Burnout subtypes and their clinical implications: A theoretical proposal for specific therapeutic approaches

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Abstract: Burnout is associated with a poor perception of health status, psychosomatic disorders and physical illness. The aim of this study is to construct a comprehensive theoretical proposal for a therapeutic intervention that is sensitive to the different clinical manifestations of this state. In order to do this, the frenetic, under-challenged and worn-out subtypes of burnout are presented in a systematic manner, together with the interventions that may provide suitable management for each subtype. Said clinical profiles may represent different stages in the progression of burnout, and have specific dysfunctional mechanisms that require a choice of adjusted intervention strategies according to the characteristics of each particular case. Finally, the degree of dedication to work and its clinical repercussions are put forward as a hypothesis to explain the progressive impairment caused by burnout, and as a target on which primary, secondary and tertiary prevention strategies could be founded.

Keywords: Stress; burnout subtypes; BCSQ; psychological treatment.

Subtipos de burnout e implicaciones clínicas: Una propuesta teórica basada en abordajes terapéuticos específicos

Resumen: El burnout se asocia con un peor estatus de salud percibida, trastornos psicosomáticos y enfermedades físicas. El objetivo del presente trabajo es articular una propuesta teórica comprensiva de intervención terapéutica sensible a las diferentes manifestaciones clínicas de dicho estado. Para ello, se presentan de forma sistemática los subtipos de burnout frenético, sin-desafíos y desgastado, así como las intervenciones que pueden proporcionar un adecuado manejo de cada subtipo. Dichos perfiles clínicos parecen representar momentos diferentes en la progresión del burnout, con mecanismos disfuncionales específicos, que obligan a optar por estrategias de intervención ajustadas a las características de cada caso en particular. Finalmente, se propone el grado de dedicación en el trabajo, y sus repercusiones clínicas, como hipótesis para explicar la progresiva erosión que supone el burnout, y como eje sobre el que fundamentar las estrategias de prevención primaria, secundaria y terciaria.

Palabras clave: Estrés; subtipos de burnout; BCSQ; tratamiento psicológico.

Introduction

The changes recently experienced in the workplace on a global level as a consequence of the circumstances imposed by the dominant economic paradigm, pose a huge challenge for workers and their ability to adapt. The rationalization and control of production and service processes brought about by the implementation of

technological and bureaucratic systems have led to significant transformations in the structure of modern societies. These require workers to make great physical and psychological efforts in order to adapt to the changing demands of their jobs. Growing volumes of work, reduction in the level of economic resources, technocratic control of productivity and new technological requirements, which have contributed to increase workers' vulnerability to stress, and by extension, to their risk of suffering from burnout.

European Union sources conclude that approximately 30% of European workers may present high stress levels in their jobs, indicating a strong growth in this type of occupational risk (Milczarek et al., 2009). The close links between stress and burnout, and their high economic cost for healthcare systems are well documented. In fact, both are now considered epidemics with serious implications for people's health and their ability to work, and also with a negative impact on the quality of services. This is due to interpersonal problems, a higher number of errors, absenteeism and delays in decision-making processes, among others (Schaufeli et al., 2009). More specifically, with an estimated prevalence of 12–25% for mild burnout (Ahola et al., 2010; Milczarek et al., 2009), this state is considered to be an important emerging psychosocial risk.

Given this background, it is not enough to merely acknowledge the situation of risk that burnout creates in the current work environment, but it is also necessary to go further by seeking to define the conditions in which new diagnostic, prevention and treatment procedures for this condition can be incorporated (Gómez-Alcaina, Montero-Marín, Demarzo, Pereira y García-Campayo, 2013; Haberthür et al., 2009). The main aim of this narrative-review is to provide a systematic view of the different manifestations and clinical implications of burnout and its subtypes, and to construct a theoretical proposal for coherent therapeutic interventions, for the purpose of informing and encouraging debate on the subject between healthcare professionals, researchers and managers.

Stress and burnout

Stress is the result of a relationship with the environment in which an individual interprets as being very important for his/her personal welfare, and whose demands or requirements exceed the available resources with which to cope with them. Coping refers to all the cognitive and behavioural efforts by the individual to manage specific internal and/or external demands that are appraised as excessive in relation to his/her available re-

sources (Lazarus, 1993; Zhang et al., 2014). From this point of view, individuals will experience stress from a particular situation if they do not possess sufficient coping skills with which to manage it adequately, while placing considerable importance on the consequences of an inadequate management. However, stress does not necessarily need a real shortcoming as a cause, as an imagined shortcoming will do just as well. Moreover, stress may exist where resources are present and objectively sufficient, but where the person is predisposed to stress or is hypersensitive because of other factors (e.g. personality traits, behaviour patterns, mistaken beliefs). In general terms, there are different coping styles for dealing with stress, such as problem-focused coping, emotion-focused coping, cognitive avoidance, behavioural disengagement and substance use (Montero-Marín et al., 2014).

It has been pointed out that inflexible coping styles, which are not suited to different situations, are associated with high levels of medium- and long-term stress (Weimberger et al., 1979). It was traditionally thought that a coping strategy mainly focused on problem-solving could be more suitable for managing stress than a strategy focused on the venting of emotions. Nevertheless, this conclusion has turned out to be overly general and offers a simplistic view of what is actually a complex interactive process, which needs to take into consideration, among other aspects regarding the nature of the situation and the individual's psychological profile (Reissner et al., 2009). For instance, it has been observed that problem-focused coping is not a suitable strategy for situations of an uncontrollable nature or of chronic length, given that it may ultimately give way to a gradual process of behavioural disengagement (Wallace et al., 2010). On the other hand, it has also been shown that emotion-focused coping is not suitable when it involves detachment from the situation, but it does become an effective strategy if it involves a positive re-evaluation (Haberthür et al., 2009). From this perspective, burnout would appear to be the result of a persistent use of inefficacious or dysfunctional coping strategies, with which workers try to protect themselves from chronic work-related stress (Lazarus, 1993; Reissner et al., 2009). But what do we understand by burnout?

The closest and most informal meaning of the term burnout is precisely that of being 'burned out': worn-out, exhausted and disenchanted by work. The first reference to this term as a psychological state, was made by Graham Greene in his novel *A Burnt-Out Case,* in the early 1960s. Burnout subsequently became the subject of scientific study for close to forty years. Its study began with its consideration as a type of stress that was

linked to helping professions, and it was associated with a gradual loss of energy and enthusiasm (Freudenberger, 1979). Essentially, burnout reflects a situation where there is a lack of harmony between an employee and his/ her workplace (Farber, 2000). It is a psychosocial state, the result of a more or less successful response in an attempt to adaptation to chronic stress. From a procedural perspective, as introduced above, it develops progressively owing of the use of relatively ineffective coping strategies, with which workers attempt to protect themselves from the work-related stress that stems from their relationships with clients and/or the organization (Maslach et al., 2001; Schaufeli et al., 2009). In the medium and long term, a key factor for the evolution of this state is the degree of passiveness presented by workers when faced with stressful situations. It is here where the coping strategy used, and its inflexible continuation regardless of the specific nature of the situation, plays an important part as mediating variables in the development of burnout. In general terms, we can said that burnout is a negative subjective experience, comprising negative perceptions, emotions and behaviours towards work, towards the people who relate with the individual in his/ her workplace, and towards his/her actual professional role (Ahola et al., 2010).

Burnout has traditionally been defined by means of the dimensions of exhaustion, cynicism and inefficacy (Maslach et al., 2001; Schaufeli et al., 2009). Exhaustion is the feeling of not being able to offer any more of oneself at work, as the consequence of a prolonged exposure to excessive demands. Cynicism is a detached attitude to tasks, colleagues and recipients of service. Inefficacy is the feeling of not performing tasks adequately and of being incompetent. This conceptualization, commonly accepted as a standard, presents a certain number of flaws, given that it was not developed through clinical observations, and that it was not based on a systematic theorization of the syndrome. Instead, it was proposed inductively by means of the factorial grouping of a more or less arbitrary set of items (Schaufeli et al., 2009). Moreover, this definition does not clarify the type of relationships that the constituent components present with each other, nor does it explain the background and general consequences of the syndrome. It therefore lacks the necessary theoretical structure. For this reason, other alternative models have been proposed, one of which we explain in detail in the following, owing to its clinical emphasis.

Burnout subtypes and their clinical implications

One of the most significant drawbacks of the classic view of burnout, particularly with regard to the develop-

ment of clinical intervention strategies, is that it considers all cases in a homogeneous way through a definition based on the same symptoms for all, whereas the psychosocial reality tends to be different for each case (Farber, 2000; Norcross et al., 2011). Given this limitation, and as an alternative to the traditional definition, different burnout subtypes or profiles have been proposed depending on their clinical particularities. These profiles can be evaluated with the "Burnout Clinical Subtype Questionnaire" by using the extended (BCSQ-36) or short (BCSQ-12) versions (Montero-Marín et al., 2010; Montero-Marín et al., 2011). The theoretical proposal of clinical profiles came about as a result of a unifying methodological process, arising from a clinical approach based on purely phenomenological descriptions (Farber, 2000), which were subjected to systematic processes of qualitative content analysis (Montero-Marin et al., 2009), prior to the subsequent psychometric validation of the model (Montero-Marín et al., 2012).

The first of these profiles is the frenetic burnout subtype, whose main characteristic is that the subjects it describes work increasingly harder until they are exhausted, seeking success on a par with their efforts (Farber, 2000). They show high levels of involvement, in the sense that their efforts are increased to cope with difficulties in order to produce the expected results. They also show unrealistic ambition, related to their great need to achieve important goals, together with the impossibility of recognizing their own limitations. Finally, they are overloaded, which means they have the feeling of risking their health and private life in the pursuit of good results (Montero-Marín et al., 2009). This profile has been associated with high levels of exhaustion and a coping style focused on active problem-solving, for which subjects employ a large number of working hours or are involved in different tasks at the same time (Montero-Marín et al., 2014). This profile also tends to display certain environmental sensitivity, with subjects making complaints regarding the hierarchical structure of the organization in which they work (Montero-Marín et al., 2013), while feeling guilty at the thought of not being able to meet the goals they had initially set for themselves (Farber, 2000). The type of stress they suffer from is basically produced by the strain caused by their high expectations, and also their frustration at the idea of not achieving them. All of these aspects form an important breeding ground for burnout, in which the organization also plays a significant role by setting guidelines for excellence that are tenaciously pursued, increasing overload. In order to maintain an adequate level of performance, subjects tend to cope with stress by focusing on tasks, while managing to regulate their emotions by

venting the pent-up discontent that inevitably accumulates (Montero-Marín et al., 2014).

In contrast, subjects described by the underchallenged burnout subtype have to cope with monotonous and unstimulating conditions that fail to provide the necessary satisfaction (Farber, 2000). They display indifference, given that they perform their work-related tasks without interest and superficially; boredom, because they suffer from lack of stimulus and monotony when performing tasks; and lack of development, understood as the absence of personal growth experiences together with their desire to take on other jobs (Montero-Marín et al., 2012). This profile is related to high levels of cynicism, owing to the lack of identification with work-related tasks, and most likely occurs in jobs with repetitive tasks or with mechanical and routine forms of working. It is associated with an escapist coping style based on distraction and cognitive avoidance (Montero-Marín et al., 2014). In general, underchallenged employees have to cope with the disenchantment and distress caused by their feelings of being trapped in an occupational activity to which they are indifferent, which bores them to a degree that becomes 'pathological', from the lack of motivation, even to incapacity (Campagne, 2012), by no longer providing satisfaction or personal challenges. As a result, they tend to continually complain about the routine that their obligations impose (Montero-Marín et al., 2013). Furthermore, they are overcome by feelings of guilt caused by their ambivalence to their work and by their desire for change (Farber, 2000). Essentially, subjects described by this profile have lost their objectivity with respect to the natural right to experience needs for personal development, and they feel a great deal of frustration when they no longer try to pursue them.

The last of these profiles, the worn-out burnout subtype, describes workers who act carelessly when faced with stress and lack of gratification (Farber, 2000). Subjects described by this profile present feelings of hopelessness, owing to their experience that they lack of control over the results of their work, and what they perceive to be a lack of acknowledgement for the effort they have invested. They finally opt for omission, disregard and neglect as a preferential response to difficulties and chronic stress situations (Montero-Marín et al., 2009). Consequently, this type of burnout is strongly associated with the perception of inefficacy and strong feelings of incompetence, after a process involving years of service in organizations with inadequate contingency systems for rewarding and penalizing behaviours. Thus, the main complaint described by this profile is about the monitoring systems of the company where they work (Montero-Marín et al., 2013). In addition, they make use of a passive coping style, owing to behavioural disengagement, which produces beliefs of incompetence. This causes them to experience feelings of guilt for not fulfilling the responsibilities inherent to their job (Farber, 2000). As with the underchallenged profile, the main source of stress is the frustration experienced, which is magnified for the worn-out profile because of the feelings of hopelessness subjects develop, without forgetting the fact that certain levels of stress in the form of tension could even force them to correct and alleviate their negligent attitude.

The burnout subtypes can be theoretically ordered into a continuum based on their level of dedication and engagement towards work-related tasks (Montero-Marín et al., 2009). Variations in the levels of dedication appear to be the way in which individuals suffering from burnout attempt to exert control over the psychological distress that leads them to the perception of lack of reciprocity in work exchange relationships. This experience of imbalance between the efforts invested and the rewards obtained is an important source of distress, and its presence is strongly related to the manifestation of psychosomatic symptoms (Ahola et al., 2010). The frenetic profile is the most dedicated, owing to its active coping style. It is followed by the underchallenged profile, because of its evasive coping style. The least dedicated is the worn-out profile, with its passive coping style (Montero-Marín et al., 2014). Therefore, the degree of dedication to work can act as a classification criterion for the burnout typology. This criterion is consistent with the idea of a transition over time between the different profiles, through changes from higher to lower levels of dedication. In this sense, the burnout subtypes could be seen as different stages in the development of burnout, which is understood to be a progressive impairment in levels of commitment, and would be affected by a different pattern of perceived stress associated with the corresponding levels of dedication.

A theoretical proposal for specific therapeutic approaches

As we have explained, burnout represents a work-related state that denies individuals' different psychological needs and capacities. These range from the fulfilment of personal goals, as occurs with the frenetic subtype, to the need to achieve a minimum level of challenges, as in the case of the underchallenged, through to the need of the worn-out subtype to perceive a certain level of control over environmental contingencies. The denial of all of these is linked to an important variety of psychosomatic symptoms, but also to significant suffering, which

if not treated in time and appropriately, could easily lead to states of depression (Haberthür et al., 2009). Despite having a consensual operational definition with a characterized aetiopathogenesis and clinical relevance, burnout is not recognized as a mental disorder in current diagnostic systems, perhaps because there is ongoing debate regarding the differences between burnout and depression (Bianchi et al., 2014). Burnout does not appear as a specific disorder in the Diagnostic and Statistical Manual of Psychiatric Disorders (APA, 2013). The International Classification of Diseases (WHO, 2007) includes it in the chapter devoted to "Factors Influencing Health Status and Contact With Health Services" (Z.73.0 "burnout state of total exhaustion", which is based on a very narrow view of the phenomenon), as an additional diagnosis, varying its probabilities for diagnosis with the labels of adjustment disorder, in its less severe form, and major depression, when symptoms are more serious. This absence of specificity is not the ideal situation in which clinicians can be sensitive to the amount of distinctions the syndrome involves, nor does it allow them to choose a specific treatment based on its stage of evolution and most prominent dysfunctional conditions. It is therefore easy to resort to general prescriptions which, while of use, are not the best first-line option and do not allow the intensity of treatment to be adjusted (Barlow, 2007; Norcross et al., 2011).

The development of therapeutic actions to combat burnout, by means of the application of interventions that have shown their efficacy on other disorders, is relatively recent (Awa et al., 2010). While not exhaustive, several examples have been reported of the benefits of applications based on a significant variety of models, objectives and theoretical orientations, applied individually or in groups, and with person-directed, organizational, and mixed targets. Some of these can be seen in Table 1, in addition to their effect sizes reached, calculated on data available in the literature.

To a certain extent, this shows burnout is a dysfunctional condition that responds to a relative degree to psychological interventions, and that there is a major lack of specificity as to how such disparate techniques and treatments can work. However, there are a number of effect sizes that are not sufficiently large, and it has also been said that cognitive treatments alone seems to be a 'low-quality' intervention for burnout. All of this has recently been highlighted in another work (Ruotsalainen et al., 2014), and this leads us back to the iconic question: "*What* treatment, by *whom*, is most effective for *this* individual with *that* specific problem, and under *which* set of circumstances?" (Norcross et al., 2011). In other words, we have evidence of the relative quality of a certain type of interventions, but this is not enough. These interventions should be part of a set of principles that determine the conditions under which their maximum therapeutic potential will be shown, with the least investment in resources and, specifically, while increasing their efficiency and cost-effectiveness at post-treatment and follow-up.

The literature shows that there are at least two important points in this respect. On the one hand, some treatments make better marriages with some mental health disorders (Barlow, 2007). And on the other, even more specifically, efficacy is increased when treatments have a direct impact on the main dysfunctional targets of the disorders (Haberthür et al., 2009; Prado-Abril, García-Campayo, & Sánchez-Reales, 2013; Torrents-Rodas et al., 2015). This is where a longitudinal approach, based on a longitudinal criterion which can act as a yardstick for clinical severity (Montero-Marín & García-Campayo, 2010), can be of great assistance in structuring a comprehensive framework for the syndrome. Principles for action and specific interventions can be derived from it to mirror what is established for other disorders. The phenomenological nature of the proposed typology also allows the targets for intervention to be identified, while remaining sensitive to the need to design tailored treatment programmes for specific groups of patients. This could result in a more efficient determination of burnout, while maximizing the well-known efficacy of certain interventions and even shortening recovery times.

Consequently, this new way of understanding burnout paves the way to the development of new forms of therapeutic intervention, adjusted to the characteristics of the burnout profile identified in each particular case, and to the specific environmental conditions in which it develops. It would prevent an excessively heterogeneous grouping of all affected individuals (Farber 2000; Norcross et al., 2011), while enabling a preventive approach to be taken according to the universal vulnerabilities to chronic stress through general and more or less common programmes (see Table 2).

Intervention on the frenetic profile

The frenetic profile refers to the earliest manifestations of burnout. If the gradual personal impairment of affected individuals is to be halted quickly, it will be essential to detect this in time. In this case, there are three targets to aim for: the subjects' tendency to become overloaded, their unrealistic ambition, and the fact that they often regulate their over-engagement by resorting to emotional venting in the form of constant and rigid complaining (Montero-Marín et al., 2009, 2013, 2014). In

Table 1. Effective interventions in reducing stress and/or levels of burnout*

Study	Design	Participants	Interventions	Outcomes	Target	Cohen's d
Cohen-Katz et al. (2005)	RCT	25 nurses	MBSR (eight 2.5-hour weekly sessions and a 6-hour day-long retreat, for 8 weeks = 26 hours) vs. no intervention control group	MBI, Brief Symptom Inventory	Person-directed	EE = 0.83 DP = 0.80 PA = 1.07
Delvaux et al. (2004)	RCT	115 oncology nurses	Psychological training programme (three 1-week courses, 3 months = 105 hours) vs. no intervention control group	NSS	Organiza-tional	NSS = 0.44
Ewers et al. (2002)	RCT	20 mental health nurses	Psychosocial intervention programme (20 days ~ 120 hours) vs. waiting list controls	MBI	Person-directed	EE = 2.68 DP = 1.20 PA = 3.03
Franco, (2010)	Quasi-exp. (pre, post, 6-months follow-up)	38 primary care physicians	Psycho-educational meditation programme for training and practice in mindfulness (one 1.5-hour weekly session, 10 weeks) vs. waiting list controls	PSQ, STAI	Person-directed	PSQ = 1.36 SA = 1.13 TA = 0.71
Haberthür et al. (2009)	Quasi-exp. (pre, post)	99 patients derived from primary care	CBT (working context and coping skills in individual and group therapy; regulation of vegetative system and mindfulness. Length not specified) vs. no intervention.	MBI, BDI, CISS	Person-directed	Post-test values unreported
Halberg, (1994)	Quasi-exp. (pre, post, 6, 12-months follow-up)	11 nurses	Psycho-dynamic (group) clinical supervision for emotional reactions (fourteen 2-hour sessions over the course of 1 year)	MBI, Tedium	Person-directed	No changes in burnout, although Tedium decreased
Jones et al. (2000)	RCT	79 student nurses reporting affective distress	Multimodal stress management (six 2-hour sessions = 12 hours) vs. waiting list controls	Stress profile, BSSI, GHQ, STAI, BDI, Coping, Absenteeism	Person-directed	SA = 1.50 TA = 0.94
Krasner et al. (2009)	Quasi-exp. (pre, post, 2, 12, 15-months follow-up)	70 primary care physicians	Mindfulness based training (8-week intensive phase: 2.5 hours weekly, 7-hour retreat; followed by 10-month maintenance phase: 2.5 hours monthly)	MBI, PMS	Organiza-tional	EE = (0.62)[†] DP = (0.45)[†] PA = (0.44)[†] DEP = (0.55)[†] VIG = (0.44)[†] FAT = (0.81)[†]
Martín-Asuero et al. (2013)	Quasi-exp. (pre, post, 6, 12-months follow-up)	87 primary care professionals	MBSR (8-week intensive phase: 28 hours; followed by 10-month maintenance phase 2.5 hours monthly)	MBI	Mixed	EE = 0.78 DP = 0.60 PA = 0.54
Poulin et al. (2008)	RCT	40 nurses	MBSR vs. relaxation	MBI	Person-directed	MBSR: EE = 0.55 DP = 0.00 PA = 0.72 Relaxation: EE = 0.05 DP = 0.00 PA = 0.35

Table 1. Effective interventions in reducing stress and/or levels of burnout* (continuation)

Study	Design	Participants	Interventions	Outcomes	Target	Cohen's d
Rowe, (1999)	RCT	126 health care professionals	Stress management (adaptive coping training. Six 1.5-hour weekly sessions, 6 weeks = 9 hours) vs. no intervention.	MBI	Person-directed	EE = 0.48 DP = 0.18 PA = 0.50
Salyers et al. (2011)	Quasi-exp. (pre, post)	74 mental health staff	Workshop day to improve awareness and skills (contemplative, cognitive, social)	MBI	Person-directed	EE = 0.65 DP = 0.42 PA = 0.12
Shapiro et al. (2005)	RCT	40 physicians, nurses, social workers and psychologists	MBSR (2-hour sessions weekly, 8 weeks) vs. waiting list controls	MBI, Brief Symptom Inventory, SCS, Interpersonal Reactivity, Cortisol	Person-directed	SD unreported
Te Brake et al. (2001)	RCT	171 dentist with high burnout scores	CBT training and counselling (1 month)	MBI	Person-directed	EE = 0.37 DP = 0.23 PA = 0.21
Van Dierendonk et al. (1998)	Quasi-exp. (pre, post)	352 direct care not specified professionals	CBT (1/2 day per week for 5 weeks to improve communication and social skills) vs. control group	MBI	Person-directed	EE = 0.34 DP = 0.19 PA = 0.32
Van Rhenen et al. (2005)	RCT	130 employees with high stress levels	Physical exercise and relaxation training vs. cognitive therapy (8 weeks)	MBI	Organiza-tional	Physical: EE = 0.20 DP = 0.14 PA = 0.16 Cognitive: EE = 0.14 DP = 0.27 PA = 0.22
Vilardaga et al. (2011)	Quasi-exp.	699 addiction counsellors	Characteristics unreported (it refers to ACT). No control group	ACT processes, SABS, Work site-factors, MBI	Person-directed	Post-test unreported
Yung et al. (2004)	RCT	65 nurse managers	Cognitive and stretch-release relaxation (four 20-minute weekly sessions = 1.3 hours). No control group	STAI, GHQ	Person-directed	SA = 0.65 TA = 0.26

* Expanded and adapted from Awa et al. (2010), Irving et al. (2009), and Ruotsalainen et al. (2008, 2014).
Note. ACT = Acceptance and Commitment Therapy; BDI = Beck Depression Inventory; BSSI = Beck & Srivastava Stress Inventory; CBT = Cognitive Behavioural Therapy; CISS = Coping Inventory for Stressful Situations; DP = Despersonalization; GHQ = General Health Questionnaire; MBI = Maslach Burnout Inventory [EE = Emotional Exhaustion, PA = Personal Accomplishment]; MBSR = Mindfulness-Based Stress Reduction; NSS = Nursing Stress Scale; PMS = Profile Mood States [DEP = Depression, VIG = Vigor, FAT = Fatigue]; PSQ = Perceived Stress Questionnaire; RCT = Randomized Contro-lled Trial; SABS = Stigmatizing Attitudes-Believability Scale; SCL-90-R = Symptom Checklist-90-Revised; SCS = Self-Compassion Scale; STAI = State Trait Anxiety Inventory [SA = State Anxiety, TA = Trait Anxiety].[†]r as an effect-size measure in brackets.

Table 2. Framework for a prevention and comprehensive therapeutic approach to burnout subtypes

Stage	Dysfunctional mechanisms	Change mechanisms	Interventions	Target
PREVENTION				
	Universal vulnerability features (daily life stressors).	Stress inoculation, promotion of a mindful lifestyle	MST-CS, MBI	Person-directed or Mixed
	Overload and work-related chronic stress	Stress management, decentring, promotion of a mindful lifestyle	MBI, Psychosocial interventions	Mixed
	Burnout risk	Early detection and screening	Regular routine assessment	Mixed
TREATMENT				
Frenetic	Ambition	Cognitive self-awareness / self-awareness of ambition/ overload triggers and patterns	Cognitive Therapy and/or adapted-MBCT	Person-directed
	Overload	Behavioural adjustment / self-awareness of ambition/ overload triggers and patterns	CBT and/or adapted-MBCT	Person-directed
	Involvement	Behavioural adjustment	CBT	Person-directed
		"Slow down" perspective / decentring from "guilty" for no overload or timeless engagement	Adapted-MBCT and/or Mindfulness and Self-compassion-based interventions	Person-directed
	Active Coping Style	Cognitive flexibility	Cognitive Therapy or adapted-MBCT	Person-directed
	Emotional Coping Style	Emotional Regulation	MBI, Physiological regulation techniques, Self-compassion programmes	Person-directed
Undercha-llenged	Lack of development	Values insight / Cognitive and emotion reappraisal / Awareness of indifference triggers and patterns	Values phenomenological exploration (ACT) and/or adapted-MBCT	Person-directed
	Boredom	Acceptance/Job enrichment	Improve challenge levels	Mixed
	Indifference	Reappraisal / Values insight / Awareness of indifference triggers and patterns	ACT or adapted-MBCT	Person-directed
	Cognitive avoidance style	Cognitive flexibility / Awareness of cognitive avoidance triggers and patterns	Cognitive Therapy or ACT and adapted-MBCT	Person-directed
	Own direction ambivalence	Values commitment	ACT	Person-directed
Worn-out	Lack of control	Sense of agency	Behavioural experiments plus changes in rewards organizational system	Mixed
	Hopelessness	Reappraisal and Reattribution / awareness of hopelessness triggers and patterns	Adapted-MBCT and/or Cognitive Therapy	Person-directed
	Neglect	Behavioural activation and sense of agency associated	Behavioural experiments plus changes in rewards organizational system	Mixed
	Behavioural disengagement	Behavioural activation	Behavioural Activation Therapy	Person-directed
	Functional impairment	Behavioural activation	Intensive treatment, included pharmacotherapy in some cases	Person-directed
	Clinical severity	Symptoms reduction	Intensive treatment, included pharmacotherapy in some cases	Person-directed

Note. ACT = Acceptance and Commitment Therapy; CBT = Cognitive Behavioural Therapy; MBCT = Mindfulness-Based Cognitive Therapy; MBI = Mindfulness-Based Interventions; MST-CS = Multimodal Skills Training for Coping with Stressors.

other words, their tendency to chronic over-activation will have to be reduced by using a pattern of tension release through procedures other than the venting of emotions. In this sense, this profile could benefit from interventions focused on reducing levels of physiological arousal, for the purpose of eliminating the distress caused by tension, and preventing fatigue and exhaustion. They are patients who have little insight into their dysfunctional condition, and therefore, little likelihood of independently readjusting their behavioural pattern towards healthier forms of conduct. In fact, these people habitually need a critical life event in order to become aware of their risk situation, or require approaches that are specifically designed to this effect. One example is the adaptation of the Mindfulness-Based Cognitive Therapy (MBCT) programme (Regehr et al., 2014), originally developed for patients suffering from major depression. MBCT focuses on cultivating mindfulness in order to facilitate self-awareness about triggers, and in the case of the frenetic burnout, it could be used to take awareness of vulnerability patterns, such as the tendency to become overloaded as a result of unrealistic ambition. This programme can also assist in developing skills for decentring, when patients feel guilty for not becoming sufficiently involved in work-related tasks. Such dysfunctional feelings might also benefit from specific interventions to develop equanimity and loving awareness by using compassion-focused treatments.

In order to take into consideration all the facets of this profile, it is essential to explore the causes of the patients' overreaching ambition, and the guilt feelings associated with their excessive need to achieve goals, perhaps by taking an approach focused on the cognitive restructuring of their deepest needs for personal recognition. A holistic framework, in which personal needs could be understood by means of raising awareness of their elevated level of daily engagement, may lead to the restructuring of mistaken beliefs relative to their values hierarchy. This in turn could facilitate and augment the benefits of techniques for reducing over-engagement, in a comprehensive framework in which physiological regulation could take place in line with cognitive change, allowing the adoption of alternative behaviours, such as the ability to postpone, prioritize and differentiate between what is urgent or important from what can wait (Farber, 2000).

In short, as occurs with certain inflexible thought patterns, cognitive change will be necessary, through which understanding of the links that exist between 'typical behaviour' and its adverse daily consequences can be established as a first step to providing a context where the techniques for readjusting behaviours maximize their

therapeutic potential (Barlow, 2007). From this point, further help would come from strategies such as assertive behaviour modelling (to set limits for accepting commitments), learning time management procedures, (making it possible to satisfy personal needs), and the development of an attitude of self-management with affection and compassion for oneself and others. The final objective would be the adoption of a healthy lifestyle, which would include physical exercise, relaxation, controlled breathing, meditation and a general 'slow-down' perspective, allowing individuals to take complete care of their health, even in the workplace (Yung et al., 2004).

Intervention on the underchallenged profile

This profile consists of a state of personal impairment which is more advanced than that represented by the frenetic profile. Underchallenged workers are already exposed to the dilemma that is the lack of direction and/or purpose in their careers and the feelings of ambivalence about taking on another job (Farber, 2000). Raising awareness is less important in this case, given that experiences of suffering and psychological distress are already fully implanted in the form of indifference towards tasks, continuous boredom and lack of personal development at work. All of this is compounded by a certain diffusion of work-related responsibilities in the form of distractions and cognitive avoidance (Montero-Marín et al., 2014). Consequently, this profile could benefit from interventions specifically focused on the restructuring of cognitive and emotional states, such as the MBCT programme, although with particular attention to the developing of awareness of triggers for patterns of dysfunctional indifference and cognitive avoidance responses, as strategies to cope with chronic work-related stress (Regehr et al., 2014).

Furthermore, the type of approach necessary for this profile should alternate phenomenological exploration and clarification of life and work values (Ruotsalainen et al., 2014), in an endeavour to find those with which to form definite commitments towards a path or direction in life, in an attempt to solve the person's state of ambivalence (Irving et al., 2009; Vilardaga et al., 2011). This could also facilitate a renewal of interest and the recovery of true satisfaction and enthusiasm, encouraging personal development at work through the establishment of new challenges that are significant for the individual. Throughout this process of exploration and cognitive restructuring, it will also be important to monitor and adjust patients' attitudes towards their legitimate right to satisfy their psychological needs for personal fulfilment. In order to alleviate feelings of guilt fed by a desire for

change that is not translated into purposeful, valuable and meaningful actions, it will be important to put all efforts in order in the right direction, pointed out by personal values, and discovered through deep exploration techniques in this regard (Vilardaga et al., 2011).

Another beneficial option would also be to redefine their relationship with their current job in terms of meaning, fostering greater presence and satisfaction through mindfulness techniques that can reduce the boredom and apathy associated with mechanical and mindless activity. It will also be useful to redefine tasks and aims, for the purpose of presenting them in an appealing, significant and generally more challenging way (Regehr et al., 2014).

Intervention on the worn-out profile

The worn-out subtype appears to have undergone prolonged exposure to a situation of serious stress (Farber, 1990), after the failure of primary prevention and detection strategies in previous stages, or owing to rapid progression of the burnout condition. For this reason, patients matching this profile will require an intervention with greater intensity and length of assistance. The worn-out subtype is characterized by presenting beliefs of hopelessness, perception of personal inefficacy and absence of control over contingencies, which are translated into neglect and disregard for job functions (Montero-Marín et al., 2009). This explains why it is possible in this case to find comorbidity with major depressive disorder (Bianchi et al., 2014). Therefore, a combined approach that could include psychiatric medication may be indicated in some cases, depending on functional impairment, clinical severity, or both.

Treatment for hopelessness, regardless of the presence of major depression, will require multimodal cognitive interventions. In addition to cognitive restructuring, these should include attribution readjustment strategies and the scheduling of objectives as part of an individualized behavioural engagement programme, and interventions such as MBCT centred on increasing awareness of triggers for hopelessness and focusing on the prevention of new depressive episodes (Barlow, 2007; Regehr et al., 2014). In the case of the worn-out profile, interventions using MBCT would be particularly indicated in the maintenance stage of treatment, and applied as a complement to other treatments to control the symptoms. In the same way, to the extent that beliefs become flexible, and the level of activity increases, a module aimed at working on patients' sense of agency should be progressively introduced in order to assimilate the notion of their own control over their behaviour. In

the same way, the assignation of responsibilities depending on their situation might also be advisable, until they understand what constitutes an efficacious action, a neglectful action and a random and unpredictable event. In other words, through the use of a systematic and firm working format, probably of long duration, an attempt will be made to gradually reverse patients' passive coping style, allowing them to regain their confidence, security and feeling of control through acceptance, and carry out the necessary actions to achieve their adequate performance of tasks. In this way, their feelings of guilt associated with non-fulfilment of their duties could be attenuated.

However, it will be difficult to overcome any psychosocial risk through interventions on individuals alone, given that this would amount to intervening on only a part of the problem (Esteras et al., 2014). Although exceeding the scope of this article, which places emphasis on person-directed targets, it will also be necessary to implement interventions that target the actual organization at the same time. For instance, it will be important to deal with contingency systems, steering them as far as possible towards adherence and commitment to tasks, through improvement to processes by means of which control can be regained, such as decision-making, acknowledgement of good work, and the obtaining of rewards determined by the efforts invested. Of course, this should be done without losing sight of the aim of fostering a positive work environment, which allows the establishment of social support networks in order to provide better quality of life in the workplace.

Conclusiones

The onset and development of burnout leads to a progressive impairment in the commitment of workers, a gradual diminishing in their level of attention to, enjoyment of and dedication to tasks, which goes from enthusiasm to apathy, even leading to major depression disorder in the most severe cases. This dysfunctional state seems to appear in its prodromic phase with the excessive involvement characteristic of the frenetic profile, and it is in this respect that action in the form of primary and secondary prevention will be key. Given that this level of dedication is a pattern caused by a more or less rigid over-engagement, exhaustion eventually sets in, and affected workers begin to adopt certain cynical detachment as a form of protection (Maslach et al., 2001, 2012; Schaufeli et al., 2009). In this way, temporary relief is provided from the excessive activity, but at the cost of increasing frustration, which is evident in the indifference and cognitive avoidance of the underchal-

lenged subtype (Montero-Marín et al., 2009, 2014). Ultimately, this detachment might have the effect of reducing the perception of efficacy, giving way to marked passive coping strategies, such as behavioural disengagement, which is typically present in the worn-out subtype.

This parallel between the development of burnout and of the different subtypes ordered according to the level of dedication, suggests the adjustment of specific interventions, in the understanding that the subtypes might be a succession of different stages in the general evolution process. This view allows specific treatments to be proposed, depending on the stage of progress, the idiosyncratic characteristics of each subtype, the level of clinical severity and the degree of functional impairment. The transversal nature of the research on burnout subtypes means that certain caution should be taken with this longitudinal therapeutic hypothesis, which will require to accumulate more validity through prospective studies to support it, although the dose-response relationships found to date back this proposal. Likewise, clarifying the role guilt may play in the development and shift from one profile to another could bring greater understanding of the clinical evolution of the syndrome than that provided by the dimensions of the classic model (Maslach et al., 2001), which is scarce and problematic in this regard. Moreover, it would enhance our understanding of the phenomenon, and add new elements for consideration to the set of clinical recommendations put forward in this work.

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