Maintenance of Clinical Burnout

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Burnout is common in many countries and is associated with several other problems such as depression, anxiety, insomnia and memory deficits, and prospectively it predicts long-term sick-leave, cardiovascular disease, and death. Clinical burnout syndrome means a general incapacity to cope with demands at home and at work. Clinical burnout or its residual symptoms often last several years and a common assumption is that recovery takes a long time by nature, despite full time sick-leave and the absence of work stress. The literature suggests models that hypothetically explain the development, but not maintenance, of the syndrome.

prolonged stress recovery burnout exhaustion maintenance

1. Introduction

The literature on burnout focused on the risk factors for developing, but not maintaining, the syndrome. As a consequence, the clinical psychologist Niclas Almén developed a theoretical model that hypothetically not only explained the development but also the maintenance of severe/clinical burnout. The aim of the model was to show that every participant probably had current factors in their lives that influenced their burnout levels and that could be changed. The theoretical model has worked as a therapeutic intervention giving people a sense of control and hope, and guidance on what to do in the present, rather than information on what they should have done in the past. The model also motivates participants who are passively waiting for better health to be more active and health goal-oriented. The model has been used in clinical practice, university courses, and in intervention research [1]. However, the model has only been available to Swedish speaking persons, since it has only been published in a Swedish article [2] and in a Swedish book [3][4].

2. Features of Clinical Burnout

Although there exists different definitions and measures of burnout, the common feature among them is *exhaustion*. Pines, Aronson, and Kafry [5] have been influential in their definition of burnout as non-transient physical, emotional, and mental exhaustion. In line with this, burnout has been considered a chronic depletion of an individual's energy resources [6] manifested by prolonged feelings of physical fatigue, emotional exhaustion, and cognitive weariness [7]. The concept of chronic or non-transient exhaustion/energy depletion should not be taken literally. People experiencing burnout are usually not *always* exhausted. Rather, they experience a reduced capacity to tolerate stress/demands, lack of endurance, exhaustibility, and increased time needed for recovery after stress and effort [8]. A marked inability to cope with demands at work and outside work due to severe levels of these symptoms is the definition of clinical burnout in this paper. Some definitions of burnout also include other

factors. One of the most used definitions of burnout formulated by Maslach and Jackson [9] includes three aspects: emotional exhaustion, and two possible consequences of this: cynicism and a reduced ability to perform at work. Another definition of burnout includes withdrawal behavior as part of the syndrome [10]. When measuring burnout, many researchers include tension and listlessness (i.e., low levels of interest in doing things) [11][12][13], although the founders of the subscales measuring tension and listlessness described these as burnout concomitants, and not burnout per se [14].

Burnout is problematic in many countries worldwide. People with burnout usually have multidimensional symptoms/problems, in particular anxiety and depression [15]. Approximately half of those defined as severely burned-out have been shown to be clinically depressed [16]. Burnout is also associated with somatic discomfort and dysfunctions (e.g., digestive problem, skin problems, and headaches) [17], reduced reproductive functions, type 2 diabetes, cardiovascular disease, and cardiovascular-related events [18]. Although burnout symptoms can be reduced over time, they often persist for several years [19], particularly among people who have been diagnosed as clinically burned out, and the symptoms are associated with long-term illness [20] and predict all-cause mortality [21]. A study by Glise et al. [19] showed at a seven-year follow-up that a third of former patients with exhaustion disorder (i.e., clinical burnout) were clinically exhausted and only 16% reported that they were fully recovered. Moreover, patients who consider themselves to be fully recovered may still have symptoms such as memory problems or sleep problems. Burnout predicts permanent work disability [22], and long-term sickness absence due to clinical burnout, which may be an indicator for premature mortality [20]. A factor that usually has significant negative consequences for a person scoring high levels of burnout, not the least in terms of work ability, is cognitive impairment and in particular in terms of attention, memory, and executive functions [23]. Apart from significant consequences for the individual, work-related stress is enormously costly for our society [24].

Many people recover poorly from clinical burnout despite full time sick-leave for long periods of time. One common assumption is that clinical burnout symptoms “by nature” require long recovery time, perhaps several years [25]. It has been suggested that the chronicity of clinical burnout syndrome may possibly be explained by chronic changes in biological functions including brain functions [19]. However, there are no biomarkers for clinical burnout [26], and thus no evidence for such an explanation or for clinical burnout lasting for many years, despite the absence of current significant stressors and stress behaviors. Accordingly, I hypothesize that clinical burnout is in many cases partially or fully maintained by current contextual and behavioral factors.

Research has to a very large degree focused on the association between stress and burnout, and researchers have highlighted the importance of further increasing the knowledge on the progression of burnout and its pathways to sick-leave [27]. However, maintenance of burnout has been neglected in research.

3. Clinical bunout may maintain itself

Cognitive behavioral therapy (CBT) is the current gold standard of psychotherapy [28]. A characteristic aspect of CBT is the use of a theoretical model explaining not only the development but also, and primarily, the maintenance of clinical disorders. Generally, these are based on learning theory/behavior analysis and/or cognitive information

processing theory, and theories and empirical data on the analyzed disorder. According to many CBT models, temporary reactions (such as anxiety or low mood) are unproblematic consequences of natural events in life, while chronicity are consequences of maladaptive coping. For example, a CBT model for depression states that depression can develop as a consequence of losses in life (e.g., to lose a close relative or a job), while long-term depression is mainly explained by behavioral patterns of inactivity, withdrawal, and avoidance [29][30]. Another problem is long-term pain, which according to a CBT model is explained by the individual's fear of pain, and pain avoiding behaviors, which may hinder recovery from the acute pain, and create new problems (e.g., physical disuse, depression, and disability) [31]. A further example is insomnia: Temporary sleep problems can be caused by loud neighbors or transient stress at work, while prolongation of sleep problems may occur as a consequence of worry about sleep and conditioned arousal in the sleep situation [32]. A last example is panic attacks. The first panic reaction an individual experiences may be due to a period in life that is very stressful, whereas repeated panic attacks may be caused by fearful thoughts regarding normal physical reactions (e.g., due to walking up the stairs) [33]. Cognitive behavioral therapy emphasizes the intervention of maintaining factors.

On the basis of a CBT-approach (i.e., learning theory/behavioral analysis, cognitive information processing theory, and theory and empirical data regarding the analyzed problems) Almén (34) hase formulated a theoretical model that aims to hypothetically explain both the development and the maintenance of clinical burnout. According to the model the burnout process does not end with clinical burnout (i.e., exhaustion) syndrome: The symptoms, often accompanied by sick-leave, also function as stimuli, often stress-stimuli (i.e., stressors), for different overt and covert behaviors, which potentially maintains the prolonged stress reactions, insufficient recovery processes, and clinical burnout syndrome, particularly among people who on a recurring basis act in accordance with the behavioral patterns described above (e.g., maladaptive perfectionism). Thus, burnout recovery may not take place even if the individual is no longer exposed to the stressors that were responsible for the development of the syndrome. In order to accomplish recovery from clinical burnout, maintenance factors of clinical burnout may need to be analyzed and intervened.

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