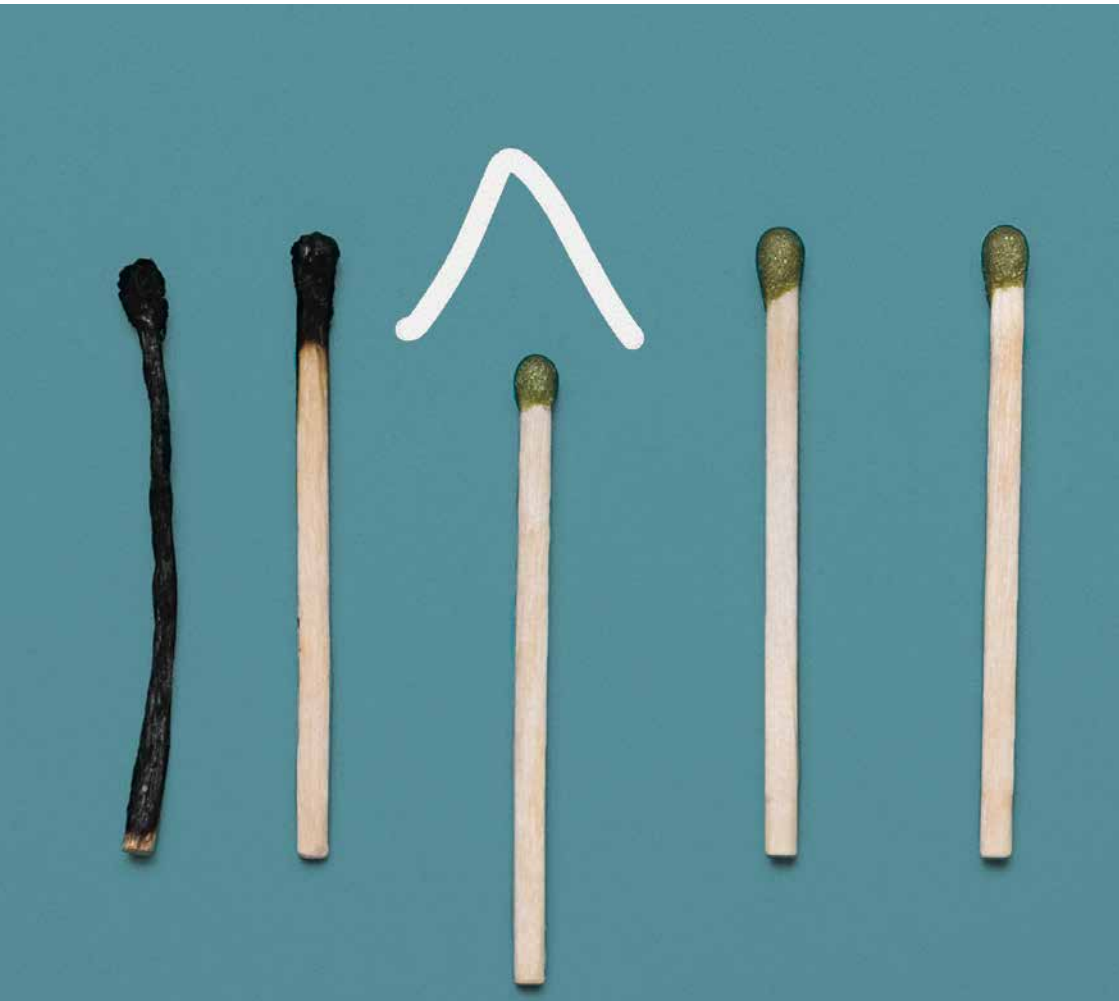
BURNOUT AND EXHAUSTION-INDUCED DEPRESSION

Information for sufferers and relatives



Dr. Joachim Leupold

For ease of understanding, the female form has been omitted.
The male form is always used to refer to persons of either gender.

About the author

Dr. Joachim Leupold is an FMH Specialist in Psychiatry and Psychotherapy. After studying medicine at the Ludwig Maximilian University in Munich, he relocated to Switzerland in 1995, where he completed specialist training in psychiatry and psychotherapy in various psychiatric hospitals and obtained a doctorate in medicine at the University of Zurich.

Since May 2003, Joachim Leupold has managed his own practice in Bad Ragaz and is a member of the Board of Directors and the Executive Committee of the medical network PizolCare AG in the southern part of the canton of St. Gallen.

Dr. Leupold is also a member of the Swiss Medical Association (FMH), the Swiss Expert Network on Burnout (SEB) and the Swiss Association of Psychiatry and Psychotherapy (SGPP). He also heads the Quality Circle of community-based psychiatrists in the medical network PizolCare AG.

He attaches particular importance to the destigmatization of mental disorders. In addressing the issue of burnout, he tries to reach and treat sufferers at the earliest possible stage. He believes that prophylaxis and the prevention of relapses are particularly important.

He likes to spend his free time outdoors, hiking, mountain biking or gardening. He lives with his wife and two grown-up children in the Sarganserland region, at the foot of the Churfirsten mountains.

Dr. Joachim Leupold
Specialist in Psychiatry and Psychotherapy (FMH)

PRAXIS dr. joachim leupold
Bartholoméplatz 3
CH-7310 Bad Ragaz
Tel. +41 (0)81 511 21 11
praxis@seelischegesundheit.ch
www.seelischegesundheit.ch

CONTENTS

INTRODUCTION AND ACKNOWLEDGEMENTS

Just as in 2007, when this booklet was first published, "burnout" is still frequently "diagnosed" and discussed at length.

Positive factors, such as the destigmatization of mental disorders, argue in favour of the construct of "burnout". But there is also criticism about its "diagnosis" because it is not listed as a psychiatric diagnosis in ICD-10 or DSM-5.

In 2007, with the generous support of Lundbeck AG, I published this booklet, now in revised form, on the subject of "burnout". The original version was partly based on the review of the literature available in 2005 on the subject of burnout undertaken by Dr. Beate Schulze. Dr. Schulze headed the Zurich Empowerment Programme for stress management and burnout prevention in healthcare at the Psychiatric University Hospital of Zurich.

A lot of work and development has been carried out in the last 13 years in Switzerland on the subject of burnout. For example, the concept of burnout has been recognized by the Swiss Association for Psychiatry and Psychotherapy (SGPP) and also by the German Association for Psychiatry, Psychotherapy and Psychosomatics (DGPPN). Almost every renowned psychiatric hospital with psychotherapeutic wards now offers special support services for this problem.

All this for a condition which, strictly speaking, does not exist as an illness (WHO, ICD-10, Chapter V/F; Dilling et al., 1991). The WHO lists burnout syndrome merely as a "factor that influences health and leads to the utilization of health services": Burn-out; ICD-10: Z73.0.

As described by the Swiss Expert Network for Burnout, SNB for short, and DGPPN, it is now assumed that individual factors and factors in the workplace cause occupational overload with symptoms of an autonomic stress response and exhaustion and, if this state persists, i.e. in the event of chronic stress, lead to burnout. And that this state of burnout can result, in turn, in psychological and physical illnesses, e.g. exhaustion-induced depression.

Drawing on the latest research and current opinions on burnout, this booklet is designed to serve as a practical guide, full of information and ideas, that will help sufferers, their relatives, the doctors treating them and company management learn key facts about the symptoms and the course of burnout states and burnout processes. The booklet focuses particularly on cognitive performance in connection with depression and its consequences, with additional thoughts on returning to work.

It is designed to show how each and every one of us can do something to help prevent burnout and exhaustion-induced depression. Moreover, based on the clinical experience of the author, it is designed to show how burnout states and exhaustion-induced depression can be successfully treated.

I should particularly like to thank my patients. As each one has overcome their individual problems, I have come to understand more and more about burnout processes, and I continue to learn and am always able to incorporate the findings into my work.

My sincere thanks also go to Lundbeck (Switzerland) AG, which, in enabling this booklet to be produced, has contributed to the destigmatization of mental problems, to self-help and preventive health.

Bad Ragaz, January 2021

Dr. Joachim Leupold

THE KEY POINTS IN BRIEF FOR THE READER IN A HURRY

1 According to the first description of burnout, this state is characterized by:

1. Emotional exhaustion
2. Depersonalization
3. Reduced personal accomplishment

Cognitive impairment with reduced performance / depression:

- Attention
- Memory and learning
- Executive functions
- Psychomotor speed

The seven phases of a burnout process according to Matthias Burisch:

1. Phase of initial warning signs
2. Phase of reduced commitment
3. Phase of emotional reactions
4. Phase of impaired cognitive skills
5. Phase of flattening of the emotional and social life
6. Phase of psychosomatic reactions
7. Phase of depression and desperation

2 The following three main factors play a crucial role in the development of burnout:

- Personality traits
- Work-related attitudes
- Job features and aspects of the work environment

For the purposes of both diagnosis and treatment, all three components need to be considered in order to be able to identify the problem as accurately as possible and treat the individual in a targeted manner.

3 **In order to prevent burnout as effectively as possible and stay healthy and productive, it is helpful to become involved in various areas of life, known as the "Four pillars of health preservation", so that each area is available as a resource for the other areas:**

1. Achievement and work
2. Social activities and relationships
3. Body and senses
4. Culture and the mental-emotional experience

A one-sided lifestyle that focuses only on the achievement aspect and neglects the other areas increases the risk of burn-out. It is important to find the "right" balance between the various areas, each of which will be weighted differently for each person.

4 **Burnout and exhaustion-induced depression can be treated successfully. The earlier the sufferer starts treatment, the quicker he will become productive again, and the lower will be the costs associated with the treatment and consequences of burnout (loss of income from work).**

In view of its complex nature, the treatment of burnout or exhaustion-induced depression has to be multimodal.

The main pillars of treatment should be as follows:

1. Exercise: be active
2. Relaxation: be mindful
3. Self-knowledge: be aware
4. Medication: be supported

Depending on the stage of the burnout or exhaustion-induced depression, treatment without medication is also possible. A case of manifest depression must be treated by a professional,

ideally by a doctor specializing in psychiatry and psychotherapy, and may possibly include drug treatment.

Psychotherapy (including short-term psychotherapy with subsequent coaching) that involves relatives and line managers in the workplace as effectively as possible is urgently recommended for overcoming burnout. If antidepressant drug treatment has to be continued in association with the psychotherapy, the prescriber should ensure that cognitive skills are not impaired under any circumstances, but are supported and promoted by the selection of appropriate medicines – also in order to foster the active cooperation of the patient during psychotherapy in the best possible way. Because, in addition to mood and drive, particular attention needs to be paid to the cognitive performance of the sufferer during reintegration in the workplace.

DEFINITION OF BURNOUT

Burnout as a state

When the psychiatrist Herbert Freudenberger first used the term in a medical context in the early 1970s in reference to volunteer helpers in a social facility for drug addicts, he described increasing exhaustion, a detached and cynical attitude among the social workers towards their clients and a negative attitude as regards their own performance (Freudenberger 1974). This burnout occurred in people who had previously approached their work with great commitment and enthusiasm, coupled with idealism.

Likewise since the 1970s, Christina Maslach, a social psychologist working in the Californian university town of Berkeley, has also been studying people in stressful jobs and how they cope with their emotional stresses. She formulated the **three key aspects of a burnout state**, similar to Freudenberger's own formulation (Maslach 1982):

Emotional exhaustion is a state in which people feel **emotionally drained.** They are no longer able to empathize with others or think and act empathetically.

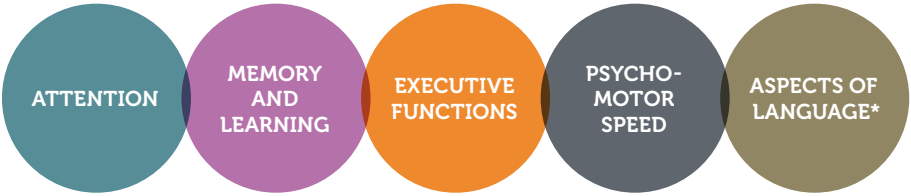
Depersonalization is a technical term which, in this context, refers primarily to the **negative perceptions and negative feelings** of people towards their customers or colleagues in a work context and which had not existed when they started work. This entails a change in the attitude of sufferers to other people who are significant in the work environment. The burnout victims are also perceived differently by those around them: "I don't know who you are anymore." They also feel that they are "different".

Reduced personal accomplishment means that those affected feel that their **professional competence is reduced,** and that their competence increasingly deteriorates in reality. They have the feeling of being unable to achieve what they are actually capable of, and what should and might be expected of them based on their qualifications. Since this can also lead to mistakes, and since sufferers may take significantly longer to carry out their tasks, those around them at work and family members will also notice this sooner or later.

Nowadays, many sufferers work in the services and communication industry. Some are particularly prone to adverse cognitive effects due to the nature of their work. For example, the important abilities of our brain to receive, process, "file" and retrieve information. Or distinguishing between what is important and what is unimportant, being able to set priorities, filtering, mentally preparing targeted activities and subsequently carrying them out. And achieving all this at a rapid processing speed and with the ability to switch focus quickly from one task to the next.

In this connection, specialists refer to **"cold cognition"** on the one hand and **"hot cognition"** on the other.

Specifically, **"cold cognition"** refers to the following activities:



"Hot cognition" refers to emotionally-laden cognitive skills, for example:

Depressed patients are known to experience problems with planning, their concentration is impaired, they react more slowly and have trouble remembering things (Hammar and Ardal, 2009; Elliott, 2003).

* (sentence construction, non-emotional semantics, i.e. meaning of words)
** (emotional semantics, i.e. meaning of words, emotional intonation and rhythm of speech)

A study conducted in 2012 showed that 52% of interviewees suffering from depression said that they were greatly handicapped at work, or had even had to stop work, due to cognitive impairment (Lam et al., 2012).

Another study found that 27% of depressed patients reported moderate cognitive complaints, while 13% even described these as serious/severe. The main problems cited were poor concentration and memory problems, although slow thinking and word-finding problems were also mentioned (Iverson et Lam, 2013).

Various universally known standard tests are available to doctors and therapists for identifying cognitive impairment.

In everyday functioning, the following questions can help you, work colleagues or family members identify or point out **signs of cognitive impairment**:

Do you find it difficult to make decisions at work or in your private life? If so, why?

Do you find it difficult to read, and absorb and understand, newspapers, letters or reports?
How about television programmes or conversations?

Do you frequently misplace things, e.g. keys, or forget the names of acquaintances or things that you wanted to buy?
Do you lose the thread when carrying out tasks at home or at work?

Do you have difficulty starting or ending completely familiar and usual tasks at work or in your private life?

Do the above-mentioned problems have a (negative) impact on your everyday life?

Aaron*

Experienced and conscientious social worker, feels drained, 48 years old, married, two children.

Experienced professional with managerial responsibility. Conscientious. For years fully committed to his clients and staff. Increasingly works overtime, but also works at weekends in order to deal with the paperwork. His family life suffers as a result.
Internally, he increasingly reacts aggressively towards clients, but really dislikes doing so and therefore feels ashamed because he wants, and is supposed, to help. Feels drained, as if his head is "empty", would ideally prefer just to stay in bed in the mornings. Suffers from severe concentration problems, forgetfulness and word-finding problems, and even forgets the names of clients that he has known for years. Doesn't recognize himself as this person and is therefore increasingly anxious. Also receives feedback to this effect from colleagues, but outwardly still brushes this aside.

**actual case, but not his real name or photo*

Burnout as a developing process progressing to exhaustion-induced depression

When we doctors see a sufferer at a particular point for the first time, we can identify and describe certain symptoms and behaviours. When we ask about the history or listen to the reports of relatives and work colleagues, then we quickly realize that the current status is part of a developing process that has, all too often, already been progressing for many months, or even years, by the time the psychiatrist is consulted.

A coherent development process of burnout that can frequently be observed in clinical practice is described by Professor Matthias Burisch of the psychology faculty of Hamburg University, who defines seven phases (Burisch, 2013):

7. DEPRESSION AND DESPERATION PHASE

Phase one with the initial warning signs is characterized by an **increased commitment to certain goals at work**, which can manifest itself as increased overtime at the workplace. The sufferers and their relatives may notice **the first signs of exhaustion, with fatigue and loss of motivation to do other activities.** Autonomic overreactions are frequently observed, in terms of completely non-specific physical symptoms such as gastrointestinal reactions, increased sweating, dry mouth, mild headaches, dizziness, sleeping problems, etc.

In the reduced commitment phase, the sufferer appears **socially withdrawn**: He tries to avoid being exposed to external influences. He becomes more taciturn, shows the first negative attitudes to his work, perhaps in certain asides, and often appears "more egoistic", more focused on his own interests. It seems to others as if he is wearing blinkers: **narrowed outlook, as if cut off, a stranger.**

Of course, these changes occur seamlessly and, without noticing it, the sufferer soon enters the **third phase, the phase of emotional reactions with feelings of inferiority and pessimism.** These are frequently accompanied by finding fault with other people, which can additionally lead to interpersonal stresses. The developing burnout process is often further fuelled by the subsequent hostile or irritated reactions of these other people. The sufferer's negative perceptions of himself are confirmed from the outside, which reinforces his internal perception of himself and accelerates the negative spiral of the process.

The **fourth phase** then manifests itself, which involves a **decline in the sufferer's cognitive skills, with a loss of motivation, problems with concentration and memory, a slump in creativity and a deteriorating flexibility and ability to set boundaries.** Both the sufferer and those around him notice forgetfulness, lack of concentration, and consequent mistakes at work by virtue of their crucial significance to our service-based economy, with the corresponding need for interpersonal skills. The negative spiral is fuelled and turns downwards ever faster.

In my practical experience, the **fifth phase** described by Burisch, during which **emotional and social life flatten,** is then observed in burnout victims at this time. They become apathetic, avoid any form of contact with others if possible, and are no longer able to empathize with others or think empathetically. **They become emotionally "blunted".** They can no longer experience pleasure, or can only do so to a reduced extent. Their interest in things that were once important to them disappears. As an important warning sign in this phase, sufferers often abandon previously cherished leisure pursuits or hobbies, which normally also contributes to a further escalation of the burnout process. **By this time at the latest, burnout victims suffer from so-called anhedonia** (Snaith P., 1993; Keller J et al., 2013). They are listless and joyless, and frequently lose their appetite. Sexuality is also affected. Anhedonia is an important **core symptom of the impending exhaustion-induced depression.** Medical and therapeutic help is needed.

Burisch describes the **sixth phase as the psychosomatic reaction phase** Although psychosomatic reactions, strictly speaking, are already apparent in the first phase in the form of mild autonomic symptoms, in the sixth phase according to Burisch these become **distressing symptoms that take centre stage** in the life of the sufferer: tense muscles with various types of pain, whether headaches, back pain, limb pain or sleeping problems of all kinds (difficulty falling asleep or staying asleep and waking up early in the morning) are characteristic findings at this stage. In their free time, even during a holiday lasting several weeks, **burnout victims are no longer able to recuperate.** There is often a change in their eating habits: some hardly eat anything anymore, while others eat too much. Very frequently they will increase their intake of alcohol or other drugs in an attempt to change course and achieve a certain degree of functioning despite their pitiful state.

In this phase, **the possibility of adjustment disorders with depressed mood, or anxiety and obsessive-compulsive disorders should be considered.** Or other so-called somatoform disorders in which the sufferers experience and report various pains or functional disorders of organs,

even though these cannot be confirmed by physical investigations. In this stage, it is possible that, in addition to the burnout or worsening exhaustion-induced depression, other psychiatric illnesses may need to be diagnosed. Sometimes there is a recurrence of a previous illness, e.g. recurrent episodes of depression, anorexia, alcohol abuse or similar conditions. These will also need to be treated of course.

The possibility that the listed, usually unspecific (stress-related), **symptoms may also cause an underlying physical illness should obviously not be forgotten.** These can include the following: anaemia, iron deficiency, an underactive thyroid (hypothyroidism), renal impairment, Lyme disease, HIV, tuberculosis, cancers, inflammatory (rheumatic) disorders, degenerative diseases of the central nervous system in the brain and/or spine, sleep apnoea syndrome or side effects of medication (Korczak, et al., 2010). As regards the required treatment, it goes without saying that, in accordance with the diagnosis to be confirmed, whether psychiatric or medical, an evidence-based and disorder-specific strategy according to the prevailing standards is required.

Unless appropriate countermeasures are taken, the sufferer moves more or less seamlessly to the **seventh phase according to Burisch, the depression and desperation phase.** This involves **feelings of futility, a profoundly negative attitude with extreme anxieties about the future and existential desperation.** This can lead to suicidal ideas and, in the worst-case scenario, to suicide itself. Moderate or severe cognitive impairment and listlessness are typically observed in most cases. By this stage at the latest, from the psychiatric standpoint and based on the prevailing symptoms and the international classification of mental disorders, **moderate or even severe depression in the sense of the exhaustion-induced form of depression will need to be diagnosed.**

Peter*

For years a successful businessman, married, two children of school age, enthusiastic mountain hiker, sporty, 52 years old.

Over the past two years has noticed an increasing decline in his performance, while also feeling that "it's just work and more work". Hardly has time for his family. Hasn't been hiking in the mountains for a year. Also takes no other form of exercise.
Has been brooding a lot for the past six months and therefore has great difficulty sleeping. Makes mistakes at work, is forgetful, can hardly concentrate anymore during meetings. Feels overwhelmed by everything and worries about increasingly losing control. Depressed, suicidal thoughts. Three-week summer holidays as a self-prescribed measure brought no improvement: no recuperation. Has therefore decided to consult a psychiatrist for treatment.

**actual case, but not his real name or photo*

CAUSES AND CONTRIBUTORY FACTORS FOR BURNOUT AND EXHAUSTION-INDUCED DEPRESSION

This section presents the specific factors that are assessed in the emergence and development of a burnout process, progressing to exhaustion-induced depression.

Personality traits

We all possess **"strengths"** and **"weaknesses"**. Everyone can doubtless agree with this general statement. Moreover, when we judge our partner, our friends and acquaintances, staff or colleagues accordingly, we quickly realize: We all have our strong sides – as well as our weaknesses.

From the psychotherapeutic standpoint, it is especially **important that we should be aware of our strengths and weaknesses.** This enables us to act appropriately depending on the context of the situation in which we find ourselves. And it is very important here that we may need to protect ourselves in respect of our weaknesses and "not hide our light under a bushel" when it comes to our strengths. It is also conceivable that a typical behaviour that represents a strength in a work-related context may be a weakness in private life. Resilience research examines how we can use our strengths to remain "healthy" even in difficult times and situations. A skill that has been thoroughly put to the test this past year (2020)!

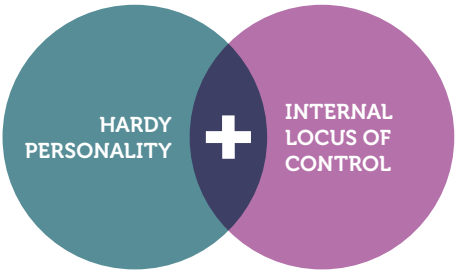
There is evidence to suggest that **people with certain personality traits are at higher risk of suffering from burnout.** But there is also evidence to indicate **that certain personality traits reduce the likelihood of burnout,** i.e. can protect against the possible development of burnout. These include **personality traits such as the committed pursuit of everyday activities, a positive internal locus of control in relation to external events and being receptive to change** (Pierce et Molloy, 1990). Individuals with these traits are described as having a **"hardy personality"**.

It has also been shown that some people cope with certain stress situations without negative consequences for themselves, while others suffer from burnout as a result. There appears to be a connection with a person's own assessment of a situation: People who experienced a situation as a threat were more likely to suffer from burnout than those who saw such a situation as a personal challenge (Gomes, Faria & Goncalves, 2013).

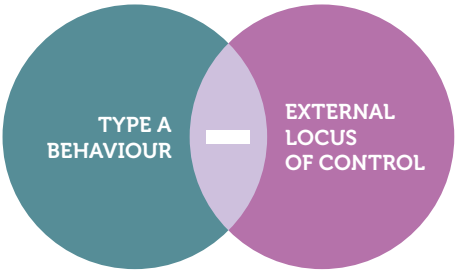
This means that people have an increased burnout risk if they tend to see themselves as being subjected to the influence of others or to chance, i.e. in practice they feel as if they are at the mercy of external factors and other people ("external locus of control"). People who tend to feel anxious, who are very sensitive and tend to react with a depressed mood or a dismissive or hostile attitude frequently feel they are "at the mercy" of other people and things. They believe that they have little power and assertiveness when it comes to themselves and their own actions. And they have an increased risk of suffering from burnout.

But, interestingly, it has also been observed that people with so-called **"type A behaviour" are also at an increased risk of suffering from burnout or cardiovascular illnesses** such as heart attacks (Miller, 1996). People with type A behaviour are very competitive, lead a success-oriented lifestyle and prefer to work under time pressure. Another typical feature of people with type A behaviour is a particular need to maintain control of their direct environment (both personal and professional).

Personality traits that reduce the risk of burnout:



Personality traits that increase the risk of burnout:



Although certain personality traits doubtless have a genetic dimension and are, to a certain extent, inalterable, it should be borne in mind that, at the behavioural level, a person is capable of learning throughout life. He can replace what are, for him, obstructive or even negative behaviour patterns during the course of his life by more appropriate strategies if these will simplify his life or increase his quality of life. But for this to happen, the person concerned needs to be perceptive and aware of the situation. This is the basis for any change process.

Work-related attitudes

It is relatively easy to see that **high or even unrealistic expectations of oneself and of work-related tasks can lead to a burnout state.** Everyone is likely to be familiar with the frustration experienced in daily life when the actual situation does not match the desired situation. The greater the discrepancy between these two situations and the more often it occurs, the more likely it is that we will fail to achieve the goals that we have set ourselves, or that have been set for us.

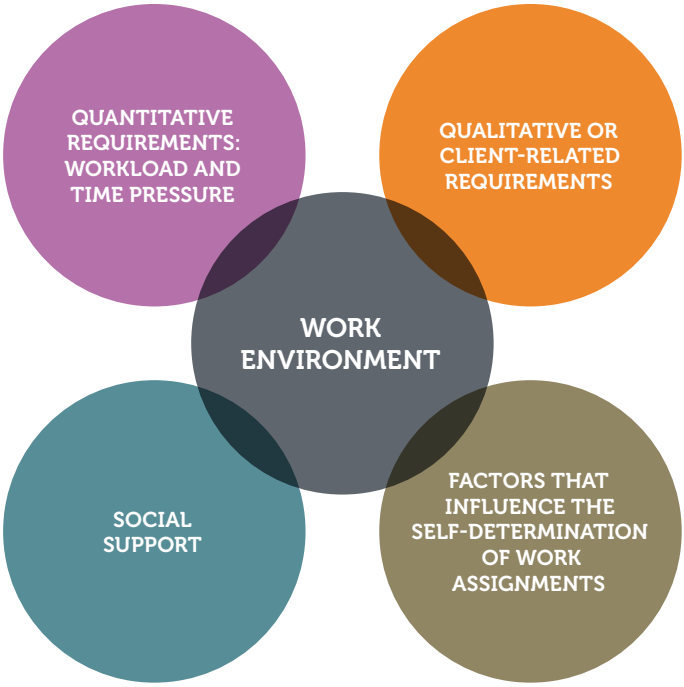
This is bad for our self-esteem and can – like the constant dripping that wears away the stone – cause us to lose any form of belief in ourselves, and therefore any motivation.

It is precisely those people who approach their tasks with a high degree of commitment and emotional involvement who are therefore at an increased risk of experiencing a burnout process. Since the personal and emotional commitment of the person concerned is very often not appreciated in today's work environment, and it is only the result, the "outcome", that counts, this can lead to great frustration and disappointment.

Of course, work-related attitudes have a lot to do with the personality traits of the person concerned. For example, there is clear evidence to indicate that people with a rather obsessive perfectionist view of things become disappointed with themselves sooner than others and are also more likely to experience frustration. At the same time, an orderly, target-oriented behaviour that strives for "100% performance" is highly regarded in our society and is even promoted as early as our school days. **So we have to ask ourselves how, at the individual level, we can sensibly deal with what are perfectly legitimate, but also ambivalent, requirements of our society.**

Job features and aspects of the work environment

As regards the features of our activities and the aspects of the organizational environment, four different dimensions can be scrutinized:



Various authors have shown that a **high workload and time pressure are associated with an increased occurrence of burnout** (Schulze, 2005). The more work we have to do in increasingly less time, the higher will be our stress level. If this situation lasts for just a short time, then most of us will manage to cope. But if it persists, sooner or later every one of us will experience a burnout process in such circumstances. We are put in a Sisyphus situation where, like a hamster in its wheel, we become more and more exhausted – and never arrive, never reach our destination or achieve our goal.

Certain jobs or task assignments are very obviously associated with an increased risk of burnout. **This appears to be due to qualitative, client-related requirements.** The more often and the longer one works directly with patients or clients, the more serious the problems of these clients or patients become, and the greater the risk of burnout (Schaufeli and Enzmann, 1998). Although burnout is often perceived as a "manager's disease", it should not be forgotten that the initial descriptions by Freudenberger and Maslach referred to people in social occupations and service providers in healthcare as the primary candidates for experiencing burnout. But it has also been observed that **role conflicts in the job setting are associated with an increased risk of burnout.** Role conflicts refer to situations in which contradictory expectations are placed on the person concerned as part of their job. Other major **risk factors for burnout are unclearly defined tasks or vague, ill-defined job descriptions and requirement profiles.**

Social support naturally plays a crucial role. We all strive for a high degree of autonomy, i.e. self-determination and personal responsibility. And yet we are all dependent on others and need support and encouragement to enable us to continue doing a good job in the long run, especially at times of high work pressure and uncertainty. **Feedback, encouragement and constructive criticism can work wonders here** if they come from the heart. Conversely, this state of affairs can be repurposed into an insidious weapon (bullying). At this point, every person with managerial responsibility should be aware of the importance of a

friendly "good morning", constructive feedback on the completion of a task by an employee or simply an inquiry about his general well-being. It is a question of how we want to deal with each other and how we also wish to convey the feeling of **"being noticed", "being taken seriously"** and "belonging" in relationships that are not emotionally close. All these points are fundamentally important in making each and every one of us feel good about ourselves.

At a time when we are trained and encouraged to become autonomous, it is of course only logical for us to want to perform our assigned tasks with the greatest possible self-determination and flexibility. But management styles still exist where the individual employee is treated as a mere "assistant" – and then also feels correspondingly downgraded. Nowadays, it is important for employees to have their own decision-making powers, be jointly involved in relevant decisions and be able to identify as closely as possible with their work and their company/employer. Various authors have shown that the **acceptance of responsibility and positive engagement with professional life are important factors in health promotion in the workplace, and therefore also count as anti-burnout measures** (Karasek et al., 1988; Lee and Ashforth, 1996).

Another article (DGPPN, 2012) discusses the possibility that the **constant changes and new requirements in the world of work may play an important role as triggers for burnout. Globalization** is also mentioned, since it leads to ever-growing competition in business life, entailing corresponding stressors such as job cuts and rationalization measures. Particularly for older people who have not grown up with computers, the technology associated with the **digitalization of the world of work** poses a challenge that can overtax them and lead to burnout states. The **issue of constant availability** through e-mails and mobile phones is obviously a significant factor. The boundaries between the world of work and private life are becoming blurred. And this is just the tip of the iceberg, since there are many other underlying phenomena in our increasingly digitalized society.


GOOD MORNING
HOW ARE YOU?
WELL DONE!
WE REALLY APPRECIATE YOUR COMMITMENT !
WHAT'S YOUR TAKE ON THIS?

Sarah*

Successful and committed journalist, unmarried, no children, 42 years old.

Accepts every job, does not distance herself from others, is full of enthusiasm, which is welcomed by her employer and places great expectations on her. But she then becomes aware of rejection and jealousy among her colleagues. Is no longer able to relax, sleeping problems. Tries to appear even "stronger and faster" to others so that they don't see her exhaustion. Worries about losing her job and the sympathy of her line manager, increasingly aware of a discrepancy between her expectations of herself and those of others and her internal exhaustion. Worries about taking time off in order not to jeopardize her position in the company. In a psychotherapy session admits that she probably should change her attitude towards the situation. "What do I really want from life? What is really important?"

**actual case, but not her real name or photo*

MAINTAINING QUALITY OF LIFE AND PERFORMANCE BY PREVENTIVE ACTION

This section deals with the frequently cited concept of **"work-life balance",** although I do not like the contrast suggested by this term: Hopefully, this "division" of our life into a work area on the one hand, and an "actual life" on the other does not correspond to our perception. Or does it? Based on Nossrat Peseschkian's "Positive Psychotherapy" (Peseschkian, 1999), I define **the following four pillars as fundamental cornerstones in preserving health and preserving our performance:**

1. Achievement and work

2. Social activities and relationships

3. Body and senses

4. Culture and the mental-emotional experience

The basic idea here is that we should make every effort to do something for ourselves in these areas in order to achieve a balance. The cross-fertilization and refreshment produced by living in these various areas and by committing ourselves to these areas in our life produces the necessary balance for preserving health and well-being.

Achievement and work

Achievement is closely tied up with our daily work, our job. In our society, achievement is a very important factor, particularly as regards the regulation of our self-worth. It also involves existential security as a basis for any other sphere of life. We have to "invest" in work and the achievement principle. Deep down, we also want it. **The feeling of self-efficiency, i.e. that we can achieve something by our own actions, is deeply satisfying and crucially important for our self-esteem.** Self-esteem is not stable in its dimensions. It is gradually worn away in our daily routine, and we should do something every day to maintain it. And the more

consciously we do it, ideally with joy, the better. But we also need to accept unpleasant aspects of our work, loosely in line with the saying that there are two sides to every coin, or that where there is light, there is always shade as well. And as long as we are rewarded fairly and our income is sufficient to finance our essential needs and obligations, we can basically consider ourselves to be very fortunate. On the other hand, there is also the well-known saying that money alone does not make us happy. But when we don't have enough money, life is no longer pleasurable in our consumerist society, because the resulting social exclusion is directly noticeable.

Social activities and relationships

Social activities are of crucial importance to our mental health. We not only live in relationships, we live for them. Our partnerships, being integrated in a family context, our activities with friends and with our colleagues in the workplace are what make us feel noticed, reflect us and nurture us. We can be there for others, and others can be there for us. We feel noticed, that we have been responded to, and find consolation, intellectual and emotional interaction. We take inspiration from our counterparts. We feel as if we belong: an important basic human need. **Community offers protection!** Challenging and encouraging as a key human interaction in order to develop ourselves and support others in their development. **"Life is living in relation to others".**

Body and senses

The third cornerstone **or main pillar of preserving health is our body, our whole conscious experience through our senses.** This area includes our diet, regular exercise and sport, although the latter is considered not so much from the standpoint of achievement, but rather from the aspect of the pleasure principle. Healthy and regular sleep. Tenderness and sexuality. "Wellness" measures, such as taking a relaxing bath or indulging in a massage, are just as important here as **mindfulness as a recommendable basic attitude** towards how we engage with things and people – including ourselves. The concept of mindfulness, which comes from the discipline of Zen Buddhist meditation, refers to the conscious perception of what is happening around us now, in this moment. It is important here to adopt a non-judgemental, accepting attitude from the outset. **In mindfulness, particular attention is paid to sensory perception: What do I see now? What do I hear in this moment? What do I feel on my skin?**

The psychotherapeutic literature focuses strongly on mindfulness, both in prevention, or prophylaxis, and treatment. Marsha Linehans' concept of dialectic behavioural psychotherapy in people with borderline personality disorders includes mindfulness as a key element of the overall treatment. This type of treatment has become established in recent years in almost all psychotherapy wards in German-speaking countries. Worth noting in this context is the mindfulness-based stress reduction (MBSR) programme run by Jon Kabat-Zinn and his team at the Stress Reduction Clinic, Massachusetts (1985). One study showed that people who were trained in mindfulness and meditation after suffering an episode of depression were less likely to suffer relapses compared with a group of other previously depressed clients who had not received this training (Bishop, 2002).

Culture and the mental-emotional experience

I define the fourth main pillar as cultural life and the mental-emotional experience. Important moments in our life and how we can experience them, for example when listening to or performing music, reading a gripping novel or watching a thrilling movie. When, lost in daydreaming, we just let things happen. Including our inner grappling with spiritual and religious questions. After all, deep down all people ponder questions such as **"Where do we come from?", "Where are we headed?"** and **"Why?" These are important questions and should be sensibly integrated in a fulfilled, balanced life.**

Someone who defines their life solely in terms of their achievements, and is involved only in this aspect, runs the risk of ultimately becoming exhausted.

The model of the four main pillars for preserving health is based on the idea that we become involved in various areas through our personal commitment. Of course, it takes time, "nerves" and possibly money as well. But ideally we should receive back from all the various areas something for ourselves that gives us, in another area, sufficient strength, courage and energy to do what we, and also those around us, expect of ourselves. And if difficulties arise in one area, for example as a result of partnership problems, loss of family members or physical illness, it is good to obtain balance, strength and courage from the other areas, so that we are able to persevere in the area that is under stress and overcome the imminent challenges.

THE FOUR PILLARS OF HEALTH PRESERVATION

ACHIEVEMENT

WORK

FINANCES

SOCIAL ACTIVITY

RELATIONSHIPS

PARTNERSHIP

FAMILY

BODY/SENSES

DIET

SEXUALITY

MINDFULNESS

EXPERIENCING NATURE

EXERCISE

"PLEASURE PRINCIPLE"

SLEEP

"CULTURE"

MENTAL-EMOTIONAL EXPERIENCE

MUSIC

READING

DAYDREAMING

SPIRITUALITY

by Joachim Leupold

James*

Successful businessman who has recovered from severe burnout, 55 years old, married, three grown-up children.

Severe burnout with exhaustion-induced depression three years ago, having been completely absorbed for years in his business and neglecting family, sport and a healthy diet. Managed to weather and constructively deal with a difficult phase in the business without a relapse after resuming regular mountain biking and skiing sessions, taking out (and also making use of!) an annual subscription to the opera with his wife, cutting down on his alcohol intake and eating a balanced diet (with corresponding counselling). Regularly performs relaxation exercises (including in his office).

**actual case, but not his real name or photo*

THERAPEUTIC OPTIONS FOR BURNOUT AND EXHAUSTION-INDUCED DEPRESSION

It is surprising to hear certain people alleging that a burnout sufferer is automatically damaged for ever, or possibly becomes an invalid and is never able to achieve anything or work again. This assessment does not apply in the vast majority of cases because, with our existing knowledge about burnout processes and burnout states, we can help a lot of people: both therapeutically and also in preventing a second burnout. But at the same time, it should not be denied that there are situations and co-morbidities, i.e. illnesses present at the same time, where people who have experienced a burnout can, in fact, no longer be reintegrated, or only partially reintegrated, in working life.

The treatment and rehabilitation of an individual with burnout and exhaustion-induced depression require commitment on the part of the sufferer himself, and also equal effort on the part of people in his personal life and his employer. It is often the case that adaptations in the workplace are needed to facilitate the reintegration of the burnout victim as effectively as possible. But there may also be a need to change jobs: What is worse for a company and sufferers than the fact that the wrong person is working in the wrong job? Or there is also the phenomenon of so-called **"presentism": employees who, although present in the workplace, do not do their work, due to illness.** An underestimated phenomenon that costs companies a lot of money. For the sufferer, this behaviour is often motivated by fear of losing their job.

The process of rehabilitation and reintegration requires caution, effective agreements and a lot of understanding. Based on my own experience, I recommend a trialogue between the doctor/therapist, patient and employer/line manager. Naturally, this is all subject to professional confidentiality. A certain sharing of information about the condition has been shown to be extremely helpful and can help minimize any rumours or "fantasies" among line managers and colleagues. This can alleviate the pressure and thereby make a significant contribution to effective reintegration. Particularly in the initial phase of reintegration in the workplace, residual symptoms, i.e. **remaining cognitive symptoms** are often present. Many sufferers report the continuation of noticeable problems

with comprehension and concentration after their mood and drive have improved. These can be countered by various measures: In addition to effective agreements with the line managers in the workplace and a step-by-step increase in the workload – both in terms of quality and quantity – medication can play a very important role particularly as regards cognitive impairment.

Matching the four pillars of health preservation, the **"four pillars of treatment for burnout victims"** are applicable here:

1. Exercise: be active

2. Relaxation: be mindful

3. Self-knowledge: be aware

4. Medication: be supported

Exercise: be active

It has long ceased to be a secret: **Exercise is the best antidepressant!** In the overall treatment of depression, activation through exercise plays a crucial role. Various investigations, including recent studies, have repeatedly demonstrated the positive effect of moderate exercise, ideally outdoors in order to "ventilate" depressive states (Kvam, 2016; Coon, 2010). This is not surprising since **the current genetic make-up of humans was "designed" for life outdoors**, when hunting and gathering formed the basis for self-preservation.

So it is alarming to note that so many of us earn our daily bread working in a sitting position for hours on end, even for the majority of the day, as if "confined".

This is why moderate exercise, certainly not as performance-oriented sport but rather as a low-key and mindful instrument for preserving our health, naturally plays a major role in treatment as well. In various institutions where people with burnout disorders are treated, endurance sports such as Nordic walking, cycling, hiking, jogging, aquafit, dancing, fitness training and many others have become an established part of the treatment. Moderate strength training practised regularly is also recommended and used to help sufferers regain a positive and satisfying feeling of self-worth.

Relaxation: be mindful

Ideally, the above-mentioned activation and exercise **should be in a sensible proportion to relaxation**. Just as the ocean washes against the mainland and then withdraws after each wave breaks, a space seems to open up, between systole and diastole, between exertion and relaxation, that keeps us constantly healthy and effective. This includes **targeted relaxation, mindful interaction with ourselves and the things around us, as a central component in a comprehensive treatment plan.** The previously mentioned study by Kabat-Zinn has proved that, in addition to actively engaging in sports, regular meditation and mindfulness exercises are important in preventing relapses in depressive and psychovegetative syndromes.

Medical hypnosis, autogenic training or complementary treatments such as traditional Chinese medicine (acupuncture, qigong), can make a valuable contribution here, and one that can be integrated in the daily routine.

A short relaxation ritual in the workplace, e.g. the conscious use of the progressive muscle relaxation technique according to Jacobson (PMR), or imagining a learned "safe place" can prevent relapses and provide optimal support in the treatment of burnout so that the sufferer can return to work in a balanced and effective condition.

Self-knowledge: be aware

The previously mentioned concept of mindfulness, i.e. the conscious perception of things around us through our senses in a non-judgemental way, **is closely connected with our self-perception.** That's why professional psychotherapeutic treatment should always be a key component of the treatment of a burnout sufferer. As time goes on, during or after the rehabilitation in the workplace, the treatment should definitely be continued. The aim here is to **employ and implement new strategies at the behavioural level.** These strategies must be developed from behavioural analyses that take account of dysfunctional, i.e. potentially self-destructive, behaviour.

This involves trying out new approaches in a conscious learning process adapted to the individual needs of the sufferer. Behavioural therapy strategies, such as the self-management technique proposed by Kanfer et al. (2000) can, as part of brief psychotherapy, quickly lead to very encouraging results and facilitate a positive turnaround and recovery.

The psychotherapeutic process constantly revolves around the question of what we ourselves can change and, on the other hand, what we must also accept. The underlying issue is whether we can achieve an improvement for ourselves and those around us by changing our behaviour. But in the context of the overall process, it can also involve targeted occupational coaching, with the possible involvement of corresponding experts. But in any case, the contact between the treating therapist and the employer or the responsible individuals in Human Resources (HR), subject of course to the consent of the sufferer, is a very helpful and important instrument for addressing aspects of the work environment and, with the support of the line managers, coming up with a constructive solution.

In this context, **systems therapy sessions** should be discussed. This refers to the **involvement of family members or line managers and colleagues** in therapeutic discussions in order to help the sufferer

reintegrate in everyday life as effectively as possible and to support the therapeutic process as effectively as possible by means of careful, situation-appropriate communication.

In addition to the systemic aspects of treatment, the focus on behavioural therapy measures and the learning of relaxation techniques, it has been my own experience that the psychotherapeutic process repeatedly addresses very existential aspects of life and of being. Shaken by their burnout, the sufferers experience feelings and thoughts that need to be identified, examined and developed. And many come to **realize that it was actually an opportunity for them.** A realization that enables them to make positive changes in their individual futures.

Medication: be supported

Drugs can play a truly life-saving role in the acute phase of depression, during which the sufferer may be showing acute suicidal tendencies. But, as already mentioned above, they can **also be very important in the workplace reintegration process,** and need to be assessed and, if necessary, adapted based on their mood-enhancing and energizing effects, including as regards their positive effects on the sufferer's cognitive performance. Here, the professional advice of a psychiatrist or psychotherapist, taking account of the core symptoms, is absolutely essential, especially given the **objective of preventing a relapse in the best possible way.** As with other depressive disorders, the risk of a further burnout or exhaustion-induced depression is particularly high especially after a corresponding episode. This means that the sufferer requires close observation and support during the first six months or, for a repeated episode of exhaustion-induced depression, as long as the whole of the first year.

In addition to benzodiazepines, i.e. sleeping pills and tranquillizers, which can help calm the worst states of restlessness and desperation in an acute phase, **antidepressants are very important in the treatment of severe burnout states, cognitive impairment and exhaustion-induced depression**. Well-tolerated modern antidepressants are definitely the drugs of choice here and play a vital role in the clinical routine. They can afford the sufferer fresh impetus and stability, giving them the strength and motivation in the first place to embark on the previously described programme of exercise, relaxation and psychotherapy sessions. An antidepressant is now available that may well have a particularly positive effect specifically on cognitive performance, thanks both to its very good side effect profile and its multimodal activity. A one-sided consideration of mood and drive could have serious consequences in terms of a rapid relapse, given that our cognitive abilities or deficits always influence our mood and our actions in a very direct manner. In our service-based economy, effective reintegration in the workplace requires not just a good situation as regards mood and drive, but also good cognitive functioning (concentration, memory, attention, adaptive capability).

Medication should be viewed like a crutch for a patient with a broken leg: After the leg has been surgically repaired and stabilized, the bone starts its self-healing process, and the muscles start to rebuild. To enable the leg to get used to increasing loads and gradually recover, it still requires support for some time. To this end, we use a crutch for the period during which the leg is unable to bear the full weight of the patient. Similarly, treatment with an antidepressant is recommended for burnout states with manifest depression. The rules for their use are based on the current recommendations for the treatment of depressive disorders.

THE FOUR PILLARS OF TREATMENT FOR BURNOUT

EXERCISE

BE ACTIVE

RELAXATION

BE MINDFUL

SUFFERERS

SELF-KNOWLEDGE

BE AWARE

MEDICATION

BE SUPPORTED

by Joachim Leupold

Thomas*

Acutely suicidal, severely depressed banker, 45 years old, four children of school age, married.

Over the past three years has become increasingly exhausted, pessimistic and unmotivated, despite having always enjoyed his work. Often irritated due to his bad mood, causing marital problems. Intensive outpatient psychiatric and psychotherapeutic treatment, including medication (antidepressant and benzodiazepine during the acute phase with suicidal tendencies), two sessions a week. Completely unfit for work for three months. Personal communication with his line managers concerning these problems (for which the sufferer waived the requirement for medical confidentiality). A gradual improvement was accompanied by activation with moderate sport (initially medical training therapy indoors, subsequently outdoors), learning relaxation exercises, integration in the daily routine. Couples therapy with instruction in the communication culture between husband and wife. Gradual reintegration in the workplace, starting with 50%, increasing in half-day increments (10%) over a period of six months. Is now fully integrated back in the workplace. Confident. Better at setting boundaries, better time management. Observes the main pillars of health preservation.

**actual case, but not his real name or photo*

REFERENCES

Berger M, et al. Positionspapier der Deutschen Gesellschaft für Psychiatrie, Psychotherapie und Nervenheilkunde (DGPPN) zum Thema Burnout. Berlin. 2012. **www.dgppn.de**

Bishop SR. What do we really know about mindfulness-based stress reduction? Psychosom Med 2002;64:71–84.

Burisch M. Das Burnout-Syndrom. Berlin und Heidelberg. Springer Verlag 2013.

Coon T, et al. Does participating in physical activity in outdoor natural environments have a greater effect on physical and mental wellbeing than physical activity indoors? A systematic review. Environ Sci Technol 2011 Mar 1;45(5):1761–1772.

Dilling H, Mombour W, Schmidt MH. Weltgesundheitsorganisation: Internationale Klassifikation psychischer Störungen. ICD-10 Kapitel V(F) Klinisch-diagnostische Leitlinien. Verlag Hans Huber, Bern, Göttingen, Toronto, Seattle. 1991.

Elliott R. Executive functions and their disorders. Br Med Bull 2003; 65:49–59.

Freudenberger HJ. Staff Burnout. Journal of Social Issues 1974;30: 159–165.

Hammar A, Ardal G. Cognitive functioning in major depression – a summary. Front Hum Neurosci 2009;3:26.

Hochstrasser B, et al. Therapieempfehlungen des Schweizerischen Expertennetzwerks für Burnout (SEB); Swiss Medical Forum 2016; 16(25):538–541 / 16(26-27):561–566.

Iverson GL, Lam RW. Rapid screening for perceived cognitive impairment in major depressive disorder. Ann Clin Psychiatry 2013;25:135–140.

Kabat-Zinn J, et al. The clinical use of mindfulness meditation for the self-regulation of chronic pain. J Behav Med. 1985;8:163–189.

Karasek RA, et al. Job Characteristics in Relation to the Prevalence of Myocardial Infarction in the US Health Examination Survey (HES) and the Health and Nutrition Examination Survey (HANES). Am J Public Health 1988;78:910–918.

Keller J, et al. Trait anhedonia is associated with reduced reactivity and connectivity of mesolimbic and paralimbic reward pathways. J Psychiatr Res 2013;47(10):1319–1328.

Lam RW, et al. Canadian Network for Mood and Anxiety Treatments (CANMAT) 2016 Clinical Guidelines for the Management of Adults with Major Depressive Disorder: Introduction and Methods. Can J Psychiatry 2016;61(9):506–509.

Lee RT, Ashfort BE. A meta-analytic examination of the correlates of the three dimensions of job burnout. J Appl Psychol 1996;81:123–133.

Kanfer FH, et al. Selbstmanagement-Therapie. Ein Lehrbuch für die klinische Praxis. Berlin, Heidelberg, New York. Springer Verlag. 2000; 3. Auflage.

Kroczak D, Kister C, Huber B. Differentialdiagnostik des Burnout-Syndroms. Schriftenreihe Health Technology Assessment (HTA) in der Bundesrepublik Deutschland (Bd. 105). Deutsches Institut für Medizinische Dokumentation und Information (DIMDI), Köln, 2010.

Kvam S, et al. Exercise as a treatment for depression: A meta-analysis. J Affect Disord 2016;202:67–86.

Maslach C. Burnout. The cost of caring. Englewood Cliffs, NJ: Prentice Hall. 1982.

Miller TQ, et al. A meta-analytic review of research on hostility and physical health. Psychol Bull 1996;322–348.

Peseschkian N. Das Geheimnis des Samenkorns. Frankfurt am Main: Fischer Taschenbuch Verlag GmbH, 1999 mit freundlicher Genehmigung des Springer Verlages Berlin, Heidelberg, New York, 1996.

Pierce CM, Molloy GN. Psychological and biographical differences between secondary school teachers experiencing high and low levels of burnout. Br J Educ Psychol 1990;60:37–51.

Schaufeli W, Enzmann D. The Burnout Companion to Study and Practice. A critical analysis. London, Philadelphia. Taylor and Francis. 1998;1 ed.

Schulze B. Burnout heute. Quo vadis? – Risiken, Auswirkungen, Prävention. In: Burnout und Berufsleben, Ärzteschaft im Diskurs mit Human Ressource Management, Swiss Burnout 2005.

Snaith P. Anhedonia: a neglected symptom of psychopathology. Psychol Med 1993;23:957–966.

Swiss Expert Network on Burnout (SNB). Hochstrasser B, Schulze B, et al.: 2014 **www.burnoutexperts.ch**

SELF-HELP

Swiss Experts Network on Burnout (SNB):
www.burnoutexperts.ch

Swiss Society for Anxiety and Depression (SGAD):
www.sgad.ch

Equilibrium – Association for coping with depression:
www.depressionen.ch

Swiss Burnout:
www.swiss-burnout.ch

Self-help Switzerland:
www.selbsthilfeschweiz.ch

CH-BRIN-0619 sto.ch

Lundbeck (Switzerland) AG, 8152 Glattbrugg, www.lundbeck.ch