The Trap of Meaning:

Recognizing overlap and distinctions between burnout and psychiatric illness . . . and learning what to do about each

Nicole Herschenhous, MD, FRCPC

Conflicts

- No conflicts of interest to disclose

Though . . .I run Balint groups and mindfulness-based interventions

Objectives

- What is burnout?
- Relationship of burnout to mental illness
- Recognizing burnout and mental illness in self and HCW patients
- Potential pitfalls in accurately identifying each
- How to address burnout and mental illness

Case

Burnout defined

- A syndrome, driven by workplace stressors, and characterized by:
  - Emotional exhaustion – emotionally over-extended and drained by others
  - “Depersonalization”- disconnected, dehumanized, cynical attitudes towards our patients
  - Reduced sense of competence and achievement

- Affects physicians’ professionalism, altruism, and sense of calling, as well as how they feel and function in their personal lives

Burnout questions (abbreviated MBI)

Red = emotional exhaustion
Blue = depersonalization
Green = personal accomplishment

How often do I experience the following? (ranging from every day to never):

- I deal very effectively with the problems of my patients
- I feel I treat some patients as if they were impersonal objects
- I feel emotionally drained from my work
- I feel fatigued when I get up in the morning and have to face another day on the job
- I've become more callous towards people since I took this job
- I feel I'm positively influencing other people's lives through my work
- Working with people all day is really a strain for me
- I don't really care what happens to some patients
- I feel exhilarated after working closely with my patients

What drives burnout?

Systemic drivers

- Workload
- Efficiency
- Flexibility/control
- Culture and values
- Work-life integration
- Community at work
- Meaning in work

All of these are influenced by national, organizational, work unit, and individual factors

"I never play doctor anymore. There's too much paperwork."

The nature of our work, and how we cope

We encounter tremendous suffering!

- *The burdens we take on from exposure to painful/traumatic experiences*
- *And the ways we try to protect ourselves*

- Secondary traumatic stress – re-experiencing, avoidance, hyperarousal, distorted affects/cognitions
- Emotional disconnection/distancing - “detached concern”
- low empathy and alexithymia associated with burnout
- high empathy and awareness of emotions associated with resilience

Is this burnout, psychiatric illness, or both?

- Some overlap between burnout and these disorders
- Both can have:
  - low energy, emotional exhaustion
  - low sense of accomplishment
  - decreased enjoyment of work
  - decreased interest in work
  - disconnection from emotions and from others
  - anxiety (worry, physical tension)
- Many burnt out physicians ALSO have a depressive, anxiety, or trauma and stressor related (TSR) disorders

Burnout can lead to mental illness

- Consequences of burnout
  - depression
  - substance use disorders
  - disrupted relationships
  - suicide

https://www.medscape.com/slideshow/2020-lifestyle-burnout-6012460

Specific to Anxiety DO’s, OCD, PTSD

- **GAD:** Pervasive worry, catastrophizing, sleep disturbance, muscle tension
- **Panic DO:** Panic attacks and fear of having another panic attack
- **Social Anxiety DO:** anxiety RE situations where exposed to possible scrutiny by others

Tx for the above – psychotherapy or meds or both

- **OCD:** Obsessions (including intrusive thoughts) and/or Compulsions
- **PTSD**:
  - Re-experiencing sx (nightmares, intrusive memories, significant distress in response to reminders)
  - Avoidance
  - Negative alterations in cognitions (I’m bad, the world is completely dangerous, no one can be trusted,” etc.) or emotions (persistent fear, horror, anger, guild, or shame)
  - Hyperarousal

Tx for the above – psychotherapy +/- meds

- **ADHD** – Meds +/- psychotherapy.
- **ASD**
- **Mania and psychosis** also happen in physicians, but easier to distinguish from burnout

Specific to Depression

2+ wks:

- Pervasive low mood AND/OR
- Anhedonia

PLUS 4 or more of:

- Sleep increase or decrease
- Guilt (*distorted*)
- Worthlessness
- Concentration
- Appetite increase or decrease
- Psychomotor agitation/retardation
- Suicidal ideation/attempts

Depression vs. Burnout themes

Depression

- Often no clear cause – *"when I'm depressed, I usually don't know why."*

May have been precipitated by stressors, but has taken on a life of its own

- Impaired functioning
- Pervasive low mood
- Dominant emotions – sadness, anxiety, dread
- Hopelessness, desperation *"feel beyond rescue."*
- Anhedonia
- Pervasive worthlessness, self-loathing
- More social isolation

Burnout

- Clear cause – work: *"I know why I'm feeling low"*

Change in circumstance may provide relief

- *"You power on because you have to."*
- Mood reactivity
- Dominant feelings: depleted/empty or irritable/angry
- Helplessness, feeling "stuck"
- Mood reactivity – still look forward to upcoming events in their personal lives, can enjoy things outside of work.
- Reduction in work-related self esteem, reduced productivity at work
- Still see family/friends, let them in emotionally

Tavella G, Parker G. Distinguishing burnout from depression: An exploratory qualitative study. Psychiatry Res. 2020 Sep;291:113212.

However . . .

- A depressed physician can attribute the way they feel to work BUT more likely to be self-blame (*"I made a bad choice," "I'm incompetent,")* than externalized blame *("the system is broken.")*
- 2-40% of all suicides occur in people **without** mental illness
- Other suicides are related to problems concerning finances, relationships, and corresponding crises, discrimination, violence, terror, and war
- Suicides can result from an interaction of temperament/personality with life circumstances (in the absence of mental illness)
- Still some debate RE the definition of burnout, and about whether it can be distinguished from depression

Bachmann S. Epidemiology of Suicide and the Psychiatric Perspective. *Int J Environ Res Public Health*. 2018;15(7)

The "Trap of Meaning"

- "Understandable" depressions -> delayed dx, under-dx, under-treatment
- Do "reasons" for depression act as its causes?
- Normalizing is well intentioned - attempt to reduce stigma/shame
- However sx of illness often get lumped in with sx of burnout
  - Don't do a Balint group to address an MDE!
- Rather than call a MDE "burnout" to reduce stigma - let's address the stigma around mental illness.

Reframe: Anyone, even doctors, can become ill, and this can be triggered or exacerbated by occupational factors.

- Lyketsos CG, Chisolm MS. The trap of meaning: a public health tragedy. JAMA. 2009 Jul 22;302(4):432-3.
- Kendler KS, Myers J, Halberstadt LJ. Do reasons for major depression act as causes? Mol Psychiatry. 2011 Jun;16(6):626-33.

CMA National Physician Health Survey 2018

BURNOUT (HIGH) (N = 2744):

- 26% High emotional exhaustion
- 15% High depersonalization
- 30% Overall

DEPRESSION (SCREENING) (N = 2740):

- 34%

SUICIDAL IDEATION (N = 2735):

- 19% Lifetime
- 8% Last 12 months

CMA National Physician Health Survey - A National Snapshot 2018

CMA National Physician Health Survey 2018

- Top reported barriers to seeking help
  - **believing situation not severe enough**
  - ashamed to seek help
  - not aware of range of services available
- Nearly half of physicians experience burnout in their lifetime
- Physicians **often don’t seek help until symptoms are severe**

Why Have You Not Sought Help for Burnout or Depression?

Reason	%
Symptoms are not severe enough	52%
I can deal with this without help from a professional	46%
Too busy	40%
Don't want to risk disclosure	20%
I don't trust mental health professionals	6%
Other	10%

'Death by 1000 Cuts': Medscape National Physician Burnout & Suicide Report 2021

Whom Did You Tell About Your Thoughts of Suicide?

	Millennials: 25-39 years old	Generation X: 40-54 years old	Boomers: 55-73 years old
A friend or colleague	39%	31%	23%
A therapist	33%	37%	33%
A family member	43%	36%	31%
A counselor on a suicide hotline	7%	3%	3%
None of the above	32%	40%	41%

'Death by 1000 Cuts': Medscape National Physician Burnout & Suicide Report 2021

What can be done for Burnout?

- Evidence is still low-quality, but from what we know:
  - systemically-oriented interventions have bigger effect-sizes than individually-focused ones
  - individually-focused interventions to build resilience are important but work best in the context of a process of systemic change
  - many low-cost, high-yield interventions can have a significant impact

Evidence based organizational strategies

- Acknowledge and assess the problem
- Leadership strategies
  - transparent communication
  - support for meaningful work: the 20% effect
- Cultivate community at work
  - COMPASS groups
  - Balint groups
  - Physician's lounge
- Promote flexibility, agency/choice, and work-life integration

- Physician-driven changes at the local level
  - improve efficiency
  - reduce administrative/clerical burden
  - identify problems in their work unit
  - generate practical solutions together
  - pass baton back to leadership to implement

- Shanafelt TD, Noseworthy JH. Executive Leadership and Physician Well-being: Nine Organizational Strategies to Promote Engagement and Reduce Burnout. Mayo Clin Proc. 2017 Jan;92(1):129-146. doi: 10.1016/j.mayocp.2016.10.004. Epub 2016 Nov 18.
- Zhang XJ, Song Y, Jiang T, Ding N, Shi TY. Interventions to reduce burnout of physicians and nurses: An overview of systematic reviews and meta-analyses. Medicine (Baltimore). 2020 Jun 26;99(26):e20992.

What Have You Done at Work to Try to Alleviate Burnout?

Reduced my work hours 28%

Changed work settings 21%

Made workflow or staff changes to ease up on my workload 20%

Spoke with my hospital/group administration about productivity pressure 17%

Hired additional clinical staff 7%

Sold/put practice up for sale 3%

Other 12%

None of the above 35%

'Death by 1000 Cuts': Medscape National Physician Burnout & Suicide Report 2021

Evidence based individual interventions

- Evidence is still limited/low-quality overall
- Most important is likely ENGAGEMENT – doing evidence-based activities that call to you

- Strongest evidence = Mindfulness-based interventions

- Panagioti M, Panagopoulou E, Bower P, Lewith G, Kontopantelis E, Chew-Graham C, Dawson S, van Marwijk H, Geraghty K, Esmail A. Controlled Interventions to Reduce Burnout in Physicians: A Systematic Review and Meta-analysis. JAMA Intern Med. 2017 Feb 1;177(2):195-205. doi: 10.1001/jamainternmed.2016.7674.
- West CP, Dyrbye LN, Erwin PJ, Shanafelt TD. Interventions to prevent and reduce physician burnout: a systematic review and meta-analysis. Lancet. 2016 Nov 5;388(10057):2272-2281. doi: 10.1016/S0140-6736(16)31279-X. Epub 2016 Sep 28. PMID: 27692469.
- Zhang XJ, Song Y, Jiang T, Ding N, Shi TY. Interventions to reduce burnout of physicians and nurses: An overview of systematic reviews and meta-analyses. Medicine (Baltimore). 2020 Jun 26;99(26):e20992. doi: 10.1097/MD.0000000000020992. PMID: 32590814; PMCID: PMC7328917.

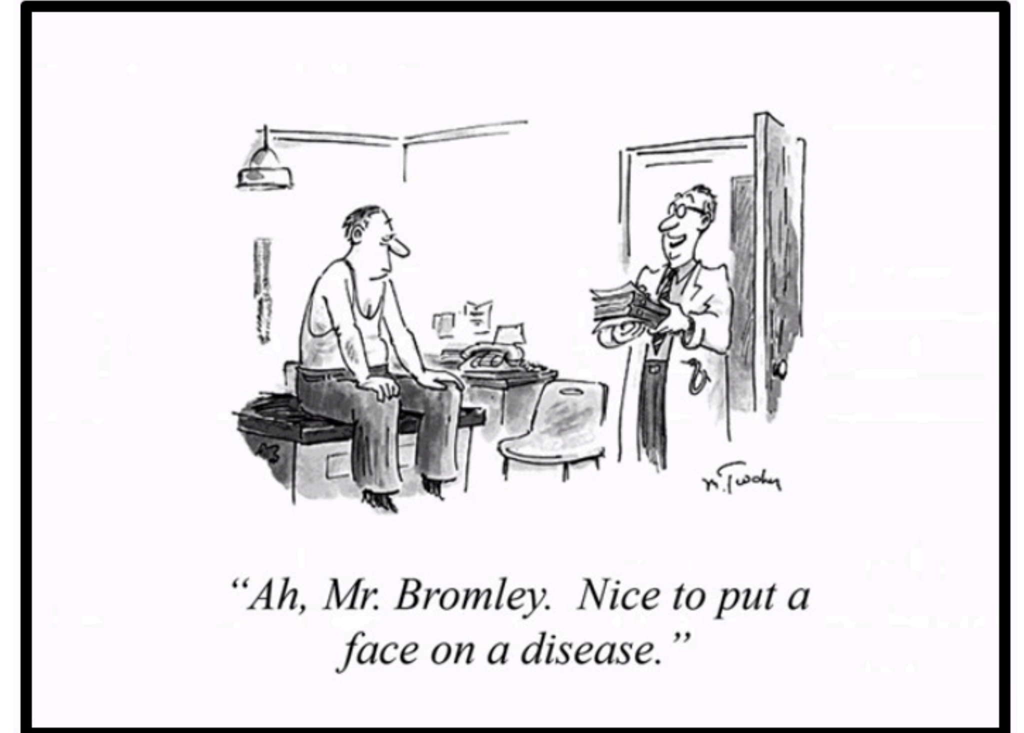
Mindfulness-Based Activities

- Helps us connect to and know what we feel
- Only by knowing this can we start to take care of ourselves skillfully
- Also gives us ways to take care of ourselves
  - Being with unpleasant experiences with equanimity and self-compassion, without (or with less) suffering . . .so we don’t need to practice disconnection (pain vs. suffering)
  - Choosing to attend to something neutral in the present moment, if being with the unpleasant experience is too much
- Maintaining our empathy

Other Evidence based individual activities

- Narrative medicine
- Balint groups* and other communication skills training
- Stress-management
- Self-care training
- Facilitated small-group discussions/curricula
- Reflection and shared experience
- Cognitive behavioural and solution focused counselling

**have been considered individual or systemic, depending on the article*



Panagioti *et al.*, West *et al.*, Zhang *et al.* – see earlier slide for full references

Depression vs. Burnout management

Depression

- Don’t make any big, lasting decisions
- May be skillful to take a medical leave or temporarily reduce/change work
- Once well, consider any contribution of work conditions, and potential changes for future
- Seek medical care – medication and/or psychotherapy
- Bolster/engage social supports

Burnout

- May need a lasting change in nature/type of work or quantity of work
- Advocate for systemic change
- Look for low-hanging fruit changes at the work-unit level that can impact the driver dimensions
- Consider seeking coaching and/or psychotherapy
- Consider emotion-processing and/or resilience building activities – Balint groups, Mindfulness, narrative medicine, etc.
- Cultivate community at work
- Talk to your family doctor

Both

- Exercise
- Eating habits
- Enjoyable activities
- Sleep hygiene

Resources

- https://medicine.dal.ca/departments/core-units/cpd/faculty-wellness.html
- Doctors NS Physician Support Program
- Your family doctor
- Association of Psychologists of Nova Scotia (APNS) https://apns.ca/find-a-psychologist/
- Mental Health Mobile Crisis Team 902-429-8167

Back to the case . . .

Back to the objectives

- Efforts to destigmatize mental health problems through normalization of symptoms can lead to under-recognition of mental illness, with consequent treatment delays and under-treatment.
- This session aims to normalize being human as a physician, with chronic and episodic illnesses, including mental illnesses, being a part of the human condition.
- We will discuss the overlap and distinctions between presentations of burnout and mental illness, and implications for treatment for ourselves and our fellow physicians.

Questions/comments
THANK YOU!!