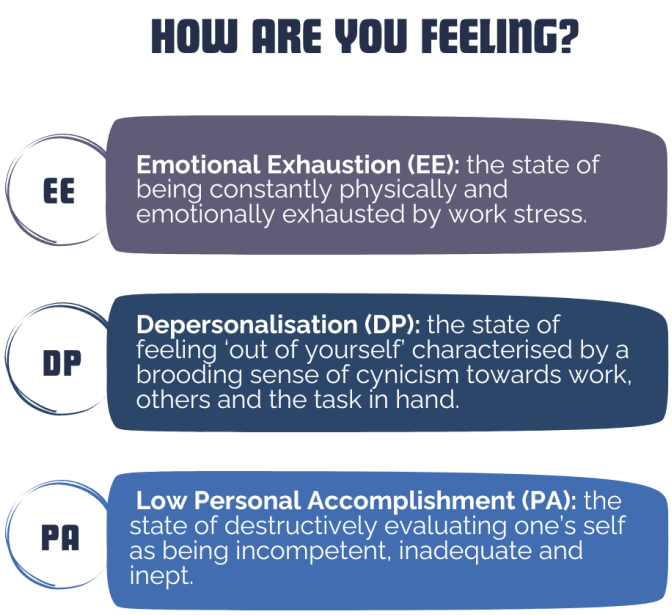
1.3. Coming to Terms with the Language of Nursing Burnout

To begin, we intend to keep our academic drift to a minimum, but it may be helpful to establish a few definitions and context as to how and why burnout has become prominent in nursing and healthcare generally. As noted by Mudallal and colleagues [1] nurse burnout is witnessable as emotional exhaustion, lack of motivation, and feelings of frustration effecting work efficacy. It is commonly accepted that burnout can be analysed as *Emotional Exhaustion* and *Depersonalization* and related to *Personal Accomplishment* [2]. These qualities have been well documented during the past 30 years and stood the test of time as relevant to how most nurses experience and witness burnout in themselves and others. Indeed, an examination of literature on the topic of burnout points up how these categories incorporate a lot of traits and constructs that we have collated in Figure 1 which go to define burnout as a state of mental exhaustion caused by one's professional life effecting aspects of personal life. It is not our intention to dwell too much on the aetiology of burnout *per se* (because many academics and researchers have done a much better job), but in order to allow us to extend the relevance of SF, we want make a mention of some prominent nursing issues how burnout pertains to many conditional issues including poor career prospects [1]; [3], reduced ability to control events [4], a mounting feeling of dissatisfaction to maintain care outcomes [5], increased turnover [6] and remodelled organisational structure [7]; [8].



[Figure 1. Common Symptoms of Burnout]

Despite a recognition that burnout in nursing care settings has an impact particularly in regard to improving monitoring [9], [10], [11], [12], it remains an ongoing battle to establish measures to understand its effects [13], [14]. There is no doubt that burnout amongst nurses continues to be something injurious to service delivery [15], the personal welfare and rise of cynicism in nurses themselves [16]. Stordeur and collesgues [17] note in their earlier work how 'role ambiguity, and active management-by- exception were significantly associated with increased levels of emotional exhaustion' and as such, representative of an increasingly agreed upon lexicon and taxonomy of what causes as well as defines burnout for nurses. One that includes the work-life-balance of healthcare professionals and burnout prone specialist services [18], [19], [20]. As part of our first aim, we have provided Figure 2 and depicting models adapted from the work of Mudallal and colleagues [1] to suggest that as a starting point, nurses both recognise as well as experience burnout in a number of ways, but usually under the pretence that 'it is personal'. That somehow, there is no illusion or trickery at play except that of poorly resourced departments, useless managers and a build-up of stress that eventually gets you. As such, the idea of recovery focusing on a locus of treating physical attributes, retraining and organisational restructure maybe the accepted stance as reflected in most models (we have drawn together a list to show these interventions – see Figure 3), but to these we're also going to add a few (to be precise: 80) of our own which are all mentioned in our claim that an SF approach to burnout is not instead of the already establish wisdom, but despite it. We will dot these contributions throughout and as previously noted hope that for the busy reader they prove a useful short cut.



[Figure 2. 3 Personal Experiences of Burnout]

1.4. The Standard Language of Treating Burnout

The 4 Leader Empowering Behaviours (1. *Enhancing the meaningfulness of work*, 2. *Fostering opportunity to participate in decision making*, 3. *Expressing confidence in high performance*, 4. *Facilitating the attainment of organizational goals*) have been well discussed since their development by Conger and Kanungo in 1988 and as noted by Mudallal and colleagues [1] added to by Hui [25] (5. *Providing autonomy and freedom from bureaucratic restrictions*). They provide the overall schema for what we tend to see as a burnout antidote and we the authors have no reason to disagree. Principally concerned with a nurse's ability to exercise power and take control of a multitude of situations the idea of both organisational and personal regulation places the issue of empowerment firmly within the realms of not only describing burnout, but also recovery from it. These 5 categories offer a broad enough spectrum from which to consider solution focused pragmatics and its stoic principles of self-resourcefulness. In fact, SF easily bolts onto the logics these 5 schemata suggest but in a manner that employs some odd curiosities that are definitely going to need some defining, so we'll start with Figure 3.

[Figure 3. 5 Empowering Burnout Antidotes]

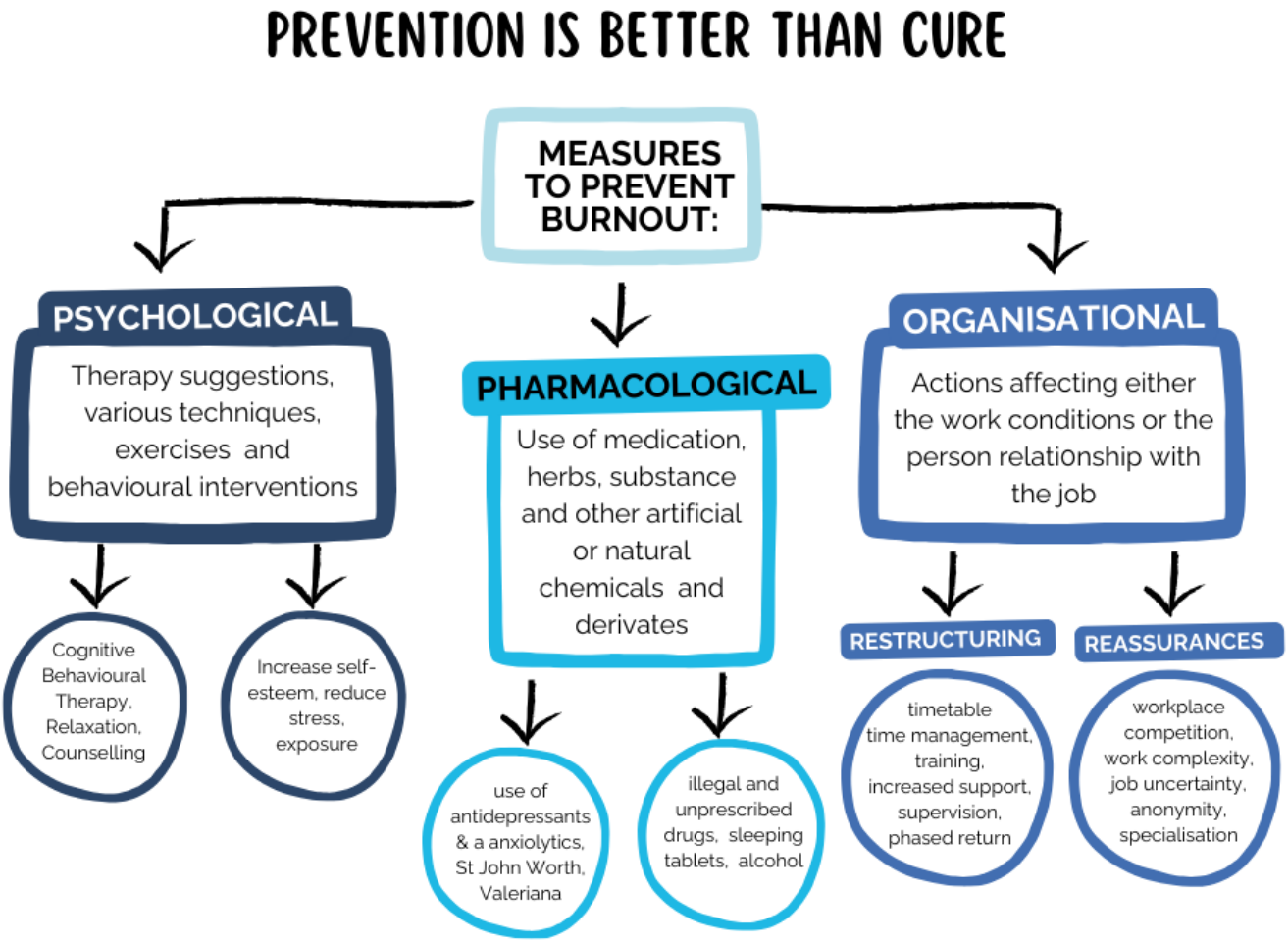
So, to begin we now suggest that if the notion of burnout is framed within mostly negative connotations related to exhaustion, out of control workloads, poor personal robustness and diminishing organisational fairness then, a solution focused approach to starting a journey of recovery is one edged by strategies promoting a detailing of *best hopes*, a focus on perceiving difference between then and now and the direct *action orientated collaboration* by the therapist, best friend and or *self-care*. So, whether applied to the large structural dynamics of a hospital organisation or the personal struggle of individual nurses, we take on board the work of Weber and Jaekel-Reinhard [22] and their claim that 'burnout is today mainly regarded as the result of chronic stress which has not been successfully dealt with' but with a twist because we acknowledge these issues usually concern the past, but for us, this does not happen at the expense of the future. That's because all best hopes have their detail in the future and for most nurses facing impossible odds and constantly dealing with monstrous demands the idea that burnout is simply a matter of being unable to cope is at last, questionable. SF and the seeking of preferred futures as a start point recognises burnout is a multi-complex phenomena which is experienced as such.

It is no surprise that interest in it has spanned 4 to 5 decades because it reflects not only a changing regard for what it means to be psychologically well, but also the nature of and demands of modern nursing in technologically dependent care settings. The complexity of organising care has not only illuminated the propensity of burnout as 'something simply personal' but also our changing relationship with it. As a side note we note that Weber and Jaekel-Reinhard comment 'the term 'burnout' was coined in the USA a good 25 years ago' (they wrote that 24 years ago) so it's had time to become something fixed in most nurses thinking. It has cultural meaning that stetches back to 1974 when psychoanalyst Freudenberger [26] published one of the first scientific descriptions of it and as such, kickstarted its pathological inheritance and subsequent climb up the cultural hierarchy of interest as something that at the time was not considered a 'ward-based hazard' ([20], also [22] point up Freudenberger's contribution). We make note of this because regardless of the extensive research and public interest to what burnout amounts to, there always remains the sneaky suspicion and cynicism that we can never really account for every variable or causal factor. No matter how many artefacts we assemble in Figure 1 and Figure 4, there will always be dispute. So, we recognise that consensus of opinion is one thing we cannot guarantee but we will attempt a fair representation as we continue our discussion into our second aim (introduce SF by way of vignettes the key ideas of 'focusing on hope', 'preferred futures' and other ferrying techniques of 'difference').

2. Background to Our Solution Focused Application

If we were to accept the assertion that burnout is a state of vital exhaustion (ICD-10 (Z.73.0)) and draw together as definition what Weber and Jaekel-Reinhard [22] assert is 'a result of stress that has not been successfully dealt with' we can begin to build an argument for why solution

focused practice, with its strange theory, can offer something new for consideration. In the first place, SF is psychotherapeutic practice based on *constructionist*, *pragmatic* and *stoic* philosophy which makes it different to most Humanist dominated psychology. See Figures 5, 6, 7 and 8 for



words in *italic*. Instead of being empathetically focused *per se* or concerned with depth hypothesis (e.g. the idea of an inner self) SF recognises language mediates our sense of reality and that change is best sort through experimental change by way of '*end of session tasks*'. As an introduction, SF is an approach to burnout that recognises the seriousness and impact it has on nurse's lives but attempts to employ constructionist theory about language to remedy it through '*collaborative conversations*', skills that '*emphasise imaginative and creative thinking*' and '*a future focus*'. It is an approach that encourages '*justification*' of a perceived future event rather than a search for the 'truth' related to a past actuality and as such, employs a pragmatic '*can do*' style of conversation that recognises everyone has *personal resources* to figure out '*what to do next*'. In this sense it promotes a move towards trying '*something new*' involving actual behaviour instead of more traditional approaches focusing on thinking through events, pathology and feelings. In terms of personal emergence, SF adopts a stoic recognition that life is struggle requiring '*a best fit*' and as such focuses on maintaining a capable degree of *confidence*, *motivation* and temperance (*acceptance*) that are the fuel necessary to help nurses change and recognise it.

[Figure 4. Measures to Prevent Burnout]

Now we acknowledge that theory is one thing and practice another so to help explain, we'll use examples from our own practice that enable us to share 80 SF skills and principles that nurses can subtly employ. Remembering that SF downplays the idea of '*therapeutic expert practice*' *per se* in favour of '*doing just enough*' it is plausible that everyone can begin to employ its ideas and simply see if they work for themselves. As a process, this may not feel like the 'psychological capital' [20], [23], 'optimism' [24] and 'emotional strategies' [27] espoused by other approaches, but they easily bolt on to existing ideas. SF concepts do not replace the theory of burnout just discussed but rather, act so as to bolt on [28]. The practical ones can be tried out on their own or, with some practice, as a complete philosophical package that can be mastered as a type of SF advanced practice.

2.1. Identifying Hope

Jack is a newly qualified Staff Nurse who has completed his first year of preceptorship in a medical unit. During this time he has been exposed to a number of staff changes, consultant swaps and reorganisation. In addition to doing more than his fair share of night shifts mostly without quality mentorship he finds himself ready to (in his own words)'chuck it all in'.

Jack:	And all they seem to want is that I go and see Occupational Health, but that goes on your record and I don't think it's fair, after all it's their fault isn't it.
SF Listener:	Hmmm…. Their fault?
Jack:	Yeah, you know, before I started working here I was able to sleep and concentrate, but now I'm all over the place…
SF Listener:	But there's times when you're not?
Jack:	No not really, things are just getting worse…
SF Listener:	Hmmm, I see, so I wonder if we can do one thing right now that can make the tiniest of difference? [Jack looks intrigued]
SF Listener:	What could you hope for, I mean the smallest of hope?

To this point we have considered how burnout is a substantial concept that has been well researched and implicated in much personal suffering and organisational disorder in healthcare settings. We've seen how there is a general consensus about its terminology and impact on nurses emotionally, their depersonalisation and lack of accomplishment. These are foundational concepts which most nurses recognise in their symptomology (which we've listed in Figure 1). So now we're introducing the idea that SF offers a pragmatic approach to rethinking how nurses suffering

burnout can reconsider the nature of their burnout via self-talk, work with an SF therapist or even groupwork (see Sharry [29]). We will insert a few short vignette's (as is the usual SF custom) to give an introductory flavour about our SF practice and we'd like it if you notice how questions are formulated to be future facing. Each of the three nurses (Jane, Jack and John) represent key SF conversational components that are inseparable from the 80 concepts list in this article. In particular, the way of reconsidering language and the importance of 'hope' for establishing positivity and '*preferred futures*'. So, in the example above, Jack's trajectory is started like all SF sessions with the establishing of best hopes that the therapist keeps in mind for the remainder of the conversation. Then there's the pace and matching of Jane so that she can begin to learn the necessary SF language and begin to get the hang of its strange attempts at *nudging* her towards alternative answers and *justifications*. Finally, there's the idea of doing an *experimental task* of some sort. So John is encouraged to *try something new* and *see what happens*. And as such, SF does what Tang and colleagues [20] offer as hypothesis in their recent paper on burnout when they suggest H1: Perceived organizational support is negatively correlated to job burnout. H2: Psychological capital is negatively correlated to job burnout and H3: Perceived organizational support is positively correlated to psychological capital. As a pragmatically focused approach to change, SF is perfectly positioned to adopt these timely hypothesis, co-exist with more traditional treatment regimens and pursue difference as an alternative [30], [31].

2.2. Learning a New Language

If we continue by suggesting that 'language is reality' rather than just the neutral thing allowing us to experience it, then we also need to explore how this shows itself in our everyday nursing. We also need to address how 'learning SF language' makes difference [30]. Well, as a means of metaphor, SF has as a foundational starting point in the belief that reality is not a truthful thing *per se*. In fact, and although SF therapists never challenge their clients' perceptions, they do implement conversations to manipulate, evolve and substantiate new realities. This is a strange conception so let us unpack it a little by exploring some of the specifics concerned with our 80 SF concepts.

Figure 5. 80 SF Concepts Part 1]

First, most traditional burnout language is problem focused rather than solution focused. We've already suggested that this is how most of us recognise our symptoms and communicate with them, but imagine if we could change this? What if during the next hour we start to notice in a different way and amplify moments which are not so bad or at least not worse? Second, most traditional burnout talk is past facing instead of future focused. There is no doubt that the experience of burnout involves real suffering, but making things better can only happen in the future. Thus, SF practice attempts to encourage us to spend more time considering future hopes in an effort to have something to work towards [32]. Third, the idea that reality is true and burnout symptoms somehow a correct measure is not disputed but can be counteracted by SF's belief in simplicity. That is, we don't need to know everything about a problem in order to seek and substantiate a solution [33]. In fact, SF is a pragmatic language of scaling justification. Fourth, this allows for an action orientated language concerned more with motivation and monitoring confidence minute by

minute, hour by hour, day by day [34], [35]. Fifth, whether it be self-talk or work with a therapist SF language is an inductive collaborative process whereby the person is prepared to make mistakes, accept impossibility whilst implementing some type of change behaviour. Sixth, SF language is creatively orientation and encourages people 'to suppose', ask 'what if' and 'seek difference' [36]. Seventh, SF language seeks detail about the best hope rather than the eventful past which helps improve a positive feel and motivate the session forward. Eight, such detailing builds on the idea that slightest of change in small steps are the best way to tackle big futures. For example, most of us think in terms of plausible goals when joining a gym but actually committing to turn up 3 times a week is another thing all together (mostly about justifying good reason and personal resources such as motivation).

The primary aim of SF conversation is to encourage clients to reconnect with neglected personal resources. This means setting up '*a can do*' atmosphere of expectation to encourage a sense of positive emotion, eliciting strategies for coping, *amplifying* often overlooked skills, detailing and increasing the chance of hopefulness by focusing on preferred futures. However, all this doesn't just occur, because when nurses are suffering from burnout they are often suspicious of authority, diminished by a sense of personal failure and overwhelmed with traumatic feelings that are multiple, complex and seemingly impenetrable. Therefore, the SF conversation and the language it employs recognises that the nurse is always '*the expert*', will always have '*the answer about them*' and given the opportunity to encounter an expectant SF space where the careful nudging of the listener with the afore mentioned aims anyone is capable of considering change in under an hour (or at least the change of a first thing in a recognisably long chain).

2.3. Best Hopes: Conversations that Justify Reality

Language that occurs in a space of expectancy is creative in itself. In SF we often use the term '*problem free talk*' not because burnout doesn't create problems which it obviously does, but as a means to allow people to experience a different conversation with themselves [37], [38]. It is easy to forget just how battered you become when constantly under pressure and neglect the many skills and personal strength you have (or 'used to have'). Nurses experiencing burnout don't just get to a point where they failed, but they often experience language that is full of it and they perceive it as truth. They sense the trauma of burnout as real and a truthful reflection of themselves. The feeling that come to define them are ones of anger, guilt, anxiousness, loss of control, sadness and so on. These and others come to circumscribe them and the moment so, encountering SF language which nudges them towards more hopeful realities doesn't necessarily come easy and it is easy to see why many would be suspicious of such claims, but bearing that in mind, every SF conversation starts with what is called 'best hopes' [39].

Burnout is all encompassing and dominates the emotional thinking of most suffers so it is often off putting to be asked: '*What are your best hopes for this session?*' or '*What is your best*

hope for the next ten minutes?' and by way of clarification an overall persistent expectation related to '*How will you know it's been useful to have this conversation?*' or '*What will tell you that things are different?*'. This opening SF language or something similar never leaves the SF conversation and guides it towards completion. The 'best hope' is similar (although not the same thing) as a session goal that starts the conversation but also allows the client to begin experiencing new language to help them rediscover their often lost selves in the trauma of burnout. But setting the conditions of hope, as previously mentioned, requires all the concepts shown in Figures 5, 6, 7, 8.

Jane has been a qualified nurse in Oncology for 5 years and constantly finds herself in charge of a poorly resourced ward. Once she had established her best hope of improving things at home we never lost sight of the irony that she too had lost her own resources (the means) to trust herself, feel confident in her wants and summon up a touch of motivation to behaviourally make her future better. So, the SF language we use gently coaxes her into the collaborative nature of the conversation:

SF Listener: So your best hope is to make things better at home?
Jane: I guess so, things have been crap for months now, I've lost all sense of proportion…
SF Listener: Aha, yeah I bet [nodding], best hopes are woolly at the best of times though, so what would I see you doing different at home, say if tonight you were making things better?
Jane: Hmmmm [pondering] I'm not sure…
SF Listener: Go on, give it a go, what's that one thing that you'll do different? Jane: I suppose I'd stop being moody…
SF Listener: [smiling in acknowledgement whilst working out an SF formulation: could ask 'how come' to explore the nature of the moody problem or, ask how being non-moody looks and congratulate for her bravery], Ok, and what else?

2.4. Language that Reinforces Hope

Imagine that for the next hour you seriously start to 'take notice' of the language people use to describe things and maybe even listen to your 'self-talk' (the stuff you say to yourself in your head), what do you think you'll get? To save you 60 minutes, you'll hear a lot of negative stuff that tends to reinforce what you think you know and justifies why you do what you do. Now also imagine that you multiply that by 10 to emulate the effects of burnout and you'll see how it is a

cycle of conversation that is hard to contain and get out of. So how can simply conjuring up a 'best hope' begin to help? Well, the theory is one thing, but the reality another because as we will go on to consider, SF language and conversation requires a constant and consistent appraisal of detail looking out for '*moments of personal resource*' and '*exceptions to the problem*' that may only have tenuous links to the perceived problem. In the case of burnout these will often include moments when the exhaustion was present, but the nurse managed to continue *despite* it. Or when the apathy of low personal accomplishment were less evident. What was it about those times that were '*different*'. We'll say that again because theoretically the notion of 'difference' is not only what triggers feelings of hope, but also the primary function of SF language in its attempt to help clients learn new focus and perceive future change rather than past catastrophe. Theoretically, and without wishing to get too bogged down in theory, the notion of difference is what enables language to work. As a closed symbolic system of exchange,

Figure 6. 80 SF Concepts Part 2

language operates through a process of differentiating meaning between things (signs) that require encoding and subsequently decoding. This means the questions we ask of ourselves and others determine the nature of the answers. This has implications for how we maintain an SF conversation and what it means to justify rather than seek truth [40]

All this heavy stuff can get in the way, so we'll keep it to a minimum, but it helps us start to summarise how beginning with hope and inviting clients to collaborate in a moment of learning new language is less about searching for absolute truths but rather coming to terms with their current situation and determining *what to do next*. This invitation starts to change the truth of what burnout is and even feels like by suggesting, and maybe even disrupting, what has reinforced their perception. These issues of hope, truth and justification are the basis of new language that not only changes a sense of reality, but also 'what to do next?'.

Jane: So you're saying I can scale my sense of confidence?

SF Listener: Yeah, why not [nodding], let's say on a scale of zero to ten [still working on the best hope of improving things at home and in particular the idea of being less uptight and moody] … where ten is appearing more relaxed [not referring to zero or moody] …

Jane: Hmmm, I don't know [pondering]… say a five…

SF Listener: [pondering in unison and making sure to be expectant and wanting her to give 'detail'] … wow, how come a five? What's the difference between that and a six?

3. Discussion

3.1. Having 'the Means': What to do Next?

We promised to keep the theory to a minimum, but we need to quickly discuss the importance of '*difference*' and suggest it works through at least 2 structural processes. The first is a process known as '*binary opposition*' relating to every sign (word) having an opposite as in the case of Jane feeling uptight (relaxed) and second, the binary of '*presence' and 'absence*' which put briefly, argues the idea of presence has dominated much Enlightenment thinking to the detriment of the absent half of the binary. The idea that Jane recognises herself as uptight, but when pushed,

Figure 7. 80 SF Concepts Part 3

can envision herself as relaxed too. It seems that absence must always be sought more and SF practice spends a lot of effort searching for such detail. In SF, the conversation will usually attempt to discuss the presence of a solution rather than the absence of a problem and it does this by recognising that if clients can tell they have symptoms of burnout, then they also know what it means not to experience them. It is with the latter that SF takes the client from a start point of 'best hope' to scale how to be convinced and motivated to decide what next?

So if 'best hopes' are about envisioning what could better then '*what next?*' is about envisioning '*the means*' to start making things better. The simple term '*better*' is used in SF to sidestep much value laden language (the presence part of binary) that dominates clients self-thinking. At its simplest we might ask: '*what will be better?*' rather than what's gone wrong? or use it as term that reinforces the general attempt to make sessions emotionally more positive: '*so how come that will make it better?*', '*what else is better?*'. That said, being convinced that you have 'the means' requires both listener and client employ words and phrases

already used in the session to demonstrate purpose and that all parties are listening enough to be metaphorically close enough to 'tap one another on the shoulder'. In order to feel safe and brave enough to engage with new types of conversation such as *problem free talk* means clients start to realise that SF is different from other problem focused approaches which tend to dwell in the past and models of inner psychological well-being. Finding 'the means' is an active process of the SF conversation that is inevitably concerned with learning that considering how I would like my life to be different requires new possibilities and detailed descriptions of them so that I can begin to envision the resources I need to maybe change one small thing.

The actual process of appreciating 'the means' and directing what is discussed incorporates many notions of reinforcement in that, if during the course of a conversation you are constantly nudged towards considering times when things went wrong (but you managed to get through it) then a slow shift starts to occur. A sense of a new you begins to emerge, or maybe just enough to jump-start your curiosity. In SF there is recognition that disrupting old thinking helps the genesis of realising how each of us has strengths like Jane, that are easily neglected when burnt out. These attempts to encourage clients to focus on devising 'the means' doesn't prevent them talking about their burnout. In fact, they are in charge of their part of the conversation and the SF listener trusts them implicitly, but the direction of the conversation is collaborative and that means SF responses that seek the exception (usually the absent part of the binary) are those that hopefully start to intrigue the client incrementally so that they too, begin doing it for themselves.

3.2. Missing Words & Not Knowing Question

It could be that the simplest method of putting 'difference' to work is something we term 'missing words'. We have emerged this from the pragmatic theory that old style philosophy tended to over theorise at the expense of actually getting on and making a difference. It is possible to see how much therapy spends a lot of time thinking about thinking and the relevance of feelings whereas Jane, John and Jack became increasing curious about simply pondering on their best hopes and equally 'the means' to achieve their preferred future.

John is a qualified nurse in Accident and Emergency. For 6 years he worked in general medicine and considers himself well balanced but during the past 8 months he's become increasingly anxious that organisational structures are plotting to change many of the nursing roles:

John: I don't know, can you say it again…

SF Listener: [knowing that on most occasions the miracle question causes confusion when attempting to elicit best hopes says it again] … suppose when you go home tonight and you go to sleep a miracle happens and all your worry about the organisation

has been put right, but because you're asleep you don't know it and then you wake up. What would be the first thing that happens to make you think 'hmmmm that's strange, a miracle must have happened'…

This 'miracle question' is used to elicit best hopes, envisage preferred futures and allow the conversations to build the detail demanded by obtaining 'the means':

John: [after some initial smiling and pondering] … I guess I'd see my boss smile more instead of intimidating us all…

SF Listener: Hu yeah right! Because miracles do happen [laughs]… what else?

John: I don't know, I suppose I would feel more energised… [spends more time pondering]

SF Listener: Well, let's stretch this miracle by taking it through your average day… you get to work early and what happens? [starts employing a future focused grand tour set of questions] … and then at breaktime your colleagues look different how come?

If our beliefs about burnout determine the questions we ask of it then focusing on the detail about future hopes is one way to overlook some of the suffering in favour of creating some positive space for asking different type of questions. Some may say that this is a reckless tactic and one which dumbs down what is obviously a serious issue. However, as a strategy, SF recognises that problems are always present and unlike solutions they rarely require an active search. The idea of joining conversations that aim to change a clients view of themselves and instil hope rather than tackle a specific issue *per se* is not to diminish the seriousness of the issue but rather change the perspective. By focusing on positive moments of a client's ability to overcome burnout is best done by 'missing words' (focus on the presence of solutions) they express about their negative experiences and instead, nudge them towards success with 'not knowing questions' that are laced with curiosity.

These type of questions concern the small things (the detail) that clients do when simply managing to cope in a manner that emphasises they are being listened to. They are little pointers in the client's journey as they attempt to make sense of their predicament and '*build their ship at sea*'. This being an SF theoretical nod towards not knowing prior to taking action and the ferrying mentioned earlier. Being curious employs 'open type questions' that assume nothing but are in many ways presuppositional. In fact they hug the centre of the conversation and aim to reinforce that the client is the most valuable thing in their own life: '*how did you mange to keep going?*', '*so there must have been something that warned you that something needed to change at work?*', '*who else has noticed you are determined to change?*', '*how has your new understanding changed you?*'. The key being that not knowing questions are always directed by and directed towards the client's best hopes and preferred futures. Even the establishing of best

hopes makes use of them: '*what are your best hopes for this session?*'. We encourage everyone to ask it of themselves.

The idea of presuppositional questioning goes hand in hand with not knowing in the sense that the way questions are phrased, especially if they are framed in a manner that focuses on best hopes and preferred futures make the assumption that change is inevitable. That a nurse suffering from burnout can overcome their depersonalisation if given multiple exposure to conversation framed in an expectant manner. Like a narrowing down of possible answers SF will always attempt to focus on that which is achievable, relevant and witnessable. To be presuppositional is to allow the client to be in charge of their own change and as a result benefit from the stoic type qualities such bravery demands when describing themselves at their very best (or justifiable best-fit).

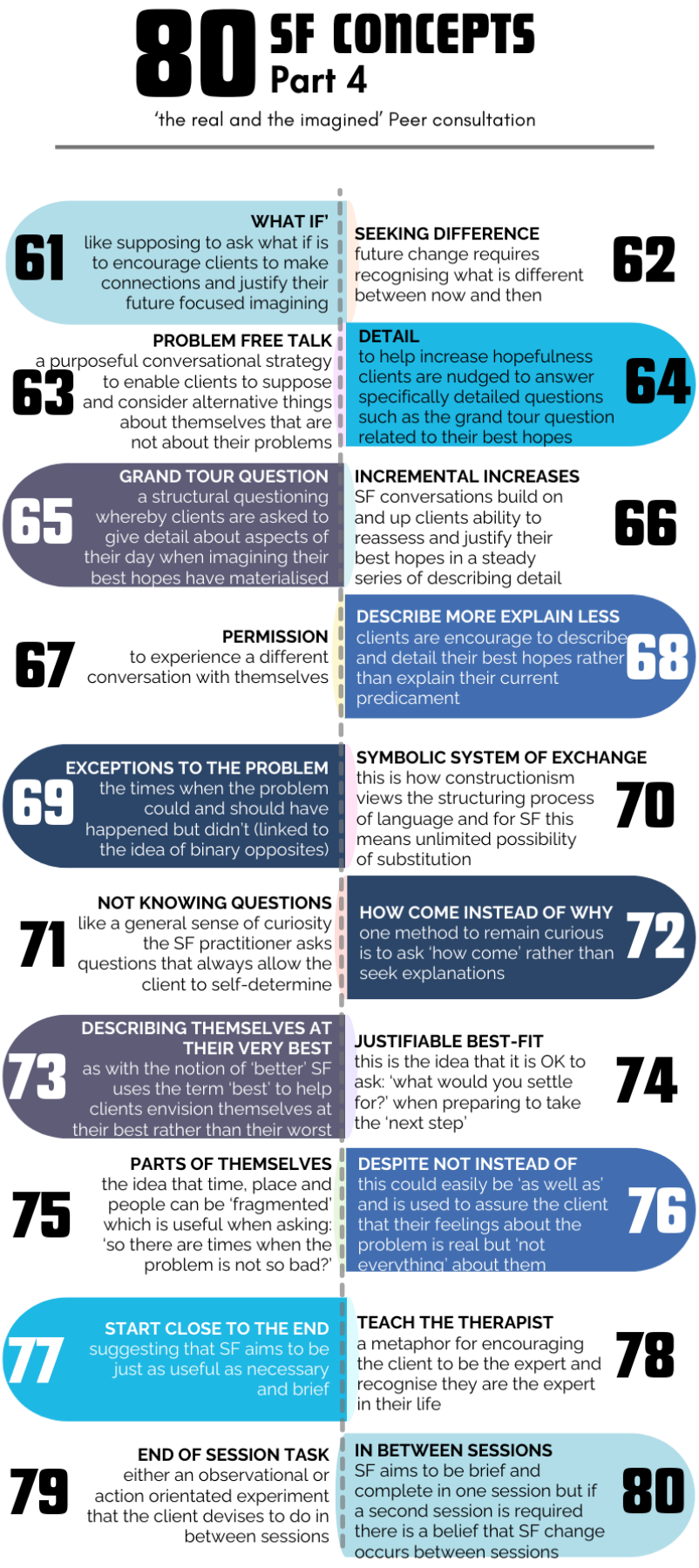


Figure 8. 80 SF Concepts Part 4

3.3. The Notion of Despite

The trauma of burnout happens and it is the client who are managing it to the best of their ability. It becomes a revelation to them that there are parts of themselves and times when they have made it through (these are usually the bits other conversations skim over – the idea of 'missing words' just reverses the process in favour of focusing on the exception). That they are in fact doing something about it, perhaps in desperation, but doing it all the same. The notion of '*despite*' builds on SF's notion of binary opposition, presence vs absence and presuppositional not knowing. Even though the sleeplessness and fatigue are debilitating there is still the desire to 'get over it and start nursing properly again'. This hope is despite not instead of. Imagining what we want when at our best doesn't change the perception of the past but it becomes part of the perceived change that, despite all of the trauma, we are still able to perceive a hope of change and as a result maybe do one thing differently in the near future to make it happen (or take a step closer to our preferred future). Everything is acceptable, but that is not the same as where we want to end, nor is it necessary to take enormous amounts of soul-searching conversation to get there. In fact, SF aims to *start as close to the end* as possible and the notion of 'despite' encourages less trauma talk and like not knowing questions, pushes the client to '*teach the therapist*' especially as they gain confidence and expand their SF language.

John: [laughs] … so that's what I'll have to do tomorrow… SF Listener: What's that?
John: [scoffs] Start pretending that the miracle has happened…
SF Listener: Well, it won't change the fact that you've been under the cosh, but it would show that despite all the worry you're up for a fight…
John: Hmmmm [ponders silently] …
SF Listener: You could start to notice what happens to others if you do though…

5. Conclusion

5.1.End of Session Task: Summary

Throughout this article we've been suggesting that SF offers a different way to have conversations about nursing burnout. Conversations that take it for granted that the type of questions we ask determine the nature of the answers. That conversations tend to be problem saturated (especially therapeutic ones) and as a result they lament the past usually at the detriment of making any future changes. We recognise that SF is not everyone's ferry or remote mode of transport but for some, the chance of change that SF conversations promote allow them to learn a new conversational language, focus on future hopes, start noticing absence more and attempt when

possible, to be purposefully presuppositional and directive. Perhaps to a point that they do something different in order to evaluate 'what happens' rather than knowing for certain beforehand. We are hopeful that these conversational ideas can continue to inspire and help nurses negotiate the inevitable deluge of burnout that many will endure and act as a new translation related to discussing trauma. So, when John joked about simply 'pretending' he was not dismissing the seriousness of his predicament, he may have been mocking his own abilities to do anything about it, but by pondering on doing something different and seeing what happens he was also contemplating ferrying himself towards his preferred future despite the fact that his past can't be changed. So, as one last conversational point, SF conversations start with purpose, continue with offering an alternative translation and end by doing something, some type of task. In our case, we'll suggest that all of us can start to notice how burnout is a real phenomenon but our conversation with it, and about it, could be better if we translated in different ways.

Use of AI tools declaration

The authors declare they have not used Artificial Intelligence (AI) tools in the creation of this article.

About the Authors

Dr Dean-David Holyoake has been a registered nurse for over 30 years. His interest in solution focused psychotherapy started in the 1990's when he worked at the University of Birmingham (Centre for Lifelong Learning) with Bill O'Connell and Stephen Conlon on the MA in Solution Focused Brief Therapy. Since, he continues practicing, researching and publishing on the topic. Unlike Anita, he is prone to seasickness and can just about swim, so ferries are a no-no.

Dr Anita Z Goldschmied is a dually qualified learning disability nurse and social worker. Anita has extensive experience using solution focused approaches in the business, public, health and social care sectors. She has a Master and a PhD in Contemporary Research and Practice. In her doctoral work, Anita has developed a novel approach, 6D solution focused practice to explore mundane and ordinary events. As a senior lecturer and researcher at Sheffield Hallam University, Anita continues to evolve and apply the 6D approach to everyday issues, currently to neurodiversity.

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