The impact of attachment status on improvements in depressive symptoms, emotional exhaustion, and emotion regulation strategies in the in-patient treatment of patients presenting with burnout syndrome

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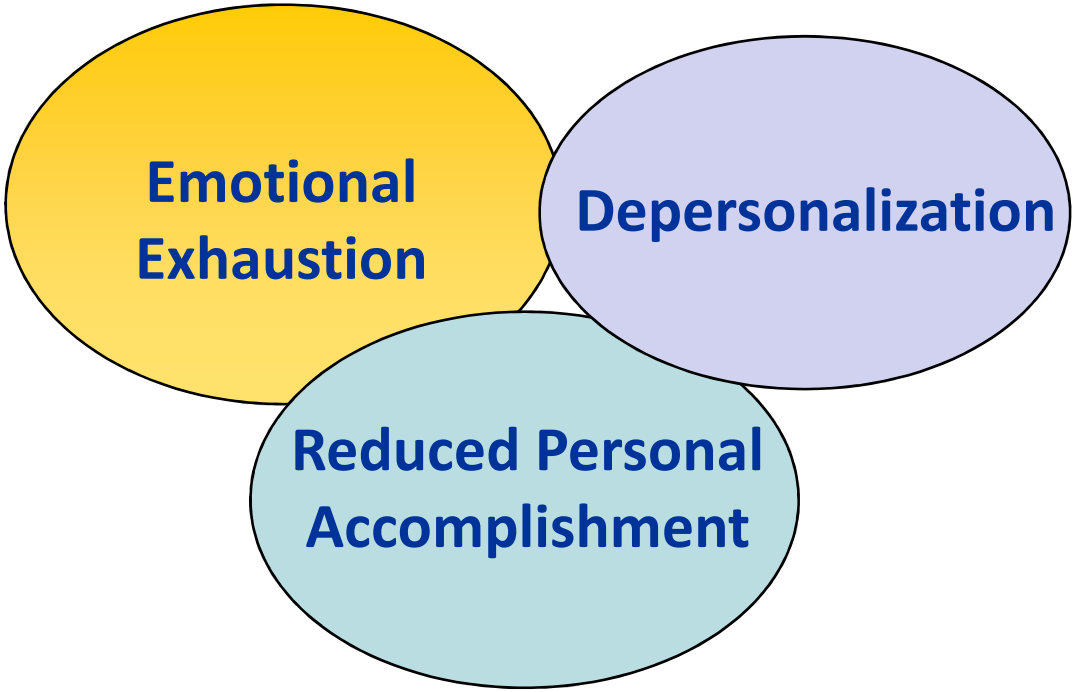
What is Job Burn-Out?

Three areas of burnout as defined by Maslach (1986)



- Patients present with depressive symptoms, sleep disoders, and functional symptoms.
- Abuse of alcohol ans tranqulizers is frequent.

What is Job Burn-Out?

➢Typical pattern of **behavior and subjective experience**

- ↓ subjective experience of success at work
- ↓ ability to distance oneself from job-related experiences
- ↓ calmness and emotional balance
- ↓ active problem-solving
- ↓ life satisfaction

Schaarschmidt, 2006

➢**Emotional and relational features**

- Feelings of helplessness, depression and exhaustion
- Emotional and physiological restlessness
- Reduced self-esteem
- Feelings of disillusionment and resignation
- Deterioration of interpersonal relationships

Burisch, 2006

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Clinical observations

Patients show

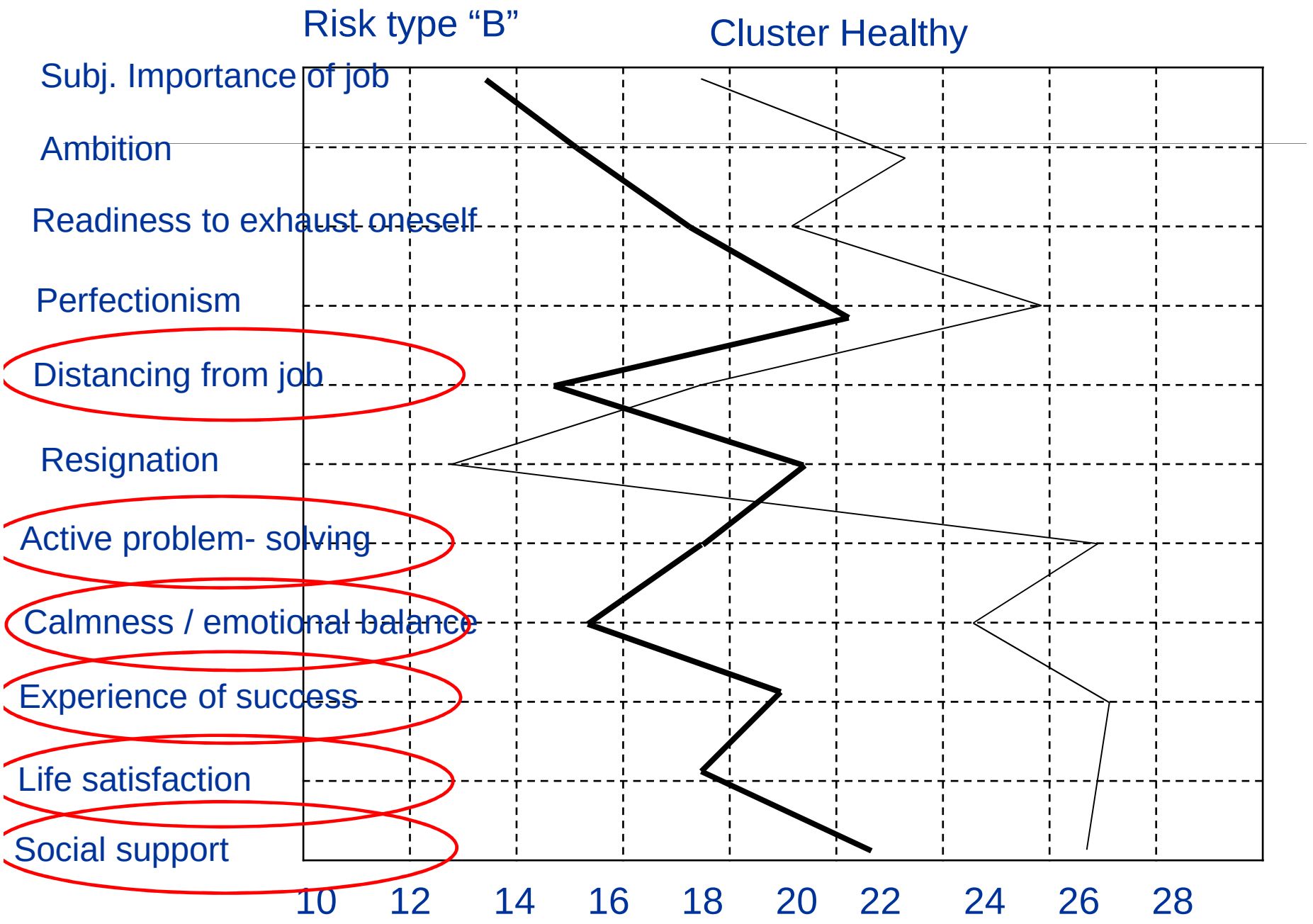
- Decreased ability to cope with work-related stress
- Interpersonal problems at the work place and at home
- Perfectionism
- Inability to distance oneself from work-related problems
- Work is urgently needed to regulate self-esteem
- Poor regulation of negative emotions
- History of losses and stressful life evennts

- **„Vulnerable population“**
- **Maybe, high prevalence of insecure attachment representation**

Mutlidimensional inpatient/day hospital treatment for patients with burnout

- Referrals by GPs, psychiatrists, psychotherapists
- Assessment before and after tx: psychiatric interview, burnout-specific measures (MBI, AVEM), symptom check-list (ISR)
- Tx duration: 4-6 weeks

- Interactional / interpersonal group therapy
- Psychodynamic individual psychotherapy
- Psychodynamic art therapy
- Theme-centered group focusing on work relations and work problems etc.
- Psycho-education
- Relaxation training, biofeedback
- Sports therapy group
- Antidepressant medication if necessary


Risk type “B”
Cluster Healthy
Subj. Importance of job
Ambition
Readiness to exhaust oneself
Perfectionism
Distancing from job
Resignation
Active problem- solving
Calmness / emotional balance
Experience of success
Life satisfaction
Social support
10
12
14
16
18
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28

Attachment, emotion regulation and coping with distress

In a previous study we found

- High prevalence of insecure attachment representation and unresolved status of loss/trauma in burnout patients compared to healthy controls
- Patients with unresolved loss/trauma showed problematic patterns of emotion regulation (dissociation, externalisation).

Söllner et al. Psychother Psychosom Med Psych 2016

- Subject with insecure attachment show problems in dealing with negative emotions and coping with distress *(Bowlby 1979)*
- They profit less from psychological treatment unless psychotherapy is tailored to the needs of this group of patients. *(Hilliard et al. 2000).*
- This might be explained by more problematic attachment to therapists resulting in poorer therapeutic alliance *(Castonguay & Beutler 2005).*

Research questions and hypotheses

H1. Patients with **insecure and unresolved attachment** representation will show less improvement in terms of symptom severity (emotional exhaustion and depression) as a result of psychosomatic in-patient treatment.

H2. **Emotion regulation** and **therapeutic alliance** will mediate this effect.

The Adult Attachment Interview (AAI)

Main, Kaplan & Goldwyn, 1985

Attachment classifications

Insecure-dismissing (avoidant)

- Low coherence: Limited access to childhood memories
- Idealization or derogation of attachment relationships
- Little acknowledgement and communication of negative emotions
- **De-activation of the attachment system**

Secure-autonomous

- Coherent narrative about positive as well as neg. experiences
- Valuing of attachment relationships
- Good acknowledgement and communication of neg. emotion
- **Optimal activation of the attachment system**

Insecure-preoccupied (enmeshed)

- Low coherence: Continuing anger or confused preoccupation with childhood experiences
- Heightened experience and communication of negative emotions
- **Hyper-activation of the attachment system**

Unresolved with regard to loss and/or trauma

- Disorientation regarding space or time when reporting losses or abuse; lost sense of reality
- **Dysregulation of attachment-related emotions** => emotional disturbance

Emotional experience and psychopathology

Benecke et al. (2008)

- Clinical observation has shown:
  Psychopathology is associated with emotional disturbance
- Fragebogen zu **E**motions-**E**rleben und -**R**egulation (EER)
  Questionnaire on Emotional Experience and Emotion Regulation

Clinical group:	Non-clinical group:
More intensive negative emotions	*More intensive positive emotions*
• Impulsiveness	• Joy
• Helplessness	• Interest
• Loneliness	*Emotion regulation:*
• Vague, free-floating anxiety, etc.	• *Reflection*
Problematic emotion regulation:	• *Distraction*
• Externalisation, Dissoziation	

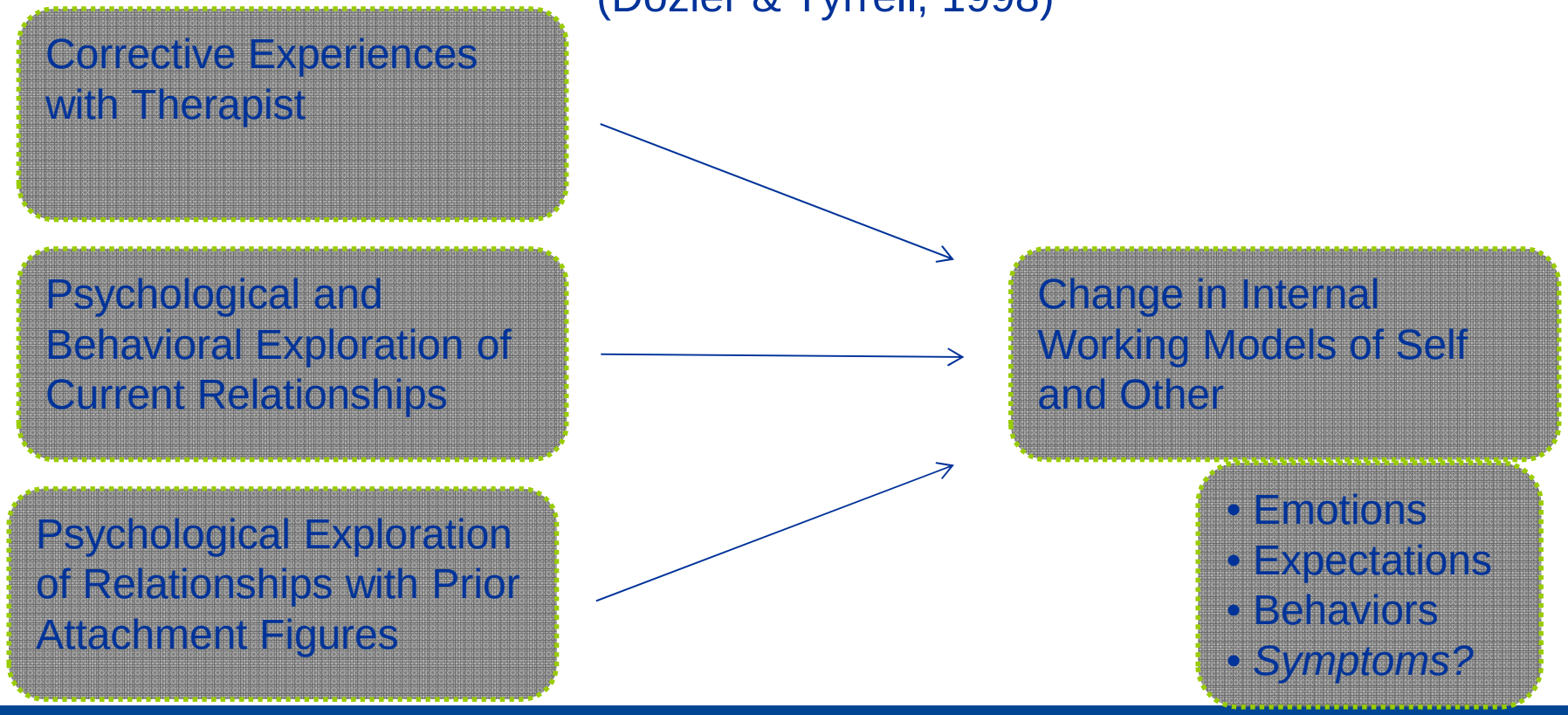
The importance of the therapeutic alliance in psychotherapy

" … the therapist's role is analogous to that of a mother who provides her child with a secure base."

Bowlby, 1988, p. 40

➔ Model of Therapeutic Change

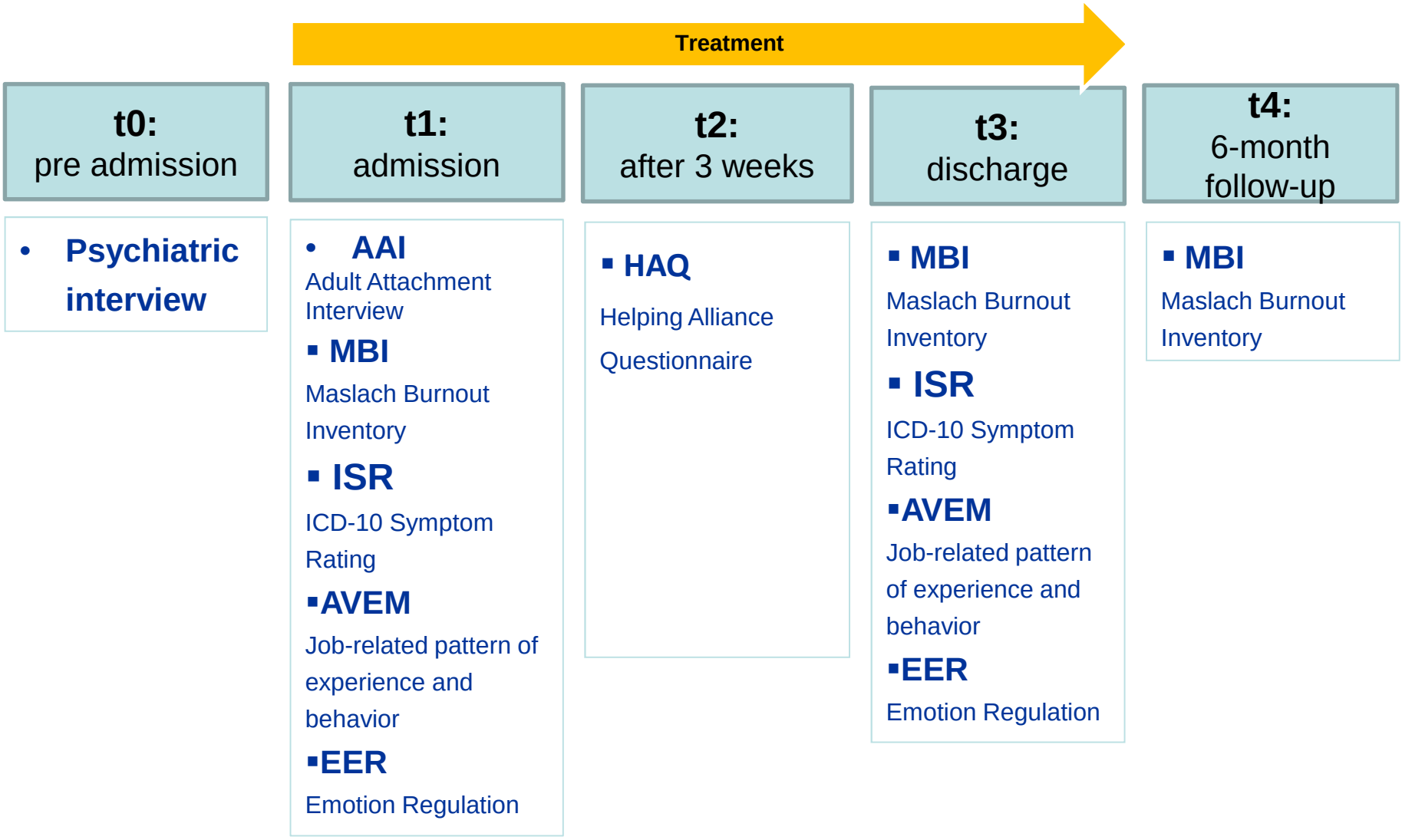
(Dozier & Tyrrell, 1998)



Assessing Therapeutic Alliance

- **Helping Alliance Questionnaire – HAQ (Luborsky, 1984)**
  - » German version: Bassler, Potratz & Krauthauser, 1995
  - » 2 versions: Patient and therapist version
  - » 11 Items assessing confidence in the therapeutic relationship and satisfaction with therapy improvements; 1 item for global assessment
  - » 2 scales:
    - Satisfaction with the relationship with therapist;
    - Satisfaction with success of therapy

Method: Design



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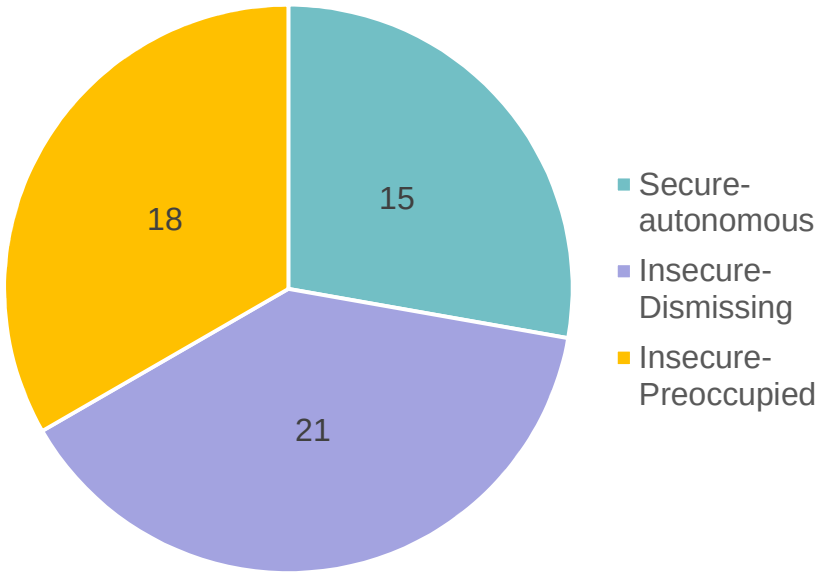
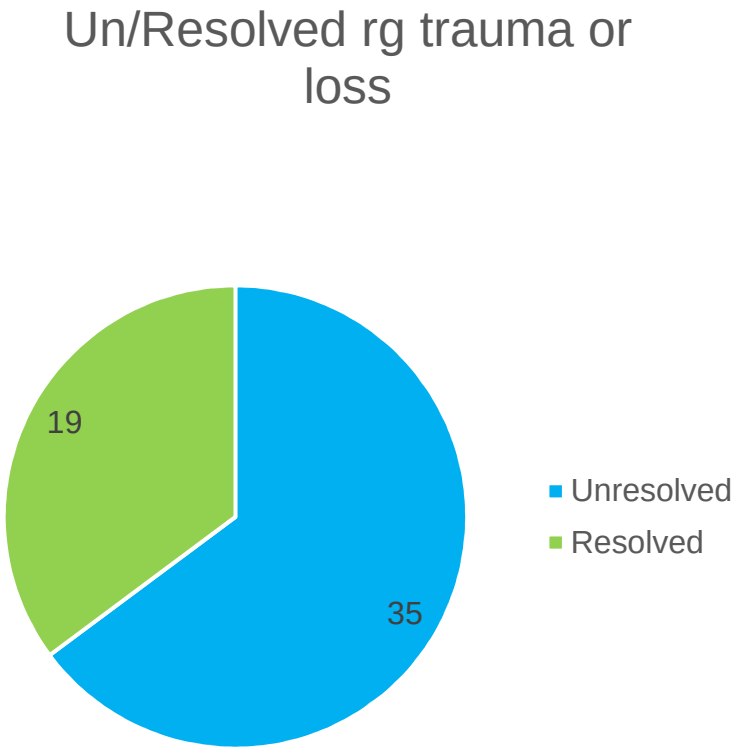
Method: Sample

- 64 patients referred to specialized tx for depression and burnout syndrome;
- 54 participated (9 denied, in one patient technical problems to record the AAI)
- Participants and non-participants did not differ in age, gender, and clinical diagnoses

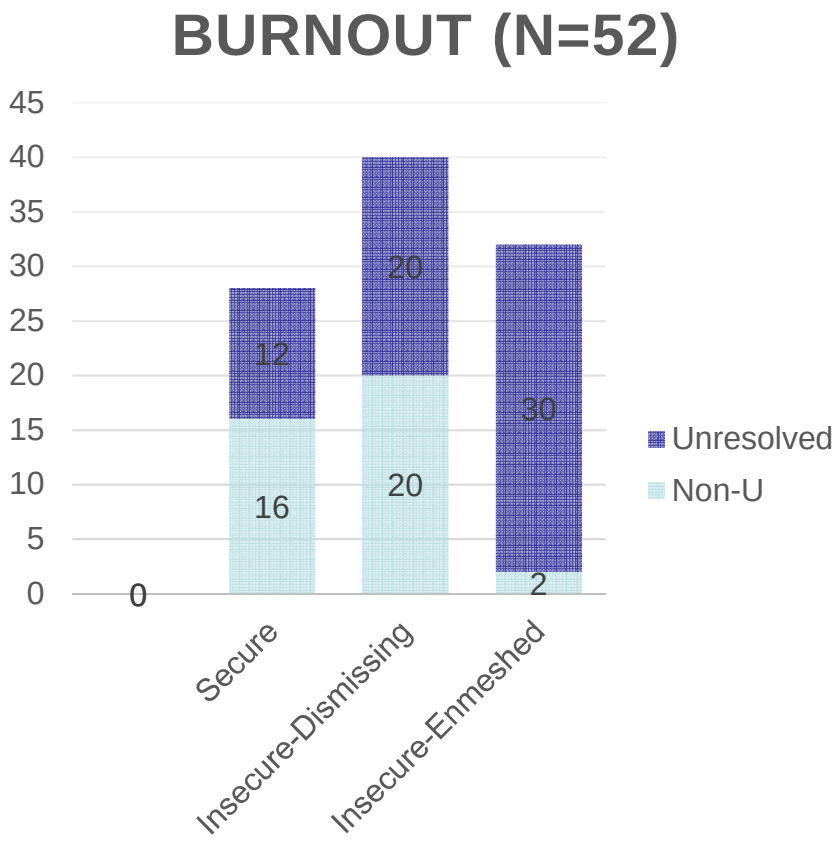
- Mixed occupational background; all suffered occupational distress
- Main mental disorders:
  - affective disorder (91%)
  - anxiety disorder, somatoform disorder (9%)
- Plus Z 73: Burnout
- 64% additional somatic complaints (hypertonia, chronic pain, sleep disorders, tinnitus etc.)

RESULTS: Dimensions of attachment representation (%)





RESULTS: Dimensions of attachment representation (%)



Therapy outcome at discharge and at follow-up

Outcome	n (LOCF)	Mean (SD) before treatment	Mean (SD) after treatment/at follow-up	t	p	Effect size d
Emotional Exhaustion (MBI) at discharge	53	4.16 (1.06)	3.53 (1.41)	3.55	.001	0.50
Emotional Exhaustion (MBI) at 6-months follow-up	28	4.12 (1.14)	3.19 (1.56)	3.13	.004	0.67
Depression (ISR) at discharge	45	2.28 (0.77)	1.46 (1.11)	5.30	<.001	0.84
Emotion regulation (EER) at discharge						
- **dissociation**	54	3.84 (0.83)	3.40 (1.06)	3.72	<.001	0.45
- **reflection**	54	2.76 (0.86)	3.10 (0.97)	-2.76	.008	-0.38
- **externalization**	54	2.92 (1.18)	2.72 (1.25)	1.48	.145	0.16
- **distraction**	54	2.88 (1.36)	2.65 (1.23)	1.27	.209	0.18

Predictors of improvement of depression (ISR) from admission to discharge

	Model 1			Model 2			Model 3			Model 4		
	B	SE B	beta	B	SE B	beta	B	SE B	beta	B	SE B	beta
Constant	.06	.51		.24	.54		3.07	1.24		3.09	1.20	
Depression at admission	.61	.21	.43**	.59	.23	.42**	.59	.19	.42**	.57	.19	.41**
AAI security				-.53	.36	-.22	-.50	.30	-.21	-.41	.29	-.17
AAI unresolved loss				.13	.16	.12	.08	.14	.07	-.07	.15	-.06
AAI unresolved trauma				.23	.17	.22	.18	.15	.17	.16	.17	.15
AAI security X loss										.67	.31	.30*
AAI security X trauma										.08	.30	.04
HAQ patient relationship							-.02	.27	-.01	-.04	.26	-.02
HAQ patient satisfaction							-.60	.19	-.48**	-.57	.19	-.45**
R^2		.19**			.31*			.54**			.61**	
F for change in R^2		8.12**			1.85			7.49**			2.48	

Hierarchical Regression Analysis for Variables Predicting Depression at Discharge (n = 45)
*$p < .05$. **$p < .01$

Predictors of improvement of emotional exhaustion (MBI) from admission to discharge

	Model 1			Model 2			Model 3		
Variable	B	SE B	beta	B	SE B	beta	B	SE B	beta
Constant	.93	.78		0.77	0.90		2.99	1.83	
Exhaustion at admission	.62	.18	.47**	.63	.18	.48**	.58	.18	.44**
AAI security				-.27	.43	-.09	-.25	.42	-.08
AAI unresolved loss				.13	.09	.21	.10	.09	.17
AAI unresolved trauma				-.04	.09	-.06	-.06	.08	-.10
HAQ patient relationship							.13	.38	.06
HAQ patient satisfaction							-.56	.27	-.34*
R^2		.22**			.27**			.37**	
F for change in R^2		11.57**			.09			2.65	

Hierarchical Regression Analysis for Variables Predicting Depression at Discharge (n = 53)

*$p < .05$. **$p < .01$

Predictors of improvement of emotional exhaustion (MBI) from admission to 6-mo follow-up

	Model 1			Model 2			Model 3		
Variable	B	SE B	beta	B	SE B	beta	B	SE B	beta
Constant	.36	1.06		-1.46	.88		2.30	1.74	
Exhaustion at admission	.12	.27	.08	.15	.21	.10	.20	.19	.13
Exhaustion at discharge	.67	.21	.60**	.60	.16	.54**	.54	.15	.48**
AAI security				.24	.09	.35	.50	.38	.14
AAI unresolved loss				.27	.08	.39**	.27	.08	.39**
AAI unresolved trauma				.46	.42	.13**	.28	.08	.41**
HAQ patient relationship							.50	.38	.14
HAQ patient satisfaction							.50	.38	.14
R^2		.41**			.72**			.80**	
F for change in R^2		7.63**			7.14**			3.13	

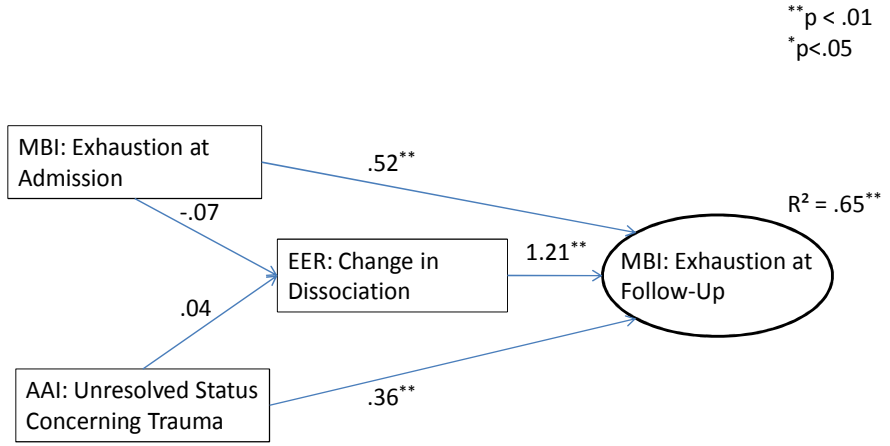
Hierarchical Regression Analysis for Variables Predicting Depression at Discharge (n = 53)

*$p < .05$. **$p < .01$

Do emotional regulation (ER) and the helping alliance (HA) mediate these effects?

- The helping alliance as assessed by the patients
- predicts therapy outcome (depression [F=14.9; P=0.001] and emotional exhaustion [F=4.8; P=0.038]
- and a pattern of emotion regulation characterised by reflection [F=8,11; P=0.009]

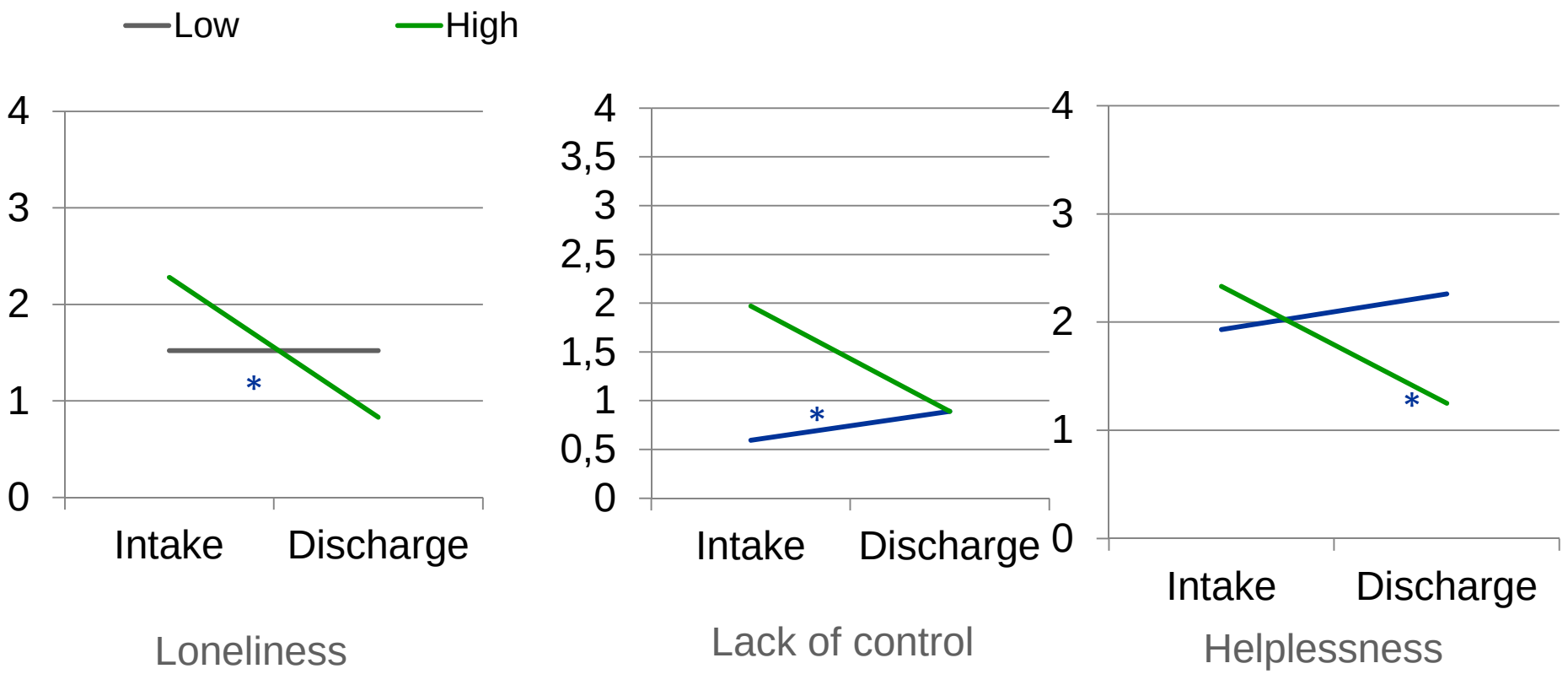
- However, HA did not mediate and ER mediated the effect of attachment & unresolved status only to a small degree



Results

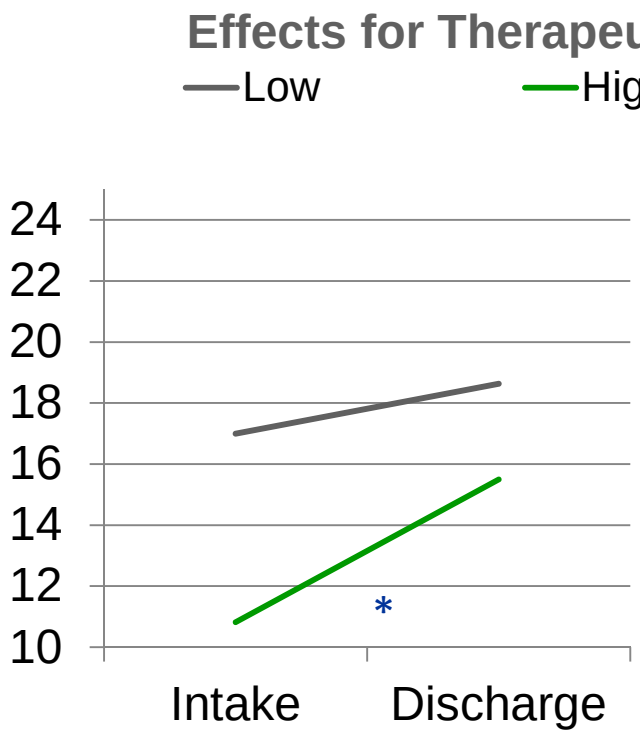
H3. Patients forming a good **therapeutic alliance** with their therapist will show greater improvement in terms of **emotional disturbance**.

Effects for Therapeutic Alliance from therapist‘s perspective

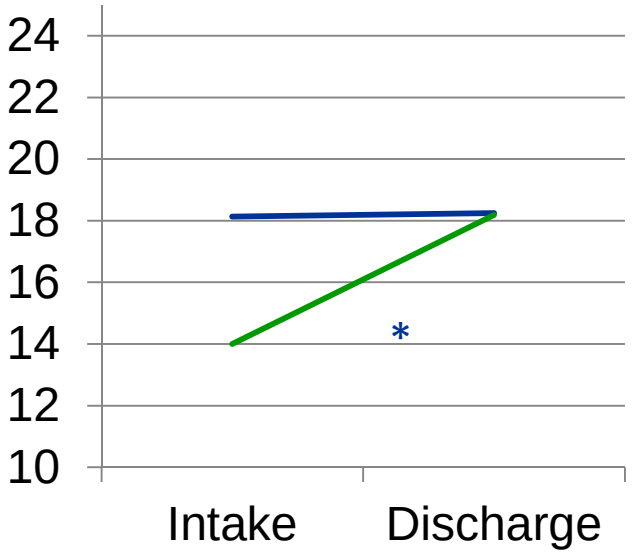


Results

H3. Patients forming a good **therapeutic alliance** with their therapist will show greater improvement in terms of **symptom severity**.



Ability to distance from work



Calmness / Emotional balance

Summary

1. Over 70 % of patients treated for burnout syndrome in a hospital setting have an insecure and 65% show an unresolved (loss and/or trauma) attachment status

2. Therapeutic alliance and the interaction between attachment status and unresolved symptoms of loss predicted therapeutic outcome rg depression

3. Unresolved attachment status rg loss and trauma predicted emotional exhaustion at 6-month follow-up.

4. The therapeutic alliance did not mediate this effect; the patterns of emotion regulation (dissociation) mediated it to a small degree.

Discussion

1. Patients with unresolved attachment status (problems to cope with loss and/or traumatic experiences) deserve special attention because of their problems to cope with negative emotions.

2. Psychological therapies should take these problems into account. Psychotherapy should be tailored to the needs of these patients (more supportive and enhancing mentalization?)

3. Need to have more catamnestic data to study long-term effects of treatment, alliance and attachment status.

Thank you!

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