Process oriented tension regulation in the treatment of burn-out complaints: are stressors relevant?

Centre for Breathing and Relaxation Therapy

J van Dixhoorn*,**

*) Centre for breathing Therapy Amersfoort and **) Spaarne Gasthuis, Haarlem,

Introduction

For unexplained symptoms. like burnout, causality is by definition unclear. Nevertheless, treatment often starts on an assumption of causes. A common view of burnout is that it results from stressors (difficult life situations) which are coped with inadequately. Process oriented tension regulation however does not assume causes, but observes whether a positive relaxation response to treatment techniques is blocked by stressors.

A multimodal approach is used to select techniques or treatment modalities for each individual subject that turn out to be feasible and successful. The therapist has a large repertoire of techniques and evaluates the process of the patient systematically. The therapist is keen to detect in the course of treatment the presence or absence of underlying complicating factors, called 'blocking stressors' (Van Dixhoorn,2013). These are difficult life situations that are outside the domain of internal self regulation, and/or maintain a high tension state. These patients are complex and in need of more specialized treatment.

We studied which factors are associated with the presence of blocking stressors.

Subjects and methods

Patients classified within the category of 'burn-out' were selected from an existing database, containing subjects who were referred for breathing and relaxation therapy from 2006-2011. They were 145 subjects (93 women, 52 men).

Measurements, at intake, at fourth and last session:

Specific individual complaints were noted at intake. By way of a qualitative analysis they were classified into 8 categories. Change in each category was rated as disappeared, strongly improved, little improvement, unchanged or worsening. Each complaint category was recoded for the analysis as 1) strongly improved or disappeared, 2) not strongly improved or persisting, 3) not applicable.

Blocking stressors: stressful circumstances or factors, social, psychic or somatic, that sustain high tension and are beyond the reach of individual self regulation, rated by therapist at fourth and last session as 1. absent or not relevant, 2. initially present but improved and not blocking any more, 3. present and actually blocking a positive response (other treatment/ actions required). Subjects were divided into two groups, those with and without blocking stressors.

Baseline variables that were univariately related to the presence of blocking stressors were included in a multivariate analysis of treatment process variables. Logistic regression analysis was used to identify baseline and treatment variables that were associated with the presence of blocking stressors.

Process evaluation of treatment

1. **Each session: successful application of technique at home?**
2. **Fourth and last session: specific response in each complaint? blocking stressors/ circumstances present?**
3. **Reasons to stop treatment: insufficient responsive**
4. **Length and content of treatment is tailored to the subject**

Table 1 Baseline characteristics of patients with and without apparent blocking stressors

Item	Responsive, n=107 (74%)	Blocking stressors, n=38 (26%)
Age	42,7 (± 10,7)	43,9 (± 9,1)
Men	38 (36%)	14 (37%)
Women	69 (64%)	24 (63%)
Employed	98 (92%)	34 (90%)
Work status, full time (%)	***21 (20%)***	***5 (13%)***
Referral		
General Practitioner	27 (25%)	14 (37%)
Occupational MD	***21 (20%)***	***3 (8%)***
Psychologist	16 (15%)	6 (16%)
Self-referred	23 (22%)	10 (26%)
other	20 (19%)	5 (13%)
Co-treatment	57 (53%)	20 (54%)
Complaints total (n)	3,4 (± 1,4)	3,1 (± 1,4)
Fatigue	62 (58%)	26 (68%)
Tension	66 (62%)	18 (47%)
Breathing	35 (33%)	17 (45%)
Sleep	***40 (37%)***	***5 (13%)***
Mental unrest	29 (27%)	6 (16%)
Headache	26 (24%)	5 (13%)
Neck shoulder	22 (21%)	7 (18%)
Anxiety/panic	16 (15%)	4 (10%)

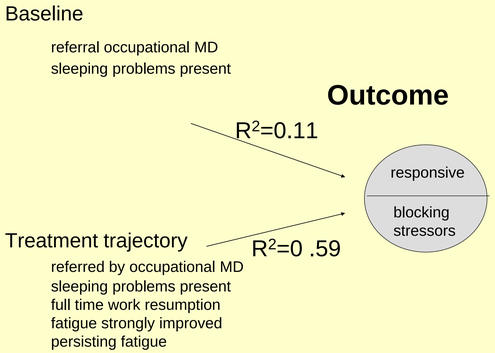
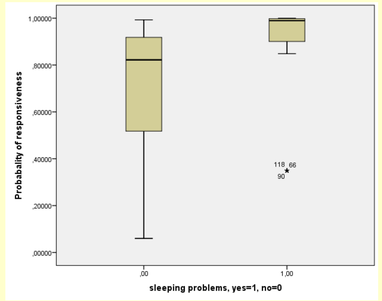
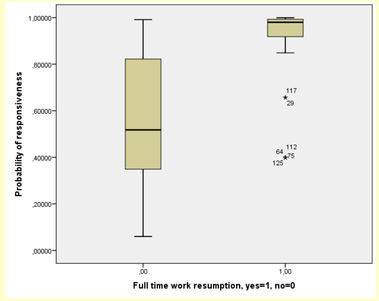
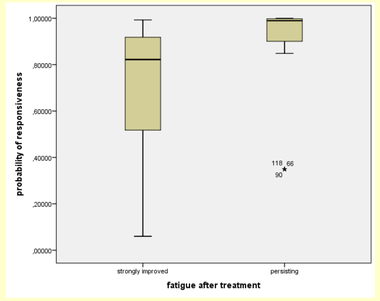


Table 2. Treatment trajectory variables

Number of sessions	7 (2- 27)	5 (1-15)
Duration of sessions (weeks)	15 (1-134)	9,5 (0-88)
Work status		
Full time	61 (57%)	5 (13%)
Complaints much improved (%)		
Fatigue	***55/62 (89%)***	***4/26 (15%)***
Tension	***59/66 (89%)***	***9/18 (50%)***
Breathing	***31/35 (89%)***	***7/17 (41%)***
Sleep	32/40 (80%)	2/5 (40%)
Mental unrest	22/29 (76%)	3/6 (50%)
Headache	22/26 (85%)	2/5 (40%)
Neck shoulder	17/22 (77%)	4/7 (57%)
Anxiety/panic	14/16 (88%)	2/4 (50%)







Results

About one quarter of the patients (26%) were classified by the therapist as unresponsive: further treatment appeared to be indicated. The others (74%) appeared to be able to handle their stress sufficiently.

Patients with blocking stressors had much less frequent sleeping problems and fewer of them were referred by the occupational medicine doctor. These factors were associated with the outcome in a logistic regression analysis: R^2=0.11 Most patients had a job (90%), but only few fulfilled their full working schedule (20-13%).

Treatment took on average 5-7 sessions in a period of 2-4 months. At the end of treatment full return to work was present in only few patients with blocking stressors (13%), whereas more than half (57%) had returned full time to work, in responsive patients. Response in complaints differed markedly, in particular in fatigue. Almost all (89%) responsive patients improved strongly in fatigue, whereas this happened in only a small minority (15%) of patients with blocking stressors. In all other complaints improvement was much less but still present in patients with blocking stressors (40-50% versus 75-90%).

In a multivariate logistic analysis both the two selected baseline variables and process variables were included. Full time work resumption correlated highly with the outcome. Fatigue was included twice, both as presence of strong improvement and as persisting fatigue. Together the association was strong: R^2 = 0.59

Discussion

For about three quarters of burnout patients self-regulation of tension appears to enable them to solve their problem. Main complaints improved greatly for most, many returned to work fully. For the others, the problem was judged by the therapist to be more complex and in need of other treatment. Complaints did improve for them and they did experience benefit, but it seemed insufficient to enable them to solve the problem.

The therapist judged in the course of treatment whether self regulation of tension was sufficient. This judgment was greatly substantiated by the baseline and treatment variables. This validates therapist judgment of outcome.

Response in a key symptom of burn-out as well as return to normal, working life are understandably important. Fatigue was not mentioned by all patients as a complaint at intake. But both its strong improvement, and its persisting presence were related to the outcome. Presence of sleeping problems indicating responsiveness may indicate that sleeping problems are a 'bridge variable', according to the network theory of psychopathology (Borsboom, 2011). That is, they are related to other symptoms and their treatment facilitates an overall positive outcome. By contrast, referral by occupational medical doctor may indicate that to his mind serious problems at work are absent.

References:

Jan van Dixhoorn, Spanningsregulatie in de behandeling van burn-out, een exploratieve studie (Tension regulation in the treatment of Burnout). Tijdschrift Bedrijfs- en Verzekeringsgeneeskunde, 2013; 21-9, 412-418.

D Borsboom, A. Cramer, V Schmittman, S Epkamp, L Waldorp, The Small World of Psychopathology. PLoSOne,2011, 6(11): e27407. doi:10.1371