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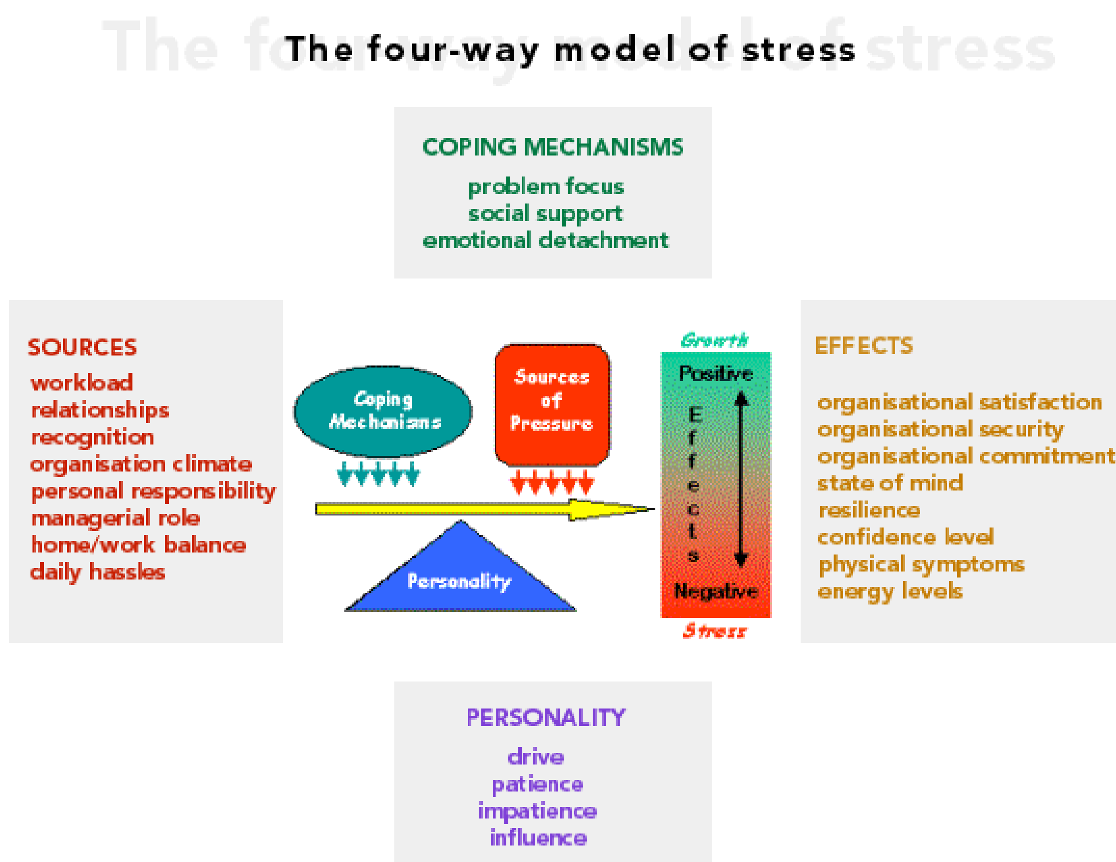
1. **Which factors and basic explanations referring to the Burnout-Syndrome do you prefer? From which theoretical background does your viewpoint result?**

Burnout is a concept introduced in the 1970s by the psychoanalyst Herbert Freudenberger and popularised around the same time by Maslach, a social psychologist. Burnout is a social problem associated with ´people work`, at first in the human services. It has at its heart, the core indicator of *exhaustion* with four accompanying symptoms:

a) distress
b) a sense of reduced effectiveness at work
c) decreased motivation
d) dysfunctional attitudes and behaviours at work (typically cynicism towards the specific client-groups that workers are responsible for)

My understanding in drawn from a transactional model of stress (Endler and Parker 1990a; Lazarus and Folkman 1984; Payne 1999) depicted below, nicely described by Steve Wiliams` work on the ´Pressure Management Indicator` (PMI), which was developed from the original Occupational Stress Indicator (OSI) of William and Cooper:



Burnout is one of the negative effects of this transactional process.

2. **Which influence do organizations/workplaces/job environments have on the development of Burnout-Syndrome?**

Burnout is a critical negative effect almost wholly situated in the person-workplace interaction. Sources of pressure at work combine with a reduction in coping added to personality and individual differences

to create burnout. Workplaces do have an effect on the development of burnout but it is too simplistic to see workplace as a simple causal factor. It is much more complex than this.

3. **Which possibilities of making a diagnosis do you think are relevant and how do you apply these?**

Burnout is much more like depression than anxiety. Many of the signs of depression have been called burnout but should be properly diagnosed as depression. In my view all patients with ´burnout` should be assessed using a psychiatric interview for depression. There are then other specific measures which can be applied – Maslach Burnout Inventory for example – and also general measures of fatigue and depression. Standardised interviews are best for diagnoses.

4. **Which kind of experiences do you have with the course of Burnout-Diseases (concerning chronic developments)?**

Most of my work has been concerned with traumatic stress at work. Here the main symptoms tend to be anxiety ones. Chronic burnout problems I have treated as if they were depressions. I have also conducted ´stress audits` of departments in organisations to identify sources of pressure and the health of the workface. I have used the OSI (now the PMI) to do this.

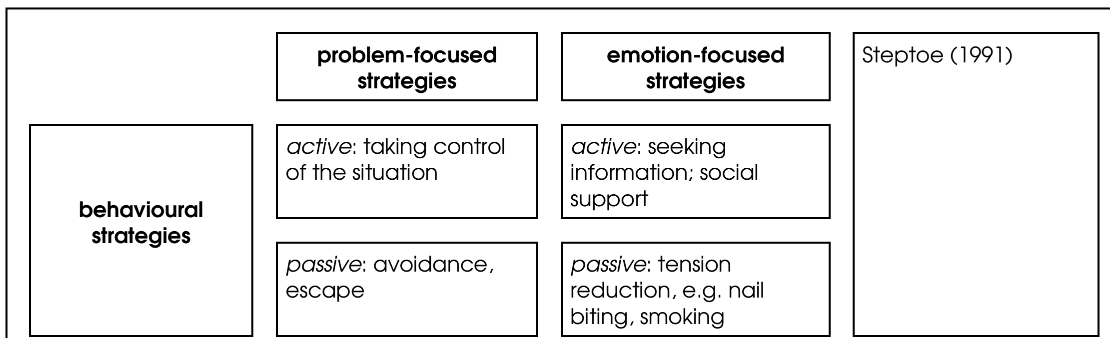
5. **Which forms of treatment do you think are promising to be successful?**

Psychological, social and pharmacological treatments are very helpful, depending on the individual. Organisational changes can also help. The most important treatments are directed at the areas of: physical, behavioural, cognitive symptoms, organisational and social relationships. Antidepressants and cognitive behavioural therapy have the most evidence and should be used routinely. Social and organisational therapy such as job retraining are helpful. All treatments need to be preceded by an assessment of sources of pressure and coping resources as well as symptoms (see model above).

Of absolute critical importance is to manage the treatment carefully. Two organisational systems of care called ´collaborative` and `stepped care` have been very successful in the US for depression treatment and are now being tested in other groups, just as successfully. Collaborative care insolves: a) the specification of a case manager role, b) liaison and educational mechanism between physical health care clinicians and mental health specialists and c) mechanism to collect and share information on individual patients. Stepped care involves titrating treatments so that an individual receives the least burdensome, but most effective treatment first before moving onto mire intensive treatment should symptoms not be improved. A scheduled review period and decision matrix is implemented at pre-determined intercals so that ´stepping up` can be made. All treatments should be initiated early, be coordinated by a case manager and should be integrated. Leaving people too long leads to poor outcomes.

6. **Which coping strategies do you consider suitable?**

Steptoe has a useful way to conceptualise coping strategies (see diagram below)



cognitive strategies	*active*: redefinition or restructuring of the situation	*active*: expression of affect, e.g. crying	
	passive: distancing; wishful thinking	*passive*: denial; repression	

In this way, behavioural and cognitive coping can be both positive and negative since they may both be actively and passively problem focussed or emotion focussed. The main issue is not the type of coping but the function of the coping – is it active or passive?

7. Which different basic prevention approaches are useful?

Organisational stress audits can identify problems in a workplace early. Monitoring sickness and morale is very important. Individual performances reviews are crucial. Most importantly is having systems in place to monitor and pick up problems very quickly. Leave them and it will be too late. Finally, attention to the workplace reward system will be a good idea. Workers need regular positive rewards, not just financial. Regular morale boosting opportunities should be taken. All these strategies should be aimed at producing a good social environment since people obtain most of their social contact at work. The more positive this social contact is, the less likely to cause burnout. In summary, strategies should be in place to monitor and address:

a) Workload (the amount or difficulty of work people have to deal with),
b) Relationships (how well people get on with their colleagues),
c) Recognition (the extent to which people feel they have their achievements recognised),
d) Organisational Climate (the ´feel` or ´atmosphere` within the workplace),
e) Personal responsibility (the amount of self-determination in the workplace),
f) Managerial Role (support to managing or supervising other people),
g) Home/Work Balance (the extent of family-friendly policies in the workplace),
h) Daily Hassles (action to address the small but significant daily irritations in the workplace.

8. Which care channels/networks do you know about for the Burnout-patients?

I am very sorry but I am not familiar with the terms you are using in this questions.