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PRACTICE ARTICLE

A cognitive behavioural model for maintaining processes in burnout

Zoe Tyrrell*

St Stephen's Hospital, Sarsfield Court, Glanmire, Co. Cork, Ireland

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Abstract. Can a cognitive behavioural approach offer a fresh understanding of the maintaining processes in burnout? This paper considers the enduring nature of burnout symptoms over time. It examines the hypothesis that some of the actions associated with 'coping' in burnout may conversely serve to perpetuate burnout symptoms. This model is considered in the context of mental-health workers and is discussed in the light of current research. It implies the need to adopt an approach to burnout that incorporates the challenging of burnout-related cognitions and the elimination of safety behaviours, rather than having a sole focus on self-care strategies.

Key words: Cognitive behaviour therapy (CBT), formulation, self-care, stress, supervision, therapist competence.

Introduction

The work of the cognitive behavioural therapist often requires the provision of compassionate and thoughtful response to those who are expressing high levels of emotion or who are feeling overwhelmed by difficulties. Such psychotherapeutic work is known to be associated with high levels of burnout among workers (Farber & Heifetz, 1982). Can a cognitive behavioural (CBT) approach provide insight into how burnout can be managed by a practitioner? Can it offer the wider working environment a model to inform the management and treatment of burnout? This paper formulates burnout in a CBT model to address these questions.

What is burnout and what is the extent of its impact? 'Burnout' was a concept identified in the 1970s by Freudenberger (1974) and Maslach (1976). It was initially intended to apply to those who did 'people work' (Maslach & Jackson, 1981) but quickly found acceptance in the general working population. Burnout is usually conceptualized as three dimensions: an experience of emotional exhaustion, depersonalization or cynicism and a perception of reduced efficacy of one's work (Maslach, 2003). It has been defined as 'a state of physical emotional and mental exhaustion that results from long-term involvement in work situations that are emotionally demanding' (Schaufeli & Greenglass, 2001, p. 501). The experience of burnout can be intensely distressing and may lead to increased absences from work, resignations or

*Author for correspondence: Dr Z. Tyrrell, HSE South, North Cork Adult Mental Health, St Stephen's Hospital, Glanmire, Co. Cork, Ireland. (email: zoe.tyrrell@gmail.com)

career changes (Kristensen *et al.* 2005), health difficulties (Melamed *et al.* 2006) and poor patient care (Neveu, 2008).

From this definition, it could be presumed that there is a direct relationship between long-term involvement in emotionally demanding work situations and the development of burnout. However, not all workers in each situation do become burnt out, nor is there evidence of a relationship between increasing time in a profession and increased likelihood of burnout, but rather the opposite (Cordes & Dougherty, 1993). Most research that has attempted to explore development of burnout in healthcare workers has concentrated on identifying factors predictive of high levels of burnout. Such factors include conflict with patients, working with terminal patients (Poncet *et al.* 2007), lack of social support (Maslach *et al.* 2001) or younger age (Maslach & Jackson, 1981). Some studies have found the number of work hours to be predictive of levels of burnout (Park & Lake, 2005). This fits with models that derive from the transactional model of stress (Lazarus & Folkman, 1984) where a person perceives the demands faced as exceeding his or her resources. However, research into environmental, worker or job characteristics have produced conflicting results, such as those for length of work experience, gender or marital status (Yildirim, 2008). Furthermore, they omit the role of the subjective view of the worker. Recently, studies re-examined the apparent relationship between workload and burnout (Shirom *et al.* 2008, Panagopoulou *et al.* 2006). They found that perceived workload, as measured by agreement with statements like working 'too many hours' and having 'too many patients', had a much greater association with burnout than actual work hours or actual patient numbers. These findings draw attention to the need to examine workers' perceptions of themselves, their roles and their environments, rather than relying solely on objective measures of these factors.

Although burnout could be perceived as a discrete event or a restricted episode, research indicates burnout tends to occur as a chronic experience. A review of longitudinal studies of burnout symptoms conducted by Taris *et al.* (2005), examined studies varying from 3 months to 8 years of duration and concluded that scores across all three dimensions of burnout tended to be stable over time. These studies, like most studies that investigated burnout, were conducted by measuring samples of individuals in the workplace. The implication of this is that many workers continue functioning within the workplace at some level whilst suffering from enduring symptoms of burnout. This may further complicate such research findings since the factors that are most significant in the development of burnout may not be the same ones that perpetuate it. It also leads to the question posed by Kristensen *et al.*: 'How do people live with their different degrees of burnout in their daily lives?' (2005, p. 198). An examination of common coping strategies and their effect on the presence of burnout can shed light on the ongoing processes that may operate in those who continue to function in the workplace despite reporting moderate or high levels of burnout. This paper aims to propose a model to explain such processes in those for whom burnout has become an enduring problem.

If burnout is so potentially devastating, what steps are recommended to protect against it? There is a variety of literature in the field of burnout that recommends an improved regimen of 'self-care'. This includes finding a better balance between work and leisure interests, access to positive social support, finding ways of reducing the volume of work and restricting the type of patients a practitioner treats (Norcross & Guy, 2007; Wicks, 2008). There are also recommendations about careful self-monitoring for signs of exhaustion (Wicks, 2008). However, there is limited published research about the efficacy of all these strategies (Maslach, 2003) and research into burnout has yet to 'achieve solutions to the original problem itself'

(Maslach *et al.* 2001, p. 420). Indeed researchers have begun to explore systemic interventions that adapt the workplace rather than trying to solve the problem of burnout within the individual (Maslach, 2003).

Processes operating in chronic burnout

The consequences of burnout may be severe both in terms of distress, finance, career progression and self-esteem. When illnesses carry severe consequences of this nature, sufferers will often adopt measures to try to reduce the likelihood of symptoms returning or worsening. This is especially relevant if, as suggested by research, symptoms are chronic in nature. Workers' attempts to avoid an increase in levels of burnout will be based on their own beliefs about how burnout is caused and how it can be prevented. Such beliefs are likely to be based on the worker's own experience of burnout. They may also be influenced by the current societal beliefs and popular literature about burnout. These conceptualize burnout as a response to prolonged exposure to stress which is best managed by improved self-care. Therefore, care is taken in an effort to reduce the levels of demands to which they are exposed and to conserve resources wherever possible.

One qualitative study interviewed nurses who had recovered from 'near burnout' and found they believed a crucial method of avoiding further burnout was to 'listen more carefully to the signals' of their condition (Vinje & Mittelmark, 2007, p. 110). Certain sensations, both emotional and physical, are associated with the last experience of burnout and therefore considered to be warning signs. A worker who is concerned about burnout is likely to engage in self-monitoring for these signs.

It is useful to explore in more detail how a worker in the 'helping professions' might try to reduce his/her exposure to stressors. Within the workplace, avoidance of potential stressors could constitute limiting certain types of patients, limiting the numbers of patients seen, restricting the degree of emotional engagement with a patient and avoiding any unnecessary involvement in the wider service. This strategy of avoidance is reminiscent of Maslach's description of the dimension of depersonalization in burnout as 'the person who is experiencing a high level of cynicism tends to withdraw from the job and do the bare minimum, rather than strive to do the very best' (Maslach, 2003, p. 191). Outside the workplace the need to avoid exposure to stress might cause withdrawal from any further emotional demands. This might include withdrawal from relationships where others need support. Norcross & Guy (2007) noted some health professionals withdrew from friends and family in an attempt to manage the stress of listening to patients all day. Similarly, any situations viewed as draining might be avoided, thus limiting leisure activities. Rest and sleep might be prioritized over any other activity.

These strategies are intended to be adaptive coping strategies. But what is the effect of continual reliance on such strategies? Such continual focus on the conservation of resources will lead to a life increasingly focused on work, restricted in diversity, limited in social support and increasingly vigilant for signs of increasing burnout. Ironically this will lead to a situation far from the ideal work–life balance promoted by self-care literature. Sensations associated with fatigue will be interpreted as warning signs and these become the guide for setting limits on work. Once these limits are made, the worker will continue to assume that he/she will increase his/her level of burnout if they are exceeded. Therefore the worker is prevented from being able to regain a sense of resilience to stressors. This is because there is no opportunity to

discover that an increased exposure to sensations and stressors can be managed by the worker. In this way these strategies, which may initially have been adaptive coping strategies, serve to maintain a worker's belief that he/she does not have the capacity to meet demands and thus in time become a safety behaviour that prevents recovery.

This response – of limiting activities, withdrawing from stressors and increased monitoring for symptoms – would be similar to attempts by some patients to manage pain, according to the fear-avoidance model of chronic pain (Vlaeyan & Linton, 2000). This model describes how patients avoid activities assumed to increase the risk of pain or re-injury and remain hypervigilant to pain-related stimuli. It is also similar to the management strategies used by those suffering from chronic fatigue syndrome, where patients consider 'anything that exacerbated symptoms was considered to be harmful or to increase the risk of relapse' (Suraway *et al.* 1995, p. 536). Both these models demonstrate that these coping strategies, which may be adaptive in an acute phase, paradoxically worsen the problem in the long term.

A model for the maintaining processes in burnout

A proposed CBT model for the maintaining processes of long-term burnout is shown in Figure 1.

In this model beliefs about burnout are generated by past experience of burnout and general views held by society. These beliefs dictate the need to monitor for signs of emotional fatigue and to minimize exposure to stressors.

As shown in the model, this resulting hypervigilance for sensations of emotional fatigue increases the degree of fatigue that is brought into conscious awareness. The effect of increased vigilance on increased awareness of fatigue has been demonstrated empirically in chronic fatigue syndrome (Moss-Morris *et al.* 2005). Attention is focused on these signs rather than on any signs or feelings of coping. These sensations are interpreted as a danger sign for burnout rather than a passing feeling or a sensation within the normal range of tiredness or an appropriate sensation for the context.

Once identified, these sensations of emotional fatigue will trigger negative automatic thoughts such as 'I can't cope' and 'I can't go on like this much longer'. These thoughts lead to increased attempts to avoid stressors in accordance with the beliefs held about prevention of burnout. As discussed, this prevents the worker from discovering they have a greater capacity to cope with the stressor than believed.

Furthermore, as avoidance leads to a decrease in tasks attempted, it is likely to affect a worker's view of his/her own performance. Performance will be evaluated less positively, leading to a reduced perception of a worker's own self-efficacy, another core dimension of burnout.

Both the reduced self-efficacy and the failure to disconfirm fears act to strengthen negative thoughts. This perceived inability to meet demands fulfils the definition of stress (Lazarus & Folkman, 1984) and this ongoing stress in turn increases emotional fatigue, the central dimension of burnout.

Implications for treatment and practice

So how does one distinguish between safety behaviours which may be maintaining a fear of burnout from those behaviours which constitute positive self-care? Adequate self-care is

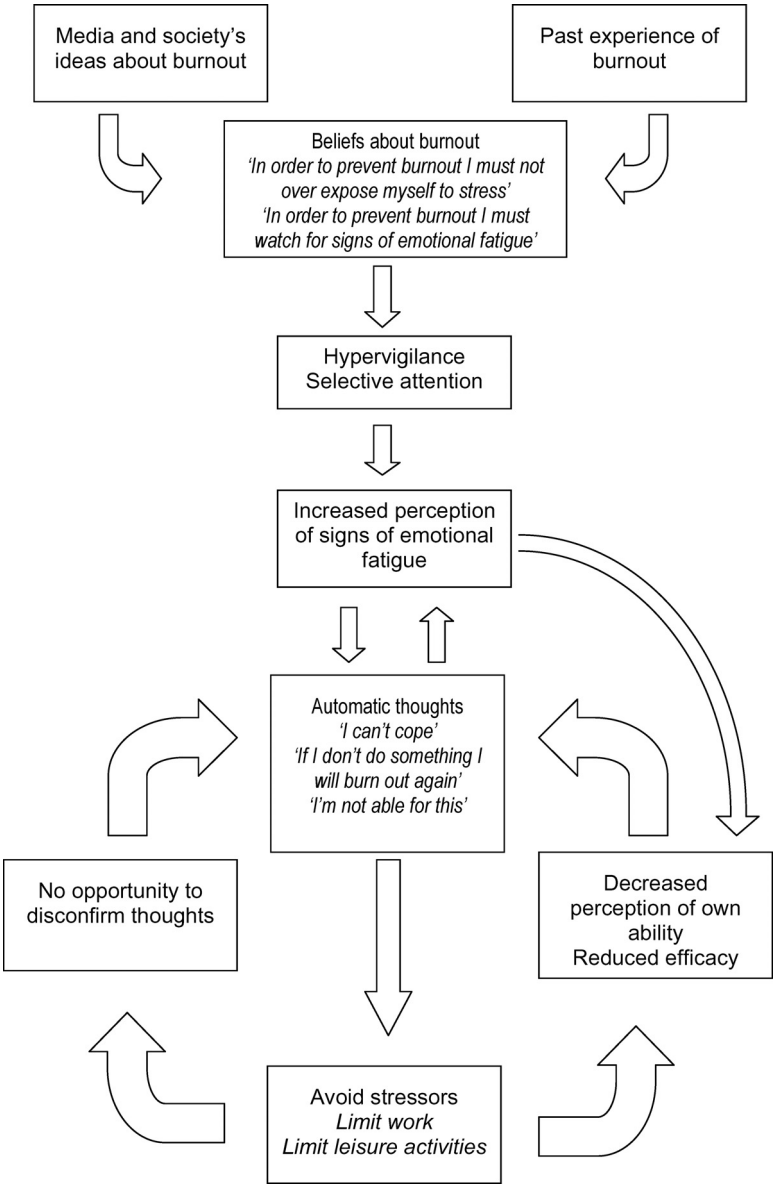

Fig. 1. A cognitive behavioural model of the maintaining processes in burnout.

extremely important for healthcare professionals. In fact, this is one of the skills sometimes taught to patients. It is important to note that this model does not advocate against it. It does not imply that exhausted workers who take some time off are engaging in an unhelpful behaviour.

Instead, this model demonstrates that behaviours that are initially adaptive, may become unhelpful over time. The possibility of behaviours changing their effect in this manner is

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consistent with the view of Thwaites & Freeston (2005) who stated 'with repeated, excessive or situationally inappropriate use, it is possible that behaviour shifts along a continuum from adaptive coping strategy to safety behaviour' (p. 178).

To distinguish safety behaviours from adaptive self-care strategies, safety behaviour may be defined as those behaviours that are responsible for maintaining negative thoughts about the capacity to cope. Rather than facilitating a graded return to the workplace, safety behaviours prevent any increase in recovery. Thwaites & Freeston consider the intention of behaviours as differentiating between safety behaviours and adaptive coping strategies. Safety behaviours and their accompanying cognitions are limiting and static rather than being intended to support increased exposure to stressors.

Safety behaviours can be elicited by asking how a worker responds or manages thoughts such as 'I can't cope'. As with generic CBT, a questioning or experimental stance can be adopted and behavioural experiments can be used to test out both the thought and the need for the safety behaviour.

As an example of this approach, the thought 'I am unable to cope with the full demands of this job' can be tested by naming the full demands of the job, being specific about what it means to 'cope' and then testing the validity of this thought. The worker may report that they have limited their work in some part of their job in accordance with this thought. A behavioural experiment could be set up in which such a safety behaviour is dropped. (This should not imply that professionals should aim to work outside the limit of the competencies in accordance with codes of ethics.) For some workers recovering from burnout, the emphasis will be on coping with a gradually widening level of demand.

Case vignette

Therapist A had struggled with burnout at several points of her career. Due to this she had tried changing posts and taking extended time off work. However, although this relieved the immediate problem it did not provide a long-term solution. She continued to feel overwhelmed by work and was fearful of returning to a point where she might require further time off work.

Therapist A attempted to maximize her energy by avoiding phone calls from friends, avoiding any evening events on weekday nights and limiting the number of patients she saw in any day. In sessions and between sessions she would attend to any feelings of being overwhelmed, burdened, cut off from a patient or unsure how to direct the session. She would interpret these as signs that she was not coping with the emotional demands of the session.

Once she noted that these sensations continued despite a reduction in the demands she placed on herself she would think 'This proves I cannot work to full capacity'; 'I'm not very able'; 'If I'm not able then I'm at risk of being overloaded'; 'I need to be careful as I am vulnerable'. This resulted in a further withdrawal, hypervigilance and negative thoughts.

Change began with the thought 'I cannot face Monday mornings, I won't be able to get through the sessions'. This was challenged by considering the evidence that she was already managing every Monday morning, albeit limiting her sessions. A new thought was generated: 'I do face Monday mornings every week so I *am* able to face them'.

Once Therapist A had started to acknowledge her own ability to cope, her number of sessions on Monday morning was increased to test if she was still able to 'face' this work. As she continued to register her capacity to manage these stressors her negative cognitions

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regarding her capacity were replaced by the thought 'I can cope'. Once she had returned to completing a full set of sessions she regained a sense of self-efficacy and her perception of emotional fatigue had diminished.

Congruence with research data

How does this fit with the research literature on burnout? Interestingly, the idea of dysfunctional coping strategies in the process of burnout has been raised in the research literature and most researchers agree that depersonalization, or reduced engagement in work, is a dysfunctional coping strategy (Kristensen *et al*. 2005; Taris *et al*. 2005). In their study, Taris *et al.* (2005) looked at the scores on the three dimensions of burnout over time. Their results suggested that emotional exhaustion was followed by high levels of depersonalization (withdrawal or avoidance) and that this depersonalization was a dysfunctional coping strategy that resulted in lower levels of personal accomplishment (efficacy) at a later date. As perceived efficacy decreased, so levels of burnout increased. This is congruent with the model proposed above, where awareness of emotional exhaustion leads to avoidance and withdrawal (akin to depersonalization), leading to reduced levels of personal accomplishment and a reinforcement of negative thoughts.

Further confirmation of this model could be obtained from conducting research into common beliefs about burnout and self-selected methods of 'coping' among those who suffer from burnout, particularly examining the use of avoidance and hypervigilance. This would determine how extensively these coping strategies are used. Additionally, this model suggests that those who engage in high levels of avoidance and hypervigilance will continue to suffer from burnout over time. Therefore it is expected such individuals will continue to report symptoms of burnout.

Summary

This CBT model of the maintaining processes in burnout highlights the danger of becoming caught in a cycle of maladaptive coping strategies that facilitates the enduring nature of burnout symptoms. It suggests the importance of identifying burnout-related thoughts and examining how coping strategies might be serving to reinforce them rather than ameliorate them. The identification and testing of these thoughts could form a useful tool both for individuals and supervisors of those who are struggling with the demands of their work, alongside the other self-care and systemic interventions currently being advocated.

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Declaration of Interest

None.

Recommended follow-up reading

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Learning objectives

- To recognize the defining characteristics of burnout.
- To understand the processes that may maintain the symptoms of burnout.
- To recognize the role of challenging burnout-related cognitions and reducing safety behaviours in the management of burnout.