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Arno van Dam

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A clinical perspective on burnout: diagnosis, classification, and treatment of clinical burnout

Arno van Dam^{a,b}

^aTranzo Scientific Center for Care and Welfare, Tilburg School of Social and Behavioral Sciences, Tilburg University, Tilburg, The Netherlands;

^bDepartment Research and Innovation, GGZ WNB Mental Health Institute, Research and Innovation, Halsteren, The Netherlands

ABSTRACT

In clinical psychology, burnout is regarded as a mental disorder assessed in patients who apply for psychological treatment and no longer work because of their symptoms or experience of serious problems in functioning at work. This definition of burnout is mostly referred to as ‘clinical burnout’. The purpose of this article is to provide insight into how clinicians in The Netherlands establish a diagnosis of clinical burnout and how they fit it in their classification systems. An outline is given on how psychological interventions for burnout are applied in therapies. The different phases in the treatment of clinical burnout – crisis, recovery, prevention, and post burnout growth, as well as their accompanying interventions are described. It may be relevant for work and organizational psychologists to realize that biological processes may play a role in the development of clinical burnout. For the physiology of stress, it does not matter whether the stress is work-related or the result of stress in private life or both. Central to understanding clinical burnout is the lack of recovery of the (physiological) stress system. It is also argued that the relevance of questionnaires, for detecting who is at serious health risk, is limited.

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Burnout and clinical burnout

In mental health care, psychiatrists and clinical psychologists approach mental disorders like diseases. The nature and severity of symptoms determine whether you have the disease or not. A symptom is an observed or detectable sign of an illness or disorder, like fatigue, insomnia, fever, or pain. The combination of a number of specific symptoms is defined as a disease or disorder. This also applies to mental disorders like clinical burnout. You either have it or you don't. Having a disorder is therefore considered as qualitatively different from being healthy and comprises clinically significant distress or impairments (American Psychiatric Association, 2013). The onset and course of a mental disorder, like clinical burnout may comprise qualitative different phases that differ from each other with regard to symptoms, emotions, behaviours, severity, and coping (Åsberg et al., 2010; Carpenter et al., 2019). This conceptualization of (clinical) burnout differs from the definition that is used by work- and organizational psychologists who consider burnout as a multidimensional construct that is assessed with questionnaires in relatively healthy working populations (Schaufeli et al., 2001).

The definition of clinical burnout is usually based on the criteria of work-related neuroasthenia in the International Classification of Diseases (ICD-10; World Health Organization, 2010), and comprises the following features (1) persistent and distressing complaints of increased fatigue after mental effort, or persistent and distressing complaints of bodily weakness and exhaustion after minimal effort; (2) at least four of the following additional symptoms – insomnia, cognitive deficits,

pain, palpitations, gastroenteric problems, sound and light sensitivity. These complaints and symptoms (3) must be present nearly every day for at least two weeks; (4) are due to psychosocial stressors that have been present for at least six months before diagnosis; and (5) lead to clinically significant distress or impairment (Grossi et al., 2015; Persson Asplund, 2021; Schaufeli et al., 2001).

Fundamental to the difference between conceptualizations of burnout applied by clinical psychologists versus work- and organizational psychologists is the role of biology. Clinical psychologists conceptualize mental disorders from the bio-psycho-social model whereas work- and organizational psychologists mainly focus on psychosocial factors (Gatchel et al., 2020; Schaufeli, 2007; Weber & Jaekel-Reinhard, 2000). The addition of biology leads to a number of notable differences in the conceptualization of burnout. First, from a biological point of view, it does not matter whether the chronic stress is caused by working conditions or private circumstances or both. It is about the consequences of (chronic) stress for the functioning of the biological processes in the organism that also affect psychological processes and social behaviour (Sanders, 2014; Sapolsky, 1998). For clinical psychologists, burnout is therefore not necessarily work-related, but rather stress-related (Van Dam et al., 2015b). A second difference that arises from the biological perspective is that the development of clinical burnout is not regarded as a linear process but like many biological processes as a process with qualitative different phases (Sapolsky, 1998).

Another difference compared to the organizational approach, arises from the fact that clinical psychologists study abnormal emotions, thoughts and behaviour in individual

patients. Therefore, a considerable attention of clinical psychologists is paid to individual differences in maladaptive coping and psychological dysfunction, whereas less attention is paid to universal factors in human functioning like work- and organizational psychologists do. An aspect that may play a role in the development of psychological disorders is that individuals differ in the extent to which they are aware of their own feelings, thoughts and physical signals of stress (Eurelings-Bontekoe et al., 2009; Ginot, 2017). That is why scores on questionnaires are not always reliable. For clinical psychologists, people with elevated scores on a burnout questionnaire are not necessarily at risk for clinical burnout. Also, individuals with short-term stress (less than 3 months) show elevated levels on burnout measures, just like individuals with other mental disorders like major depression and anxiety disorders do (Kleijweg et al., 2013; Van Dam et al., 2015a).

It is essential to differentiate between short-term stress and clinical burnout, because short-term stress has a more favourable prognosis than clinical burnout. Research shows that an average of 80% of all employees with short-term stress recover within a few months and are partially or fully back at work within six to twelve weeks (Van der Klink et al., 2003). The recovery of clinical burnout, however, may take more than one year (Eskildsen et al., 2016; Van Dam et al., 2012b). Some studies show that even after 2 to 4 years, a substantial part (25–50%) of the patients with clinical burnout is not fully recovered (Dalgaard et al., 2020; Eskildsen et al., 2016; Van Dam et al., 2012b). Therefore, questionnaires and assessments that focus solely on symptom levels are not sufficient to make a distinction between clinical burnout and short-term work-related stress. It is important, however, to make this distinction, because the prognosis for recovery of clinical burnout is much less favourable than for the mild short-term stress disorders.

Both approaches, the clinical and work- and organizational, are useful and generate specific knowledge about stress, work, and fatigue. It is relevant to be specific about which definition is used because it is not known whether findings obtained in clinical populations are applicable to the general population and vice versa (Deligkaris et al., 2014).

Yet another reason to be specific about which definition of burnout is used is that there is discussion among clinicians and health insurance companies whether burnout is a mental disorder and qualifies for reimbursement (Grossi et al., 2015; Schaufeli, 2007; Van der Voort- van Beusekom et al., 2016; Van Dam et al., 2017). Clinical samples should therefore be homogeneous, consisting of persons with severe symptoms and fulfilling the work-related neuroasthenia criteria of the ICD-10 (Grossi et al., 2015; Persson Asplund, 2021; Schaufeli et al., 2001; World Health Organization, 2010). Research shows that this is not always the case, which is problematic because it may fuel discussion about the legitimacy of the diagnosis of clinical burnout (Bianchi et al., 2015; Van Dam, 2016).

Work- and organizational psychologists who take the burnout perspective of clinical psychologists may learn that particularly the combination of work-related stressors and stress in private life plays a role in the development of mild burnout symptoms into clinical burnout. In addition, work and organizational psychologists should be careful regarding the dominant role of questionnaires that is

prevalent in their work. In this article, I will show that the relevance of questionnaires is limited when it comes to detecting who is at serious health risk.

The purpose of this article is to provide insight into how clinicians establish a diagnosis of clinical burnout and how they fit it in their classification systems, despite the controversies about the phenomenon. Furthermore, an outline is given on how psychological interventions for burnout are applied in burnout therapies. In this way, I hope to show that tailor-made care is needed, not only in the field of clinical psychology but also in the field of work and organizational psychology. A crucial point is that people with the same score on a questionnaire may require different approaches to prevent mental illness. This is also relevant for work- and organizational psychologists who develop interventions for people at risk for burnout in the work-environment but also for researchers interested in different pathways to clinical burnout.

Diagnosis and classification of clinical burnout

A complication for clinicians to establish clinical burnout and differentiate it from mild stress disorders is that burnout is not included as an official disorder in the Diagnostic and Statistical Manual of Mental Disorders (DSM; American Psychiatric Association, 2013). In the International Classification of Diseases (ICD-10; World Health Organization, 2010), burnout is classified as a “State of vital exhaustion” (Z73.0) under “Problems related to life-management difficulty” (Z73), but it is also not considered a disorder. In their review, Grossi et al. (2015) showed that there is no consensus among clinicians which classification matches clinical burnout. The classifications used by clinicians are “work-related” neuroasthenia (ICD code F48.0), undifferentiated somatoform disorder (DSM IV code: 300.82; ICD code F45.1), severe stress and adjustment disorder (DSM IV code: 309.9; ICD code: F43.20), “other reaction to severe stress” (F.43.8), and major depression (DSM IV code: 296.xx.; ICD code F32.xx). In some studies, clinically burned-out participants were diagnosed with a range of axis I disorders – mainly anxiety and mood disorders – when assessed according to DSM criteria (Grossi et al., 2015). In order to solve the diagnostic controversies, the Swedish Board of Health and Welfare, introduced “exhaustion disorder” (ED; F43.8A) into the Swedish version of the 10th revision of the International Classification of Diseases (ICD-10-SE; Socialstyrelsen, 2010), which resembles “clinical burnout” and is also based on the criteria of work-related neuroasthenia in ICD-10 (Grossi et al., 2015; Socialstyrelsen, 2010; World Health Organization, 2010). However, the addition of exhaustion disorder to the ICD-10 is limited to Sweden and therefore also not a universally used definition of clinical burnout.

This variety in classifications for clinical burnout must be seen in the light of a broader discussion about the tenability of classification systems for psychological disorders. The reliability and validity of traditional taxonomies are limited by arbitrary boundaries between psychopathology and normality, often unclear boundaries between disorders, frequent disorder co-occurrence (overlap), heterogeneity within disorders (subgroups), and diagnostic instability

(symptom change). These taxonomies went beyond evidence available on the structure of psychopathology and were shaped by a variety of other considerations, which may explain the aforementioned shortcomings (Kotov et al., 2017). New dimensional models are developed that are empirically driven and are based on neuroscience and advances in quantitative research on the organization of psychopathology (Clark et al., 2017; Kotov et al., 2017; Panksepp & Yovell, 2014). These models thus show similarities with the dimensional approach of the organizational psychologists, although the dimensions seem to be different. Some studies suggest that the dimensions associated with clinical burnout are distress and dysphoria which are also related to depression, but there is no consensus yet (Schonfeld et al., 2019; Van Dam, 2016).

Because individuals with short-term stress show elevated levels on burnout measures, just like individuals with other mental disorders like major depression and anxiety disorders a clinician cannot solely rely on questionnaires in order to make a qualitative distinction between the mild stress disorders and clinical burnout (Kleijweg et al., 2013; Van Dam et al., 2015^b). Instead, clinicians need to reconstruct the pathogenesis, which is the history and sequence of life-events, symptoms, and mechanisms that lead to the syndrome (Beekman & Hengeveld, 2014; Schiavone et al., 2015; Weber & Jaekel-Reinhard, 2000).

Pathogenesis of clinical burnout

In this section, I will explain the difference between the development of clinical burnout compared to individuals who seek help when having relative short-term stress symptoms (less than 3 months). Individuals with short-term work-related stress report a clear relation between a stressor and the mental problems within a period of not more than 3 months after the stressor emerged. Stressors that are often mentioned are conflicts with colleagues or the supervisor, a merger, and an increase in workload (Weber & Jaekel-Reinhard, 2000). The fact that these persons seek help after a relative short period of experiencing stress symptoms may be regarded as a healthy coping mechanism (Bakker & de Vries, 2021; Roohafza et al., 2016). Patients with clinical burnout, however, report that they ignored stress symptoms for several years (Maslach & Goldberg, 1998; Weber & Jaekel-Reinhard, 2000). Living a stressful life was a normal condition for them. Some were not even aware of the stressfulness of their lives, until they collapsed. The ultimate reason for collapsing may be a relative minor stressor. The clinician needs to understand that it is not only that minor stressor that led to the total breakdown, but that the minor stressor is the final straw that broke the camel's back after years of chronic stress. Final stressors that are often mentioned by patients with clinical burnout are conflicts, being unable to relax during holidays, and not recovering from flu.

The coping style of clinical burnout patients seems to be quite different from that of patients with short-term stress-related disorders. Those with clinical burnout are not inclined to seek help when there is stress but persist without complaining. This observation is in line with research showing that the coping style of burnout patients is characterized by perseverance (continued effort to do or achieve something despite

difficulties) and reluctance to asking social support (Martínez et al., 2020; Van Dam et al., 2013, 2015b; Wallace, 2017). Research in relative healthy populations suggests that perseverance is a protective factor for burnout. Perseverance may indeed be beneficial when someone is actually having control over one's situation (Fabelico & Afalla, 2020). However, in case of lack of control, perseverance is not adaptive anymore and individuals should shift to other coping strategies like asking for social support and reflecting on one's situation and feelings (Bakker & de Vries, 2021; DeLongis & Holtzman, 2005; Sapolsky, 1998; Van Dam et al., 2013). Perseverance may in that case contribute to the maintenance of chronic stress.

In the literature on fatigue in healthy individuals, it has been shown that fatigued individuals adapt their performance strategy in order to regulate the mobilization of mental effort (Hockey, 1997/2011). Strategic adjustments can be achieved, for instance, by allowing failures for secondary goals. For instance, an individual may selectively neglect low-priority task components (e.g., the speed or accuracy of responses) or they may neglect subsidiary activities or shift to simpler response strategies with fewer demands on working memory. Because fatigue is a central characteristic of the burnout syndrome, one may expect that burnout patients will also start to routinely select less demanding performance strategies. Several studies have suggested that the opposite is true: in contrast to healthy fatigued individuals, burnout patients do not appear to be particularly reluctant to expend high levels of effort (Bakker & de Vries, 2021; Demerouti et al., 2014; Van Dam et al., 2013). These findings point out a tendency to cope with stress with perseverance and trying to maintain high standards of task performance.

In the reconstruction of the years prior to the establishment of clinical burnout, a number of phases in the development of clinical burnout can be distinguished that describe the process of burning out (Hamming, 2020; Weber & Jaekel-Reinhard, 2000). These phases broadly outline how individuals develop burnout. Individual variations are, of course, possible and phases may overlap in time. The phases with their main features, processes, and symptoms are described in Table 1.

Lack of recovery

The process to burnout starts with lack of recovery from physiological stress reactions (Geurts & Sonnentag, 2006; Hamming, 2020; Weber & Jaekel-Reinhard, 2000). A human being is capable of enduring considerable amounts of stress, if stressful periods are alternated by periods of rest and one is able to recover (Ganzel et al., 2010; Geurts & Sonnentag, 2006). There are fewer opportunities to recover from stress when there are problems both at home and at work. For example, there is work stress due to a reorganization and conflicts and there is stress in private life due to caring for ill family members, long-term problematic renovation of the house, and/or financial problems. In this phase, individuals may experience need for recovery and an aversion to spend effort (Hunter & Wu, 2016; Meijman & Mulder, 1998)

Changes in stress physiology

When stress levels continue to be high over prolonged periods of time, the stress system adapts itself. New homeostatic stress

Table 1. Phases in the development of clinical burnout.

Phase	Main features and process	Symptoms
1	<i>Lack of recovery:</i> Stressful events combined with limited possibilities to recuperate	Need for recovery Aversion to spending effort
2	<i>Changes in stress physiology:</i> Higher homeostatic stress values	Hyperactivity Sleep difficulties Inability to relax Restlessness
3	<i>Chronic stress symptoms:</i> Physical symptoms: Mental symptoms: Emotional problems: Behavioural problems:	headaches intestinal problems muscle tension or pain chest pain fatigue reduced sex drive stomach upset vulnerability to diseases concentration deficits being forgetful and absent-minded trouble staying focused indecisiveness impaired learning capability impaired planning and control feeling frustrated and angry irritability overreacting feeling upset or sad without knowing why feeling unable to control one's emotions anxiety and panic conflicts social withdrawal drinking alcohol, taking medicine, eating too much quitting hobbies and sports
4	<i>Pseudopsychopathology:</i> Reduction of the complexity of reality by applying more rigid ways of problem solving and cognitive simplification Stigma and blaming the victim	compulsive and rigid behaviour dependency on others being suspicious reduced creativity reduced empathy reduced self-reflection
5	<i>clinical burnout:</i> Reduced motivation and passivity	Emotional breakdown Severe fatigue Passivity Inability to motivate oneself learned helplessness mood problems

Based on: Boksem & Tops, 2008; Hamming, 2020; Van Dam et al., 2017; Van Zweden, 2015; Weber & Jaekel-Reinhard, 2000.

values are established, which means that the organism sets a higher stress level as the default level (McEwen, 2017; Sterling, 2004). Due to chronically elevated stress levels, sleep problems emerge. People experience difficulties to fall asleep because the stress system is still active at the time they want to sleep. This is a major problem because sleep quality appears to be predictive of recovery of burnout (Grossi et al., 2015; Sonnenschein et al., 2008). Another problem that arises is that people cannot relax anymore even when there is no pressure. The stress system is activated whether there is a stressor or not. As a result, individuals become hyperactive and cannot relax anymore. This often leads to restlessness in spare time and the inability to relax during holidays (Eden, 2001; Fritz & Sonnentag, 2006).

Chronic stress symptoms

long-term physiological stress leads to physical, mental, behavioural and emotional problems (Geurts & Sonnentag, 2006; Sapolsky, 1998; Weber & Jaekel-Reinhard, 2000)

- Physical symptoms: Stress has a major impact on our immune system, cardiovascular system, digestive system, endocrine system, and reproductive system (Sapolsky, 1998). Therefore, chronic stress may lead to a variety of physical symptoms in burnout patients, like headaches, intestinal problems, muscle tension or pain, chest pain, fatigue, change in sex drive, stomach upset, and vulnerability to diseases.

- **Mental problems:** Chronic stress also affects cognitive performance. Several studies have shown that cognitive functions such as attention, concentration and working memory are impaired in clinical burnout (Deligkaris et al., 2014). The cognitive impairments observed in burnout patients seem to especially affect the more complex, higher cognitive processes, such as executive functioning rather than the more simple cognitive processes (Deligkaris et al., 2014; Van Dam et al., 2011; Van der Linden et al., 2005). Specific symptoms include difficulties to think clearly and learn new things at work, being forgetful and absent-minded, indecisiveness, poor memory, attention and concentration deficits, and trouble staying focused at work. Since executive control is essential for performance on tasks that require planning, control, evaluation, adaptation and problem solving, these impairments may well result in an overall impaired job-performance (Bakker et al., 2008; W. Schaufeli et al., 2020; Taris, 2006).
- **Emotional problems:** Stress reduces the capability to control emotions (Raio et al., 2013). Chronic stress therefore leads to emotional instability which is manifested by intense emotional reactions and feeling overwhelmed by one's emotions. Specific symptoms include feeling frustrated and angry at work, irritability, anxiety and panic, overreacting, feeling upset or sad without knowing why, and feeling unable to control one's emotions at work (W. Schaufeli et al., 2020; Van Dam et al., 2015^a).
- **Behavioural problems:** Due to the cognitive impairments and increased emotional lability, burnout patients will have more conflicts with other people. The conflicts usually first arise in private life, because people try to maintain adequate social functioning at work as long as possible. In private social situations, burnout patients tend to withdraw themselves and are more easily agitated which evokes negative reactions of family members and friends. Eventually, these conflicts also emerge at work. Another type of behavioural problem that emerges has to do with the desire of the overstressed person to comfort him or herself by drinking alcohol, taking medicine, eating too much, and quitting hobbies and sports. This unhealthy lifestyle usually makes things worse as it has a negative effect on sleep quality and health in general (Monk et al., 2003).

Pseudopsychopathology

Stress affects the way in which information is processed and how we deal with the world. In order to reduce stress, individuals reduce the complexity of reality by applying more rigid ways of problem solving and cognitive simplification (Hockey, 2011; Michailidis & Banks, 2016). These mechanisms are catastrophic in regard to creativity, empathy, and the ability to reflect on complex problems as well on one's own functioning. Bakker and de Vries (2021) showed that coping is also affected by stress. They argue that when stress increases, individuals are less likely to use adaptive coping strategies (e.g., job crafting and recovery), which means that they do not build the job and personal resources needed to cope with ongoing job demands. As a result of this, it may seem that the person has maladaptive

personality traits. This syndrome, which develops on the basis of chronic stress, can best be qualified as pseudopsychopathology (Van Zweden, 2015).

Importantly, this often leads to the false interpretation of employers, but also clinicians, that burnout symptoms are a result of adaptation problems due to maladaptive personality traits. This may lead to blaming the victim and trying to fix the individual instead of the suboptimal and stressful environment (Bakker et al., 2014). Pseudo maladaptive personality traits that are often observed in clinical burnout are obsessive compulsive, dependent and paranoid personality traits, which manifest itself by being very compulsive and rigid, not daring to make decisions without consulting others or being suspicious.

It is crucial to find out whether this rigid maladaptive interpersonal style is a cause or a result of chronic stress. A good possibility to check this is to ask a relative whether the person has always been like that or whether personality changed during the burnout process. Personality disorders are persistent inflexible or impaired patterns of thought and behaviour that usually cause difficulties in forming and maintaining interpersonal relationships and in meeting the daily demands of one's personal and work life (APA, 2013). These disorders typically become apparent during adolescence or early adulthood. Pseudo personality psychopathology develops as a result of chronic stress and not in a specific stage of life. Moreover, the newly acquired clinical profile disappears with the recovery from burnout.

Reduced motivation and passivity (clinical burnout)

This final stage is the condition in which people meet the diagnosis of clinical burnout. The hyperactivity that characterizes the initial phase of chronic stress may change to passivity and a relatively permanent impaired motivation (Boksem & Tops, 2008; Schaufeli et al., 2020; Van Dam et al., 2015b). Instead of trying to maintain performance of work tasks at high levels, burnout patients seem not to be able to motivate themselves anymore. Research shows that whereas some burnout patients are active showing high task engagement, others are passive showing low task engagement (Tops et al., 2007). The groups probably reflect the different phases in the burnout process. The final phase in the burnout process that is characterized by chronic demotivation and high levels of stress may be related to the phenomenon of "learned helplessness" (Seligman, 1975). Learned helplessness refers to a state in which a person believes they have no control over the situation and, therefore, does not try to cope with the situation any longer and experiences high levels of stress (Sapolsky, 1998). Several studies showed that burnout patients exhibit implicit (unconscious) associations with failure, which is also indicative for learned helplessness (Brenninkmeijer et al., 2001; Van Dam et al., 2012b).

Treatment of clinical burnout

The variations in the conceptualization of burnout also have an impact on the literature on the treatment of (clinical) burnout. Meta-analyses usually fail to make any distinction between research on interventions for employees with relatively mild short-term work stress complaints and interventions for

Table 2. Phases in the treatment of clinical burnout.

Phase	Treatment goal	Therapeutic interventions
Phase 1: Crisis	Recognition of the patient that the problems are serious, and that serious action is required.	Psychoeducation Sick leave Dropping domestic tasks and social obligations Inform social network
Phase 2: Recovery	Recovery of the (physiological) stress system to normal allostatic stress levels.	Registration of stress and activities. Relaxation exercises Mindfulness Healthy lifestyle advices Graded exercise Gradually resume activities Psychoeducation social network and employer Gradual return to work
Phase 3: Prevention, learning from the past	Acquiring insight and skills to prevent relapse in clinical burnout.	Analysing stressful situations Analysing dysfunctional thought patterns Learning new coping skills Learning social skills Job crafting Time management Making choices regarding career and personal life
Phase 4: Post burnout growth	Improving sustainable quality of life.	Setting priorities regarding quality of life and interpersonal relationships.

Based on: Hamming, 2020; Keijsers et al., 2004; Van Dam et al., 2017; Van Zweden, 2015; Weber & Jaekel-Reinhard, 2000.

patients with clinical burnout complaints (Ahola et al., 2017; Awa et al., 2010). Moreover, some interventions are more focused on the prevention of burnout whereas others are aimed at the treatment of clinical burnout. Therefore, it is not possible to draw firm conclusions about the effectiveness of treatment programmes. However, there are indications that the majority of patients with clinical burnout improves significantly after treatment (Oosterholt et al., 2012; Van Dam et al., 2012b). In this paper, I will describe the therapeutic interventions that are commonly used in the treatment of severe clinical burnout.

Various burnout treatment protocols have been described in the literature (Hamming, 2020; Keijsers et al., 2004; Van Dam et al., 2017; Van Zweden, 2015). These protocols have in common that they are aimed at restoring a healthy balance between effort and rest, recovery from chronic stress, and improving coping skills. Different phases can be distinguished in the treatment of clinical burnout: (1) crisis, (2) recovery, and (3) prevention (Hamming, 2020; Van Dam et al., 2017; Van Zweden, 2015; Weber & Jaekel-Reinhard, 2000). In this paragraph, interventions will be described for each specific phase and also which interventions are contraindicated in that specific phase (see also Table 2).

Phase 1 Crisis

The first phase of the treatment is characterized by crisis (Van Dam et al., 2017; Van Zweden, 2015). Despite severe fatigue and distress, the patient tries to fulfill all obligations at work

and in private life and notices that (s)he makes many mistakes, is unable to concentrate, is emotionally unstable and prone to conflicts. It may also be that the patient feels so severely fatigued that he feels unable to do anything and finds himself staring and doing nothing most of the time. The patient feels despair and hopes the therapist can do something that makes him/her able to again fulfill all obligations at work and in private life.

In this first phase, it is necessary that the therapist is empathic to the feelings of the patient but also honest and straightforward regarding the possibilities of quick recovery (Van Dam et al., 2017; Van Zweden, 2015). The therapist makes it clear to the patient that clinical burnout is the result of prolonged periods of stress and that there are no quick tricks or solutions. The balance between stress and restoration has to change and the body needs to recover and find a healthy balance again. And this takes time. The first thing to do now is to make recovery possible and to create time and opportunities to take a good look at the situation (Van Dam et al., 2017). This can be done by dropping almost all responsibilities for the next few weeks. For many patients, this is very difficult to accomplish because of strong feelings of responsibility and feeling uneasy about bothering others. Indecisiveness may also be fuelled by cognitive impairments (Deligkaris et al., 2014; Van Dam et al., 2011; Van der Linden et al., 2005). Because higher cognitive processes such as executive functioning are impaired, patients may experience difficulty getting an overview of their situation and diminished problem-solving capabilities. It is recommendable, in this phase of the treatment that the therapist takes the lead and actively helps the patient to find solutions and if necessary, communicates with the social network about the measures being taken.

Phase 2: Recovery of the stress system

The main purpose of the second phase is recovery of the stress system. Homeostatic stress values need to return to normal levels (McEwen, 2017; Sterling, 2004). Therefore, it is important that stress is reduced. In the first phase of the treatment, sources of stress are drastically reduced by skipping social obligations and avoiding work and household chores. In the second phase, patients will resume activities gradually. The relative distress an activity causes is registered, and the therapist advises the client to start with nonwork activities that cause little stress for limited duration – alternated with rest or relaxing activities. It is essential that the individual will be able again to switch from arousal to rest.

Therefore, the therapist and patient make schemes in which activity and rest are alternated (Keijsers et al., 2004; Van Dam et al., 2017). Only if the patient feels recovered after two hours rest, the number and duration of activities can be extended. In the course of phase 2, reintegration to work should start gradually. The pace at which reintegration can take place must be geared to the degree of recovery. It is wise to involve the employer in this process and explain how the recovery will proceed and what can be expected regarding task performance. This also depends on the extent to which the employer is willing to take into account the limitations of the patient during the recovery process (Brouwers et al., 2020).

A healthy lifestyle needs to be promoted because it is beneficial for recovery. Healthy food, alcohol in moderation, moderate exercise and especially a healthy sleep pattern are essential for recovery (Sonnenschein et al., 2008). Another problem that needs attention in this phase is that ignoring signals of the body like fatigue and stress has become a habit or lifestyle for many burnout patients. The strong ability to persevere and postpone need gratification makes that they are less tuned to signals of their body and tend to choose their actions on basis on what they think that they should do and not on what they feel. Relaxation exercises, meditation and mindfulness exercises can be helpful to become more receptive to signals of the body again (Bednar et al., 2020).

During this phase, which lasts several months, the patient will become less fatigued and will be motivated and able again to perform tasks. For a part of the patients, the cognitive impairments seem to decrease in a slower pace than the other symptoms (Dalgaard et al., 2020; Van Dam et al., 2012b). This should be taken into account when someone reintegrates into the work. The duration with which someone can perform complex cognitive tasks is limited and should therefore be alternated with other tasks.

In the second phase, it is also important not to do a number of things because it will hinder recovery. First, it is inadvisable to start psychotherapy. Psychotherapy may be emotionally demanding and stressful and therefore hinders recovery from chronic stress (Linden, 2013). In addition, due to the chronic stress, there may be pseudopsychopathology (Van Zweden, 2015). This will disappear by itself when someone recovers. For the same reasons, no assessment or psychological testing should take place at this stage. As a result of the chronic stress, people will score less intelligent and more disturbed on the tests than they actually are.

Many burnout patients experience relational problems because family members experience that the burnout patient is often irritable and reluctant to engage in social activities (Carnes, 2017; Davis et al., 2011). It is helpful to involve partners or family members in the treatment to provide explanations and advice on how to deal with the symptoms. However, focusing on the relational problems would only increase the stress and be unnecessary because the relational problems will probably disappear once the patient has recovered (Cuijpers, 2007; Heffner et al., 2004).

In order to be able to properly estimate whether complaints are the cause or consequence of the chronic stress, it is best to ask family and acquaintances how the patient's functioning was before the chronic stress episode. Another point of attention is that in an attempt to solve the problematic situation, people may take drastic decisions like changing jobs, divorce or emigration. This is seldomly a good idea in this phase because of the efforts it requires to adapt oneself to a new (work) environment while being already exhausted and experiencing difficulties in cognitive control (García-León et al., 2019; McCarthy & Lambert, 1999).

Phase 3 Prevention, learning from the past

In the third and final phase, the patient is almost fully recovered, and the time has come to explore the reasons why someone ended up with burnout. Knowledge about factors that

contributed to the burnout may help to prevent that a person will go through years of chronic stress again. Research shows that fifty percent of the individuals who returned to work after burnout had a relapse in burnout within two and a half year. Six percent of the individuals who received a structured workplace-oriented intervention had more than two relapses compared to fourteen percent of the individuals who did not receive the intervention (Karlson et al., 2014).

Factors that may influence vulnerability to burnout are circumstances, coping, and dysfunctional thought patterns.

-Circumstances: Circumstances may lead to chronic stress reactions when there are not enough possibilities for recovery. In some cases, people have very limited influence on conditions that cause stress (Bakker & de Vries, 2021; DeLongis & Holtzman, 2005; Sapolsky, 1998). You can think of a combination of a bad atmosphere at work in combination with caring for a sick family member. The therapist and the burnout patient can take a look at whether it had been possible to deal with the situation differently by asking for more social support or setting limits.

-Coping: An effective way of dealing with problems is to make far-reaching but necessary decisions. This is something that many people find difficult to do (Maslach & Goldberg, 1998). It may be the case, for example, that due to changes at work, someone no longer really likes his work that much, but does not want to admit it to himself or is not fully aware of it (Follmer et al., 2018). The same process may also play a role in private life. Some people appear not to be our best friends when we take a closer look (Lee et al., 2010). Another dilemma may occur when someone has made a career change and would experience it as a failure to recognize that this job does not suit him and go back in social status and salary (Verheyen & Guerry, 2018). It is essential that a therapist confronts clients with a mismatch between desires and possibilities and also helps them make painful but necessary decisions. Improving coping skills may also comprise learning new ways to solve problems, social skill training, time management and job crafting (Keijsers et al., 2004; Van Dam et al., 2017).

-Dysfunctional thought patterns: As a result of education and experiences in life, people develop thoughts and expectations about themselves, others, and the world (Sauerland et al., 2015). These thoughts can be functional if they contribute to happiness and the ability to adapt to changing life circumstances. Thoughts are dysfunctional when they allow people to enter patterns that are rigid and non-adaptive and contribute to stress, emotional problems and destructive behaviour patterns (Keijsers et al., 2004; Sauerland et al., 2015; Van Dam et al., 2017). In burnout patients, this may express itself in perfectionism, conflict avoidance, sub-assertiveness, the idea of always having to prove oneself or an excessive sense of duty. Cognitive behavioural therapy may then be effective in breaking through these dysfunctional patterns by changing dysfunctional thought patterns and learning new social skills (Keijsers et al., 2004; Van Dam et al., 2017).

A successful treatment of burnout may move into a fourth phase. There is a body of literature suggesting that people exposed to even the most traumatic events may perceive at least some good emerging from their struggle with tragedies. This is called posttraumatic growth

(Tedeschi et al., 2018). At least three broad categories of perceived benefits have been identified: changes in self-perception, changes in interpersonal relationships, and a changed philosophy of life. In recovered burnout patients the same phenomenon can be observed (Glouberman, 2007; Semeijn et al., 2019; Van Dam & de Leeuw, 2004). Many former burnout patients report that they have learned from their burnout and that their life is better now than before their burnout. They know better who they are and what is important to them in life; they spend more time with their friends and families; and they changed their priorities. Many former burnout patients allow themselves to enjoy life more and to be happy. This may be called post-burnout growth. These observations are in line with empirical findings (Semeijn et al., 2019) and may hopefully contribute to a different (more positive) perspective on burnout.

Conclusion

In this article I have explained the difference between syndromes resulting from short-term stress and those resulting from chronic stress. Because individuals with short-term stress show elevated levels on burnout measures, just like individuals with other mental disorders like major depression and anxiety disorders a clinician cannot solely rely on questionnaires in order to make a qualitative distinction between the mild stress disorders and clinical burnout. The difference between these syndromes, in terms of people who are predisposed for them and the prognosis, is qualitative rather than dimensional. It is relevant for work- and organizational psychologists to know that biological processes play an important role in the development of clinical burnout. It does not matter for physiological processes whether the stress is work-related or the result of stress in private life or both. Central to understanding clinical burnout is the lack of recovery of the (physiological) stress system. Work- and organizational psychologists could pay more attention to coping instead of symptom level to determine who is at risk for clinical burnout. Furthermore they could adjust their interventions to the various risk profiles; for example, stress management programmes for employees with mild stress symptoms and healthy lifestyle programmes for individuals with excessive perseverance.

I hope that this contribution will inspire work- and organization psychologists in designing interventions and conducting research.

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