CORRESPONDENCE

Burnout: a Fashionable Diagnosis

by Prof. Dr. med. Wolfgang P. Kaschka, Dr. rer. pol. Dieter Korczak, Dr. med. Karl Broich in volume 46/2011

Term Indicates Severity of Exhaustion

Whether the term burnout is fashionable or not, Germany's population is increasingly exhausted, and this includes doctors themselves. It is obvious to me too that research is needed regarding the classification, diagnostic evaluation, and therapy, and to establish the scientific basis. However, I would like to continue using this diagnostic term on sick notes. I take a pragmatic view as this term reflects the severity of a patient's exhaustion if, for example, someone is still exhausted to the same degree of severity after being signed of sick for four weeks, if sadness was not the primary factor, and if the preceding workload was enormous.

According to Farber (reference 7 in the review article by Kaschka et al.), it is a patient's internal pressure to be better than others, have more money, etc. The authors mention six internal personality factors in this context.

Among the 22 external factors that vitally contribute to burnout, the authors mention the word "pressure" several times. I also see this pressure in people's increased workloads, thanks to which Germany again became the engine of the European Union according to the Agenda 2010. Almost all work sectors are affected. The authors justifiably demand preventive measures in occupational health promotion.

In order to avert multifactorial burnout, health promotion should be started early; conflict training, for example, should be included in school curricula, while the ability to work as part of a team, relaxation techniques, regular breaks, part-time working, reduction in bureaucratic processes, and adequate pay are also vitally important.

For doctors, burnout could be prevented largely by changing the remuneration system, by giving doctors and patients back the necessary time by paying adequately for this. It is a fact that doctors are forced to take on more work because they are remunerated on the basis of case numbers in the outpatient system and diagnosis-related flat-rate payments in hospitals (with increasingly shorter intervals between admission and discharge).

DOI: 10.3238/arztebl.2012.0338a

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Wilhelm Breitenbürger
Berlin, wilhelm.breitenbuerger@t-online.de

Conflict of interest statement
The author declares that no conflict of interest exists

Useful Illness

The number of copycat cases of burnout is likely to be much higher than the number of those who are actually affected—similar to the situation with tinnitus patients.

The reason is Say's law, which says that supply always creates demand and was ascribed to the French economist Jean Baptiste Say (1767–1832).

Many patients regard burnout with tinnitus as a solution to their problems and an opportunity to acquire a degree of disability while being physically healthy. From the patients' point of view, burnout is a "useful illness" (1).

DOI: 10.3238/arztebl.2012.0338b

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Dr. med. Volker Baschek
Dr. med. Wilhelm Steinert
Gelsenkirchen
baschek-steinert@gmx.net

Conflict of interest statement
The authors declare that no conflict of interest exists.

Need to Differentiate Between Doctors' and Patients' Perspectives

The authors cite the review of a health technology assessment (HTA) commissioned by the German Institute for Medical Documentation and Information (DIMDI, Deutsches Institut für Medizinische Dokumentation und Information) on burnout (Cologne, 2010), which primarily complains about the lack of standardized diagnostic criteria. A fundamentally different perspective thus remains overlooked, according to which Herbert Freudenberger (1974) and burnout patients define burnout as a paradigm describing an impaired ability to perform and general malaise, providing an explanation (excessive professional/general stress), and providing an excuse (overwork). Freudenberger pointed out that the symptoms differed in each patient, which puts the phenomenon beyond any descriptive-operationalizeable ICD-10 entities. Experiencing burnout reflects primarily a subjective disturbance model in those affected. The perspective is diametrically opposed to that held by experts. If only standard recognized criteria existed: which individual who feels affected could be persuaded that they were not burnt out? Without a categorical differentiation between doctors'/therapists' perspectives and the patient's perspective, all attempts to define standard diagnostic criteria for burnout and valid instruments to measure

burnout will predictably fail or remain frustrated. Burnout is substantially more than a fashionable diagnosis. The phenomenon presents an existential challenge for today's medicine, which is fixated on scientific criteria (among others, reliability, validity). On the one hand, there is a risk that doctors with a "customer friendly" focus uncritically jump on the "burnout wagon," which may increase turnover in the short term but would result in a loss of long-established diagnostic and therapeutic standards. On the other hand, it is impossible to ignore the extent to which current psychiatric diagnoses according to ICD-10 have become removed from the needs of patients, who (rightly) desire not only a label for syndromes but an explanation for the suffering they are experiencing. The challenge is to find a balance between medical necessities and patients' needs that is fit for purpose in our time.

DOI: 10.3238/arztebl.2012.0338c

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Prof. Dr. med. Ulrich Voderholzer
Prof. Dr. phil. Dr. med. Andreas Hillert
Schön Klinik Roseneck
Prien am Chiemsee
BaSchuhmann@Schoen-Kliniken.de

Conflict of interest statement
Professor Voderholzer has received honoraria for preparing scientific further educational events from Lundbeck, Pfizer, Lily, and Aphalen. Furthermore, he has received honoraria from Lundbeck for acting as an expert consultant. Professor Hillert has received funding from the German statutory pension insurance scheme (Deutsche Rentenversicherung) and the Bosch Foundation for a research project that he initiated.

Consider Etiopathogenesis

From my perspective as a psychoanalytically oriented medical psychotherapist I wish to add further to what the authors said in their informative article.

My personal mission is to research the etiopathogenesis of burnout. The causes may lie within an individual's "intrapsychological conflict." In my practice I have often encountered persons who unconsciously repeated experiences from their early life (for example, a perceived lack of appreciation by close contacts) in the workplace. In the present this can trigger exhaustion owing to overcommitment and overwillingness—in the hope to finally gain the desired praise and recognition, so to speak.

This sort of "psychodynamic" is one possible factor among many others that may contribute to burnout.

Why not look for such causes of this self-harming behavior—for example, by means of psychoanalytically based psychotherapy?

By taking a thorough history and paying attention in the therapeutic sessions to the patient's feelings and behaviors vis-à-vis the therapist ("transference"), possible causes can be elucidated. The aim is to establish, jointly with the patient, keys to gaining insight into themselves. By so doing one provides an opportunity to let go of old behavioral patterns, and the symptoms of burnout will subsequently vanish.

DOI: 10.3238/arztebl.2012.0339a

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Dr. med. Dieter Wankelmuth
Ostlandstraße 2
88529 Zwiefalten
wankelmuth.psychotherapie@t-online.de

Conflict of interest statement
The author declares that no conflict of interest exists.

Medicalization and illness identity

When the authors talk about the fashionable diagnosis of burnout one of the implications is that social factors are contributing to popularizing the term. Two concepts may be helpful, which have both been developed in (medical) sociology in recent years: medicalization and illness identity. Medicalization describes a process by which a social phenomenon that to date was not perceived as medically relevant now becomes defined by medical terms and/or treated with medical means (1). Recent analyses of medicalization processes have shown that non-medical social sectors play an increasing part in this, whereas doctors frequently meet the expansion of the area where medical definitions apply with some skepticism. The concept of illness identity makes clear how illness identities develop in the interaction of individual experiences (of suffering) and publicly available, media-popularized images and explanations of certain states of being or of illness (2), coming together into a specific disease narrative.

The purpose of this perspective, which in any case is complementary to medical views, is to gain a better understanding of the heterogeneous causes and background factors of the increased presence of burnout syndrome. Effective counter-measures may be prevented, for example, if the "problem" is perceived as merely that of the individual and as preferably treatable by medical means. It is important to understand how novel challenges from the workplace are translated into individual self-interpretations and images of identity (3), and what problematic effects socially predominant role models which are popularized by discourse may bring about in this setting. Especially in patients who overemphasize their capacity for competition and market-conform behavior without having reflected these sufficiently—for personal reasons—such internalized role models may contribute to people's transgressing beyond their own limits to a degree that damages their health and may influence their personal management style.

DOI: 10.3238/arztebl.2012.0339b

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PD Dr. phil. Peter Wehling
Dr. rer. pol. Willy Viehöver
Philosophisch-Sozialwissenschaftliche Fakultät, Lehrstuhl für Soziologie, Universität Augsburg

Prof. Dr. med. Harald Gündel
Universitätsklinik für Psychosomatische Medizin und Psychotherapie, Universitätsklinikum Ulm
Harald.Guendel@uniklinik-ulm.de

Conflict of interest statement
The authors declare that no conflict of interest exists.

Gaps in Review Article

The review article contains gaps; the authors did not include important aspects of the biopsychological and scientific medicine of recent years. Signs of exhaustion are core characteristics of burnout as well as depression, and these diseases are often subsumed into a single clinical entity. However, this is incorrect because depression is defined by means of many, clearly different, symptoms and not exclusively by "exhaustion". From a biopsychological perspective, burnout can nowadays be characterized clinically by

- Excluding depression and fatigue (by means of clinical symptoms)
- Characterizing "exhaustion" by bio-typical somatic patterns, which is possible by measuring the diurnal profile of cortisol in the saliva, the neurotransmitters noradrenalin and serotonin in the urine, and qualifying the autonomic nervous system by means of heart rate variability and a detailed questionnaire test.

This approach was independently developed by Hellhammer et al (1) in the form of the "neuropattern" as well as by our own working group in a slightly different form (2). On the basis of the tests, four characteristic subgroups of burnout are found:

- Subjective "exhaustion", but biological resources are intact
- Exaggerated uptake of noradrenalin
- Lowered concentrations of the "stress brake" serotonin
- Exhaustion of the adrenal production of cortisol.

This differentiation opens up targeted individual integrated measures, such as behavioral therapy, stress processing techniques and relaxation techniques, and substitution of deficient biological substrates. Epigenetic, neuroendocrine, immunological variables, which have a sustained effect, should also be included in the reasoning.

Burnout should be considered in a more differentiated manner and, in view of the rapid increase of psychiatric illnesses, should be approached by using modern scientific-holistic methods.

DOI: 10.3238/arztebl.2012.0340a

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Prof. Dr. med. Alfred Wolf
Elchingen
drfredwolf@yourprevention.de

Conflict of interest statement
The author declares that no conflict of interest exists.

In Reply:

Our review article has stimulated a lively and controversial discussion, which underlines the relevance and current importance of the subject.

Breitenbürger correctly points to a series of circumstances and conditions that may increase burnout symptoms, among others, in doctors as a professional group. As far as possible therapeutic approaches are concerned, we mentioned in our article a general approach not limited to any specific school (p 786). The personal experiences with psychoanalytically oriented psychotherapy as described by Wankelmuth could easily be subsumed here.

In response to Wolf, we wish to point out that the primary objective of our article was not to provide a comprehensive explanation of the neurobiological causes of burnout, which at this point in time would be premature owing to a scarcity of data. We wish to point out, however, that the first author of the article, with his working group, conducted studies of the function of the autonomic nervous system in affective disorders on the basis of heart rate variability some considerable time ago (see among others [1–3]). The literature review for the cited health technology assessment (4) was concluded on 14 August 2009; the studies mentioned by Wolf were published in 2011 and were therefore not included.

Volderholzer's and Hillert's comment, that the experience of burnout is primarily a subjective experience of disturbance in affected patients, does not contradict our argument, which is implied in the section on the history of the term burnout. However, this does not release us from the challenge of trying to objectivize and operationalize the phenomenon as much as possible. Admittedly, we settled on the title's "fashionable diagnosis" intending to provoke and probably erred on the side of conciseness.

The letter by Wehling et al introduces an additional, interesting perspective—namely, that of medical sociology. The example of burnout serves excellently for studying the medicalization and development of an illness identity. However, this should not be confused with the status of an illness identity in the medical sense.

We welcome the fact that the German Association for Psychiatry and Psychotherapy (Deutsche Gesellschaft für Psychiatrie, Psychotherapie und Nervenheilkunde, DGPPN) has issued an invitation to a capital symposium on burnout and has set up a task force regarding the subject.

DOI: 10.3238/arztebl.2012.0340b

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Prof. Dr. med. Wolfgang P. Kaschka
ZfP Südwürtemberg,
Klinik für Psychiatrie und Psychotherapie I der Universität Ulm
wolfgang.kaschka@zfp-zentrum.de

Dr. rer. pol. Dieter Korczak
Institut für Grundlagen- und Programmforschung, München

Dr. med. Karl Broich
Bundesinstitut für Arzneimittel und Medizinprodukte

Conflict of interest statement
Professor Kaschka has receved expenses for continuing medical educational events from Servier Deutschland, Bristol Myers Squibb, and Merz Pharmaceuticals.
The other authors declare that no conflicts of interest exist.