Development of a Transactional Analysis Diagnostic Tool for Burnout with a Case Study Application in Switzerland

Abstract

Referring to the addition of burnout into the ICD-11, the authors review the literature and propose a combination of transactional analysis concepts with systemic-psychodynamic, cognitive-behavioural and logotherapy perspectives to generate a three-dimensional heptagon in which each summit represents a dimension of the burnout condition: cognitive, behavioural, motivational, emotional, somatic, relational and existential. They indicate how here-and-now symptoms are representations of there-and-then experiences and demonstrate how these elements may be represented within the script system developed by O'Reilly-Knapp and Erskine (2010). They go on to combine this with Freudenberger and North's (1992) 12 steps model into a simplified five phase model of Honeymoon, Suppression, Denial, Dehumanisation and Burnout. Based on this material, they have developed a proxy-rated Burnout Assessment Chart (BAC) and a semi-structured Burnout Assessment Interview (BAI). A case study is then included of this material being applied with a 56-year-old male client in Switzerland. Whilst the limitations of this single case are recognised, the authors propose that the material can be used in developing a manual for working with burnout, with the different phases making it applicable to the various fields of TA application.

Key words

transactional analysis; burnout; systemic-psychodynamic therapy; cognitive-behavioural therapy; logotherapy; Burnout Assessment Chart (BAC); Burnout Assessment Interview (BAI)

Introduction

Burnout has been recognised as a psychiatry pathology in the *International Classification of Diseases (ICD-11)* (World Health Organisation, 2019), where it is presented as a syndrome resulting from chronic workplace stress that has not been successfully managed, and defined by (1) feelings of energy depletion or exhaustion, (2) increased mental distance from one's job, or feelings of negativism or cynicism related to one's job, and (3) reduced professional efficacy.

Different psychotherapeutic models have been used to treat burnout, including systematic-psychodynamic (Freud, 1921; Cilliers, 2003), cognitive-behavioural (Maslach, Jackson, Leiter, Schaufeli & Schwab, 1986) and logotherapy (Frankl, 1976; Längle, 2003). Between them, these cover cognitive, behavioural, motivational, relational, existential, emotional and somatic areas. However, two symptoms emerge as the principal focus of major burnout treatment: cognitive and behavioural symptoms. In our opinion, this neglects the existential aspects which are fundamental to better understanding the cause of burnout and developing treatment plans. We have therefore added transactional analysis to develop a three-dimensional vision that includes the history of past events in the there-and-then to the current context of the person in the here-and-now,

We also noted that most commonly used questionnaires for burnout evaluation are self-rated, which impacts on the therapeutic relationship, so we have developed a proxy-rated Burnout Assessment Chart (BAC) to be integrated with a semi-structured Burnout Assessment Interview (BAI) for an evaluation that identifies severity of symptoms such as cognitive (suicidal ideas), behavioural (acts of violence), emotional (depression), somatic (fatigue), relational (withdrawal) and existential (alienation).

We have also incorporated five prototypic levels of burnout severity which we have labelled Honeymoon, Suppression, Denial, Dehumanisation and Burnout, is a simplification of models such as Freudenberger and North's (1992) 12 step model and Ulrichová's (2012) 10 phases.

We provide a case study of our use of the BAC and BAI, integrated with an analysis using O'Reilly-Knapp & Erskine's (2010) script system with a client whom we believed to be between the Dehumanisation (Phase 4) and the Burnout (Phase 5) level of burnout severity.

We also report on how the practitioner used the Copenhagen Psychosocial Questionnaire (COPSOQ); Kristensen, Hannerz, Hogh & Borg, 2005) to better understand the client's working environment; this instrument has been developed for occupational risk assessment in order to improve the psychosocial work environment. It has been translated in 18 different languages and it is used in 40 countries worldwide (Pejtersen, Kristensen, Borg & Bjorner, 2010). The psychosocial dimension that the COPSOQ explores and measures are the following: demands at work, work organization and job contents, interpersonal relations and leadership, work-individual interface, social capital, offensive behaviours, health and well-being.

The practitioner also used the Change Interview Protocol (CSEP 9/99) (Elliott, Slatick & Urman, 2001) to evaluate result.

Literature Review

Job burnout concept emerged in the 1970s in America as a social issue and it is now considered as a global phenomenon. Initially, Freudenberger (1974) utilised the term to explain the gradual emotional draining, loss of motivation, and reduced engagement among volunteers in health service such as psychotherapist, health care and social workers. Maslach (1976) found that service workers, as a consequence of the emotional turmoil, often felt emotionally exhausted developing negative feelings and perception about their clients and experiencing a crisis in term of professional competences.

The term burnout alludes to the smothering of a fire or the extinguish of a candle as a metaphor for describing the exhaustion of an individual's ability to sustain an intense commitment that has a relevant impact at work (Schaufeli, 2006). Maslach, Jackson & Leiter (1996) assert that: "Burnout is a syndrome of emotional exhaustion, depersonalisation, and reduced personal accomplishment that can occur among individuals who work with people in some capacity" (p.4). Moreover, it is "… a state of exhaustion in which one is cynical about the value of one's occupation and doubtful of one's capacity to perform" (Maslach et al., 1996, p. 20). Furthermore, burnout is seen caused by a persistent imbalance of demands over resources (Aiken, Clarke, Sloane, Sochalski, Busse, Clarke et al., 2001) and by the fact that employees have values, vision and mission that differ from the organisational ones (Hemingway & Mclagan, 2004). The consequence of this led to

conflicts and alienation, promoting vulnerability to exhaustion, cynicism and inefficacy that define burnout (Schaufeli, 2006). An interesting correlation analysis considers the development of some countries with the burnout increase – it seems that globalisation, privatisation and liberalisation, cause high-speed changes in life style such as increasing demands of learning new skills, the need to adopt new type of work, pressure of higher productivity and quality of work, time pressure, which in turn, may produce burnout (Schaufeli, 2006).

Maslach, Schaufeli and Leiter (2001) identified six critical areas of work life that can be risk factors for the burnout syndrome: a mismatch in workload, in control, in lack of appropriate rewards, the loss of a sense of positive connection with others in the workplace, between the person and the job when there is not perceived fairness in the workplace, and when there is a conflict between values. Burnout arises from chronic mismatches between people and their work setting in terms of some or all of these six areas. Maslach and Leiter (1997) explained that greater the gap between the person and the job, the greater the likelihood of burnout will be. Fixing these mismatches demands an intervention from both the worker and the organizational context. A clearer vision about workload means adequate resources able to satisfy the balance between job and private life, in order to encourage workers to revitalise their energy. A clearer vision about values means setting clear organizational values that workers can apply to with enthusiasm. A better connection with the community means creating a supportive leadership and a supportive relationship among colleagues.

Freudenberger and North (1992) proposed a 12 steps model of burnout development, from initial compulsion to prove oneself to the final Burnout syndrome, which we report below: (1) compulsion to prove oneself (excessive ambition, trying to demonstrate own worth obsessively), (2) working harder (incapacity to switch off from work), (3) neglecting own needs (sleeping, eating, interacting), (4) displacement of conflicts and needs (problems are dismissed with psychosomatic disturbs, more mistakes are made), (5) no longer any time for non-work-related needs (values are revisited giving no space for family, friends and hobbies), (6) increasing denial of the problem, decreasing flexibility of thought/behaviour (intolerance of others), (7) withdrawal, lack of direction, cynicism (very little or no social life, person can star abusing alcohol or drugs), (8) behavioural changes/psychological reactions (family and friends are concerned for behavioural changes), (9) depersonalization (loss of contact with self and own needs), (10) inner emptiness, anxiety, addictive behaviour (activities are often exaggerated to overcome negative

feelings), (11) depression (increasing feeling of meaninglessness, of exhaustion and lack of interest) and (12) burnout syndrome (psychophysical exhaustion that can be life-threatening with suicidal ideas).

Despite Transactional Analysis (TA) covering all four fields and being a privileged point of convergence for both observation and intervention on the burnout problem, only five articles within the TA literature cover this, two of which are not published in TA journals.

In the first TA article, Clarkson (1992) focuses on burnout syndrome in a caring work environment. She distinguishes three different rackets systems as burnout predispositions for professional helpers, creating a connection between script, life positions and Freudenberger's (1975) typologies. In the second, Karpman (1984) explains how unnoticed games can generate a continuous frustration which can lead to burnout, providing several examples using the drama triangle. In the third, Johnson (2015) explains the implementation of a psycho-educational model to support educators to better deal with burnout risk in traumatic environment. The model integrates trauma release exercises, transpersonal psychology and TA and the author discusses the benefit of TA interventions that allow relationship improvement between educators, colleagues, families and students.

Systemic-Psychodynamic perspective

When considering approaches to addressing burnout, it is pertinent to consider systemic psychodynamic therapy (SPDT) first, since this is the closest to Berne's own theoretical background. The SPDT derives from the psychoanalytic frame of reference (Freud, 1921) merged with the systemic approach (Cilliers, 2003). The approach focuses on individual experience and mental processes such as dreams, fantasies, object relations, transference and resistances, as well as the experience of social groups and process which can be unconscious and at the origin of unresolved organisational tribulations and stress. On the other hand, the systemic approach includes the structural aspect of an organisation such as "its design, division of labour, level of authority and reporting relationships, the nature of work tasks, process and activities, its mission and primary tasks and in particular the nature and pattering of the organisation's tasks" (Cilliers, 2003, p.26).

The research carried out by Cilliers (2003) argues that "burnout involves the individual as micro, as well as the group as meso, and the organisation as macro systems; thus, coping with burnout becomes a "total

endeavour" (p.26). From Cilliers (2003) system-dynamics perspective burnout is a persistent, negative, work-related state of mind and a behaviour which develops gradually and remains unnoticed for a long time. Moreover, it is defined as an exhaustion, a distress situation which impacts work effectiveness and motivation developing dysfunctional personal and societal attitudes (helplessness, hopelessness, disillusionment, a negative self-concept) and behaviours (negative attitudes towards work, people and life itself) which self-perpetuates because of inadequate coping strategies. Based on the above explanations, the hypothesis of burnout generation is based on the fact that the system develops work performances and relational conflicts which are not consciously addressed in an adequate way, creating discomfort such as pain and anxiety that are suppressed into the collective unconscious. When these conflicts are not opened up, anxiety becomes unbearable and as a consequence of this, the system finds relief by projecting the conflicts onto an external object (an individual) in order to function normally again.

The individual is generally seen as a hard worker who wants to progress and achieve great goals, but satisfaction of their neurotic needs for acceptance means they are not ready for this challenge. The issue is that the individual could identify with the projection and start experiencing the system's conflicts as his/her own, so that over time this leads to emotional exhaustion, depersonalisation, (loss of distinctiveness), low personal accomplishment (feeling of being unable), physical, cognitive and affective symptoms and lack of motivation. The signs of burnout from this perspective are characterised by emotional exhaustion, reduction in emotional responses, feeling drained, depersonalisation (the individual experience a loss of individual distinctiveness, as well as low personal accomplishment) and a feeling of being unable to meet other's needs. Physical, cognitive and affective symptoms such as headaches, dizziness, nausea, sleep disturbances, coronary diseases, poor confrontation, forgetfulness, helplessness, hopelessness and powerlessness are other characteristics that help the practitioner to assess if the person is experiencing burnout. Moreover, lack of motivation (stagnation and inability to move dynamically) or hyperactivity (not knowing what to do), isolation, negativism, hostility, suspicion and aggression because of poor impulse control, can be considered motivational and behavioural symptoms of a potential burnout.

Cognitive-Behavioural Perspective

Cognitive-Behavioural Therapy (CBT) grew from the scientific branch of psychology, which was focused

on reducing problematic behaviour with methods based on clearly defined and rigorously validated scientific principles. To a large extent, CBT theory is founded on the idea that reorganisation of individuals' self-statements will lead to a corresponding reorganisation of their behaviour. The primary focus is on the cognitive and behavioural characteristics of the presented issue. It targets directly symptoms, with the aim to re-evaluate thinking which should lead to a new useful behavioural response (Leichsenring, Hiller, Weissberg & Leibing, 2006). The CBT practitioner structures the interaction and introduces topics, giving the client explicit directions and suggestions, and describing the rationale behind the CBT technique approach and treatment (Beck, 2005). Emotions are seen as a phenomenon to control rather than experiences to deepen (Boswell, Castonguay & Pincus, 2009). Trust is seen as a vital component for the therapeutic relationship, but is not considered the primordial vehicle of change – the relationship between client and practitioner is generally less close and less emotionally intense than in SPDT.

Burnout is considered a psychological syndrome and is based on three component constructs: depersonalisation, reduced personal accomplishment and emotional exhaustion (Maslach et al, 1986). Job stress influences depersonalisation (which is seen a dysfunctional method of coping) that over time decreases a sense of personal achievement; the increase of depersonalisation and the decline of personal achievement eventually lead the individual to become emotionally exhausted (Golembiewski, Boudreau, Munzenrider & Lupo, 1966). Individuals can also show impaired cognitive functioning such as attentional and memory issues (Oosterholt, Maes, Van del Linder, Verbraak & Kompier, 2014) There is abundant evidence that prolonged stress can have destructive effects on neuronal structure concerned with cognitive functioning, such as the reduction in total brain weight, atrophy of both hippocampus and prefrontal cortex (Oosterholt et al., 2014).

Logotherapy perspective

Logotherapy is a humanistic and existential psychology (Ponsaran, 2007) which sees neurosis grounded on an existential vacuum giving rise to a deep feeling of meaninglessness. In life, the decision is not between right or wrong but between authentic and inauthentic – one can discover despair despite success, and fulfilment despite failure (Frankl, 1976). Burnout for logotherapy entails a sense of unfulfillment and a lack of meaning.

Burnout is seen as an "enduring state of exhaustion due to work" (Längle, 2003, p. 131), which entails the

somatic, psychological and noetic dimension (Marseille, 1997). According to Längle (2003), noetic dimension concerns the retreat from relationships with denigrating attitudes towards self, others and the world. He claims that "the symptoms of burnout do not happen accidentally but flow from a personal and subjective understanding of one's existence and what guides one's actions" (Längle, 2003, p. 136). The existential frame of mind taken in case of burnout, "misinterprets" the requirement and elements for successful human existence. The aetiology of burnout has its origin in a non-existential attitude – the idea of life "foreign to existence" and thus leads to exhaustion (Längle, 2003, p. 136). Burnout starts when the person experiences a sense of alienation, separation from the aim or inner motivation in relation to the task in itself. The work loses its meaning and "the person is orientated toward an aim or goal but not towards the unique value and meaning of the work" (Längle, 2003, p. 136). These aims remain lifeless, reducing contact with the person's true values, and producing stress which results in a disregard for the intrinsic worth for others, objects, tasks and for the value of own's own life.

Ulrichová (2012) added that personalities who suffer from burnout are influenced by the experience "I must" (p. 502) and as a consequence the individual loses their relationship with the job, experiencing emptiness and hopelessness since they does not perform values they believe in – a lack of self-appreciation. Such people do not appreciate themselves unless they are efficient. This attitude leads to an emotional disengagement and work becomes a mere substitute for a lack of closeness and affect which culminates in a form of depression. Burnout from logotherapy perspective is viewed as a deficiency in the personal-existential primordial motivation. Furthermore, Ulrichová (2012) defined 10 phases of burnout which are based on Freudenberger and North's (1992) 12 step model.

For logotherapy, the primary symptoms of burnout are feelings of emptiness and meaningless, an existential vacuum which is a loss of interest, which leads to a boredom, lack of initiative with a consequence of experiencing a sense of apathy (Längle, 2003). Burnout "can be seen as a form of the existential vacuum" (Längle, 2003, p.132), a confusion between existential meaning or semblance of meaning. As a consequence, the individual who feels alienated and emotionally disengaged from their job, and is not motivated by the substance of the job but stimulated by some external consideration or appreciations, is more inclined to be at burnout risk (Längle, 2003).

Transactional Analysis perspective

TA is a very versatile therapeutic approach that integrates psychodynamic, cognitive-behavioural and existential-humanistic perspectives (Widdowson, 2009). The basic assumption is based on the ego states (Berne 1966) and script concepts (O'Reilly-Knapp & Erskine, 2010), allowing flexible interventions focused on: (a) beliefs and behavioural changes (Widdowson, 2009), (b) unconscious childhood experiences that lead to repetitive and predictable interpersonal behavioural patterns (Novellino, 2003) and (c) meaning and purpose in life (Berne, 1966; Clarkson, 1992).

Karpman (1984) defined burnout as "an exhaustion and mental collapse at work, prompting a person to change profession" (p. 10). According to Karpman, the origin of burnout is in the script that induces the client to repeat the game *I am Only Trying to Help You*, doing unsolicited work for ungrateful people. This approach to work from a Rescuer position often leads to a Victim position in the drama triangle (Karpman, 1968), causing frustration. Thus, Karpman links frustration and burnout, proposing the drama triangle for the analysis of frustrating daily events that accumulate over weeks and months, inevitably lead to burnout. He proposed a set of questions to identify and clearly define frustrating episodes that occurred in the past week, and a further set of questions to conduct game and script analyses.

Clarkson (1992) defined burnout referring to the definitions of Freudenberger (1975), of the Webster's dictionary (Gove, 1986), and of Maslach (1976), focusing on the loss of concerns, positive feelings, sympathy or respect for clients that might consequently occur along with physical and emotional exhaustion in professional helpers. Clarkson proposed three prototypical racket systems with an associated fairy story, and linked them to both Ernst (1971) life positions and Freudenberger's (1975) three personality types vulnerable to burnout (the dedicated and committed type, the overcommitted with unsatisfactory private life type, and the authoritarian and patronizing type). She then proposed analysis of the script system (O'Reilly-Knapp & Erskine, 2010) and the existential life position (Berne, 1962) as a way to diagnose and treat burnout.

An Integrated TA Diagnostic Tool for Burnout

The Heptagon

From our literature review it emerged that these four models share some common aspects so we integrated them, combining:

- systematic-psychodynamic - emotional, interpersonal, somatic and motivational aspects;
- cognitive-behavioural - cognitive and behavioural aspects;
- logotherapy - existential and emotional aspects;
- transactional analysis - interpersonal, cognitive, behavioural, emotional, somatic, existential and script aspects.

We created the heptagon in Figure 1 that describes what we need to focus on for assessing the burnout syndrome, with seven areas and each summit corresponding to a specific symptom: Cognitive, Behavioural, Emotional, Motivational, Relational, Existential and Somatic (Table 1).

However, every human being has a different background (historical, cultural, emotional, behavioural…), so script aspects should be considered as part of the individual and included in the personal frame. The script system "is a self-reinforcing, distorted system of feeling, thoughts and actions" (Erskine & Zalcman 1979, p. 53), organised around interlocking beliefs about the self, others, and the world. It includes three elements: script beliefs and associated feelings; expression of script with observable behaviour; and supporting memories (Cornell, 2018). We believe that an integration of the script system with the seven symptom dimensions is possible and useful for burnout diagnosis and treatment plan, as shown in Table 2.

During sessions, the seven areas and the Script System may be investigated within relational episodes (in which the client refers relationships external to the therapy), scenic episodes (that the client actualises in the therapy room with the practitioner) and archaic episodes (in which the client recalls life episodes of their past). Relational and scenic episodes refer to the here-and-now in the heptagon, whereas archaic episodes refer to the there-and-then, creating a three-dimensional heptagon, meaning that today's symptoms recall past ones

Burnout phases

Since the burnout syndrome generally develops over a long span of time, it is useful to differentiate its phases. As previously mentioned, Freudenberger and North (1992) underlined 12 steps that lead to burnout, which we summarised into five subsequent phases to simplify the original model. Phase 1: Honeymoon is the lowest level of burnout, characterised by a feeling of wellbeing, slightly hypomanic, hyperactive, and with omnipotent thought. Phase 2: Suppression is characterised by the emergence of slight depressive symptoms,
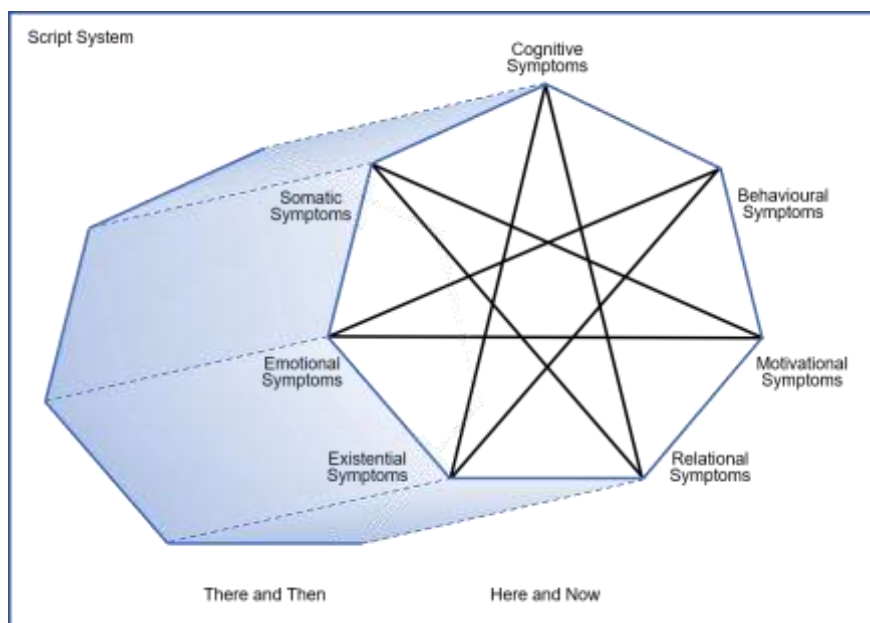
Figure 1. The three-dimensional Heptagon.

Diagnostic areas	Signs
Cognitive	*Suicidal ideas, lack of concentration, lapses of memory, difficulty with complicated assignments.*
Behavioural	*Being extremely active, impulsivity, elevated utilisation of illicit drugs and increased consumption of caffeine, tobacco, alcohol, renunciation of recreational activities, uncontrollable need to criticise, accuse or disapprove.*
Motivational	*Loss of enthusiasm, giving up, discouragement or apathy.*
Emotional	*Desolation, mood swings, weepiness, emotional exhaustion, accumulation of stress or apprehension or concerns.*
Somatic	*Chronic fatigue, nausea, headache, faintness, vertigo, muscle pain, sleep and gastrointestinal disorders.*
Relational	*Cynical toward others, withdrawing from society.*
Existential	*Deficiency in the personal-existential primordial motivation, alienation.*

Table 1: The seven dimensions described in detail

Script System

Script Beliefs and feelings	Expression of scripts	Supporting memories
Beliefs about: 1) Oneself (**Cognitive symptoms**) 2) The other (**Cognitive symptoms**) 3) Life and the world (**Existential symptoms**) Intrapsychic processes: Repressed feelings and needs during script-decisions (**Emotional symptoms**)	1) Observable behaviour (**Behavioural** and **Relational** symptoms) 2) Internal consequences such as somatic disorders and muscle tension (**Motivational** and **Somatic** symptoms) 3) Fantasies which maintain the script and which connect you to the pain in the script (**Existential symptoms**)	Emotional memories of script-forming moments (**three-dimensional Script System**)

Table 2: The Script System (O'Reilly-Knapp & Erskine, 2010) integrated with the seven symptom dimensions.

compensatory behaviour such as abuse of caffeine or even more active psychotropic substances, and change in relational environment. Phase 3: Denial is characterised by an increase in depressive symptoms and defensive compensation, and a deterioration of relationship. Phase 4: Dehumanisation is characterised by overt depressive and somatic symptomatology, strong decline in self-esteem, change in personality traits, and social withdrawal. The final Phase 5: Burnout is characterised by suicidal risk, violence, and alienation.

Combining the seven symptom dimensions and the five phases, we can differentiate which symptoms are more prominent within each phase to create the five prototypic models of burnout gravity level shown in Table 3.The Burnout Assessment Chart (BAC) and the Burnout Assessment Interview (BAI)

The BAC, included as Appendix A, is a proxy-rated test that analyses the seven symptoms previously cited (Cognitive, Behavioural, Motivation, Emotional, Somatic, Relational and Existential) on a five-point scale, (5=severe, 1=healthy). The symptom patterns contemplated in the tool have been extrapolated from analysis of different psychotherapy approaches and from literature. The BAC guides the practitioner through the subjective experience of the evaluation of client burnout symptoms. Measuring burnout gravity level is useful in identifying which symptoms are more at risk and outlining clear and immediate therapy plan and goals. It is user-friendly and it can be integrated with other TA diagnoses. However, is not a test and does not generate data separate to the practitioner's insight. Rather, it is intended as guidance to for systematising, to support diagnostic formulation and treatment planning.

The BAI is a semi-structured interview with closed and open-ended questions, shown in Appendix B. It is used as a compass for diagnosis and for completion of the BAC. We provide below a clinical illustration with a detailed description of the application of BAI combined with BAC. It was administered at the beginning of therapy, taking 90 minutes. The interview was also recorded for a later transcription analysis. The level of intensity was considered by taking into account the description of the events from the client's point of view and also by asking the client to give an evaluation of the intensity level for each symptom. The aim was to more fully understand which factors were driving the client symptoms and evaluate their level of severity.

The final evaluation considers material emerged both from the BAI and from the BAC. Longer term intention will be to provide reliable and comparable qualitative data.

Comparing the BAC with other commonly used tools

In literature there are several instruments to measure burnout, so we selected three tools currently used in this field and compared them to BAC, as shown in Table 4: the Maslach Burnout Inventory (MBI; Maslach et al., 1986), the Multidimensional Organizational Health Questionnaire (MOHQ; Avallone & Paplomatas, 2005) and The Acceptance and Action Questionnaire-II (AAQ-II; Bond, Hayes, Baer, Carpenter, Guenole, Orcutt et al., 2011). The MBI is a self-report questionnaire with 22 items distributed in three subscales which evaluate: emotional exhaustion, depersonalization and reduced personal accomplishment. The client rates his distress on a 7-point scale (0=never, 6=every day).

The MOHQ is a 109 item self-report questionnaire with eight subscales: scale 1 (comfort at work), scale 2 (clarity of organizational goals, appreciation of competences, active listening, availability and circulation of information, conflict management, collaborative interpersonal relationships, operative fluidity, organizational equity, sense of social utility) scale 3 (stress factors), scale 4 (injury security and prevention), scale 5 (tolerance of work duties), scale 6 (inclination and openness to innovation), scale 7 (negative indicators, positive indicators) and scale 8 (psychophysical malaise indicators). These items are rated on a 4-point scale (1=never, 4=often).

The AAQ-II (Bond et al., 2011) is a self-report with 7 items, one per scale, and are rated on a 7-point scale (1=never true, 7 = always true).

Finally, the BAC is a proxy-rated questionnaire with 7 items, one per scale, which evaluate different aspects of life: cognitive, behavioural, motivational, emotional, somatic, relational and existential). The practitioner rates each item on a 5-point scale (1=healthy, 5=severe). BAC is combined with BAI semi-structured interview.

For all these instruments, higher score indicates higher level of burnout. The most evident difference between these three commonly used instruments and BAC is self-rating (filled in by the client) versus BAC as proxy-rated (filled in by the practitioner) and combined with a semi-structured interview (BAI).

MBI, AAQ-II and BAC are shorter questionnaires and require less time to be filled in by the client or practitioner, whereas MOHQ is more time consuming

BAC is the only instrument that considers different aspects of life (cognitive, behavioural, motivational, emotional, somatic, relational and existential), is focused on clinically significant factors, and monitors

Phase/Symptoms	1. Honeymoon	2. Suppression	3. Denial	4. Dehumanisation	5. Burnout
Cognitive	Thoughts of omnipotence.	Lack of concentration; Doubts about one's capacity to perform; Difficulty with complicated assignments.	Attention and memory issues; Irrational beliefs; Distorted thoughts.	Thoughts that life is hopeless; Negative self-concept.	Suicidal ideas; Persistent negative state of mind.
Behavioural	Hyperactivity.	Increased consumption of caffeine, tobacco, alcohol, illicit drugs.	Tearfulness.	Avoid society, social contacts; Poor impulse control.	Acts of violence toward family or co-workers; Inability to sustain intense commitment.
Motivational	Enthusiasm, desire to give more and more.	Abandonment of recreational activities; Loss of enthusiasm.	Discouragement; Reduced engagement.	Apathy; Giving up.	Loss of motivation and just need to sleep.
Emotional	Sense of joy.	Mood change.	Mood swings; Emotional exhaustion; Tension/anxiety.	Anger toward others and themselves; Emotional draining and disengagement.	Strong depression; Negative feelings.
Somatic	Euphoria.	Headache; Nausea.	Anxiety; Breathing issues.	Vertigo, dizziness; Coronary disease.	Chronic fatigue; Feeling drained.
Relational	Great involvement in group activities.	Group activities start to lose importance.	Nervousness and anxiety when working with others.	Cynical toward others.	Withdrawing from society.
Existential	Enthusiasm and feeling of completeness.	Values differ from the organisational ones.	Misinterpretation for successful human existence.	Deficiency in the personal-existential primordial motivation.	Alienation.

Table 3: The five phases to burnout across the seven symptom dimensions.

Tools	MBI	MOHQ	AAQ-II	BAC
Type of questionnaire	Self-report	Self-report	Self-report	Proxy-rated, combined with the semi-structured interview (BAI)
Number of items	22 items	109 items	7 items	7 items (one per scale)
Subscales	1) Emotional exhaustion 2) Depersonalisation 3) Reduced personal accomplishment	1) Comfort at work 2) Subscales: Clarity of organizational goals; Appreciation of competences; Active listening; Availability and circulation of information; Conflict management; Collaborative interpersonal relationships; Operative fluidity; Organizational equity; Sense of social utility; Stress factors 3) Injury security and prevention 4) Tolerance of work duties 5) Inclination and openness to innovation - Subscales: Negative indicators; Positive indicators 6) Psychophysical malaise indicators		1) Cognitive 2) Behavioural 3) Motivational 4) Emotional 5) Somatic 6) Relational 7) Existential
Scoring	7-point scale (0 never – 6 every day) Scale 1 and 2: higher score, higher burnout; scale 3: lower score higher burnout	4-point scale (1 never – 4 often) Higher score, higher burnout	7-point scale (1 never true – 7 always true) Higher score, higher burnout	5-point scale (1 healthy – 5 severe) Higher score, higher burnout
Final score	Score: three, one per scale	Score: one	Score: one	Score: seven, one per scale

Note. MBI = Maslach Burnout Inventory (Maslach et al., 1986). MOHQ = Multidimensional Organizational Health Questionnaire (Avallone & Paplomatas, 2005). AAQ-II = Acceptance and Action Questionnaire-II (Bond et al., 2011). BAC = Burnout Assessment Chart. BAI = Burnout Assessment Interview.

Table 4: Comparison of three different instruments that measure burnout (MBI, MOHQ and AAQ-II) with the BAC.

risk areas (i.e., the cognitive scale looks out for suicidal ideas; the behavioural scale for violence toward others; the emotional scale for strong depression; and the somatic for severe cardiological pathologies). MBI and AAQ-II are focused on the impact of burnout on emotional, cognitive and self-awareness, and only MOHQ includes somatic aspects.

Clinical Illustration: Jorge
Introduction
The client agreed to 20 one-hour therapy sessions, including one pre-treatment/assessment session, which was focused on explaining the research project and on obtaining consensus, and two assessment sessions focused on the diagnosis (submission of the COPSOQ and administration of the BAI).

The integration of COPSOQ and BAI helped complete the BAC, which was useful to filter essential information from sessions, especially because it was a short-term therapy. The BAC prompted attention to behavioural aspects and interventions on both the diagnosed driver and the underlying injunction of Don't feel fatigue. It also helped consider meanings and existential aspects of the client's life.

Since a 20-sessions therapy is considered a short-term therapy, the BAC has been used as a filter and symptoms considered moderately severe and severe were considered of greater relevance and priority for the treatment. Having selected the major issues to focus on, at the end of the third session the practitioner and client created the Personal Questionnaire (PQ) items (Elliott, Wagner, Sales, Rodgers, Alves & Café, 2016). This tool measures and assesses changes during psychotherapy, with the purpose of identifying goals and strengthening the therapeutic alliance. The PQ was administered at the beginning of treatment (Session 3), in the middle (Session 10), and at the end of treatment (Session 20).

Ethical Considerations
The research protocol follows the requirements of the ethical code for Research in Psychotherapy of the Italian Association of Psychology, and the American Psychological Association guidelines on the rights and confidentiality of research participants. The research protocol has been approved by the Ethical Committee of the University of Padua. Before entering the treatment, the client received an information pack, including a detailed description of the research protocol, and gave a signed informed consent and written permission to include segments of disguised transcripts of sessions or interviews within scientific articles or conference presentations. The client was informed that he would have received

therapy even if he decided not to participate in the research and that he was able to withdraw from the study at any point, without any negative impact on his therapy. All aspects of the case material were disguised, so that neither the client nor third parties are identifiable. All changes are made in such a way that does not lead the reader to draw false conclusions related to the described clinical phenomena. Finally, as a member checking procedure, the final article was presented to the client, who read the manuscript and confirmed that it was a true and accurate record of the therapy and gave his final written consent for its publication.

Inclusion and exclusion criteria
The psychotherapist participating in this case study included the first new client with a burnout condition, as diagnosed by the clinician, who agreed to participate in the research. Jorge was assessed as meeting ICD-11 criteria for burnout: he experienced feelings of energy depletion or exhaustion (criterion 1) and increased mental distance from his job, feelings of negativism and cynicism related to his job (2). As for ICD-11 criterion 3 Jorge did not experience a reduction in professional efficacy because he started therapy to prevent a total burnout condition (or Phase 5). Moreover, psychosis, domestic abuse, bipolar disorder, active current use of antidepressant medication, alcohol or drug abuse were all considered as exclusion criteria.

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After having worked for almost five years in that position, one day before going to bed he experienced a feeling of heaviness. The day after he could not stand up from his bed. He called his wife saying that he could not move and that his hands were paralysed. His level of anxiety rose and for the first time in his life he experienced a slight panic attack. He decided to consult his general practitioner who noticed a marked fatigue and hypothesised a beginning of burnout, suggesting a period of vacation. Jorge took a month off, conscious that his job was absorbing him too much. After his sabbatical month he went back to his job but the situation did not improve. On the contrary, his anxiety rose, he started having difficulties in meeting his employees, becoming too pretentious with his colleagues and feeling tired of being overwhelmed by employees' complaints. On the advice of his general practitioner, he sought therapy to prevent severe burnout.

The Practitioner
The psychotherapy was conducted by a 50-year-old, white, male Italian clinical psychologist with a diploma in TA counselling. He worked for more than 20 years as psychologist in the organisational field and since 2018 he is working in a psychiatric clinic in Switzerland. For this case, he received weekly supervision (20 sessions) by a Provisional Teaching and Supervising Transactional Analyst (Psychotherapy) (PTSTA-P) with 5 years of experience.

Diagnosis
Case formulation was conducted conforming to TA diagnostic categories. Jorge assumed a life position (Ernst, 1971; Berne 1972) I'm Not OK, You're Not OK, that interacted with his stroke economy (Steiner, 1974). His family context was characterised by a lack of positive strokes and a lot of negative ones. His father was very demanding and emphasised achievements by associating value with doing. His absent, passive and needy mother contributed to a lack of self-esteem and sense of guilt for not being able enough to help her with her depression. The observable drivers (Kahler, 1975) identified in order of importance were: Be Perfect, Try Hard and Please Others. Additionally, the Injunctions (Goulding & Goulding, 1976; McNeel, 2010): Don't Be a child ("*I have to take care of my mother and my sister and show I am independent*"), Don't be important *("I have to be humble and I cannot show off my abilities*"), Don't' enjoy ("*First the tears, after the cake*"), Don't feel ("*My emotions are barriers for goals achievement*"), were also identified. The client internalised an under-functioning Nurturing Parent and a strong Critical Parent which activated intense self-reproachful and self-doubting internal dialogues. In the drama triangle he assumed the role of Rescuer when taking care of everything and everyone in his

company, and Victim when his manager did not show enough interest in his health and for his extra working hours. The typical games the client played were: Kick me and See How Hard I'm Trying (Berne, 1964).

The practitioner used the BAI, BAC and script system. The level of burnout intensity, and corresponding phase, was considered by taking into account event descriptions from the client's point of view and also by asking him to give an evaluation the level of the intensity for each symptom (Appendix A). The practitioner also assessed Jorge using the COPSOQ; to better understand Jorge's working environment.

During the first session the practitioner had an impression of Jorge as a scared and lost child. Jorge had difficulties in expressing what was going on in his life, and felt to be like a "*broken mirror*". He described himself as a perfectionist, scared to make mistakes, very demanding with himself, and naturally prone to helping others – he considered this aspect fundamental for his self-realisation (Beliefs about Self, Figure 3). In addition, he declared his need to be in control of others, especially his direct reports, because he believed they were unable to carry out their duties (Beliefs about Others, Figure 3). His cultural and family environment had a strong/heavy impact on his vision of life. He grew up in a very harsh and austere climate, where values were deeply directed at sense of devotion to work and sacrifice. Being strong, independent and supporting others have been the pillars of his life: he could not conceive his existence without these values (Quality of Life, Figure 3). He remembered a very demanding and authoritarian father-figure - who on some occasions he saw incarnated in his manager – with the tendency to give Jorge harsh punishments if he did not follow his/the rules (Reinforcing Memories, Figure 3).

Jorge described a sense of emptiness pervading his life: *"What is the meaning of life?… I feel confused and very sad",* (Intrapsychic process, Figure 3 and Existential symptoms, BAC, Appendix A). He also referred to being conscious that his job was starting to take over his private life and that his work has always been a priority for him (Observable behaviours, Figure 3). He mentioned feeling exhausted from overwork, due to the lack of sleep (Somatic symptoms, BAC, Appendix A), and having an irregular diet. He reported that all of these factors were having an impact on his job performance and leading to loss of enthusiasm (Motivational symptoms, BAC, Appendix A), which consequently was undermining his self-esteem, generating a sense of guilt and rapid mood swings (Reported internal experience, Figure 3). The idea of being the

model employee was gradually dissipating (Fantasies, Figure 3) which was leading him toward a sense of frustration.

Despite this high sense of despair, alienation, mood swings, and high accumulation of stress and preoccupations (Emotional and Existential symptoms, BAC – Appendix A), which sometimes he tried to mitigate by smoking cigarettes or cigars (Behavioural symptoms, BAC, Appendix A), Jorge showed a moderate level of suicidal ideas (Cognitive symptoms, BAC, Appendix A). In addition, Jorge evoked his concern regarding his struggle to engage with others. He described himself as very social but having at the moment the proneness to withhold affection, to be overly stubborn and to be overbearing with his wife and children, and to avoid contacts with close friends even if opportunities to meet arose (Relational symptoms, BAC, appendix A).

Results from the COPSOQ highlighted that Jorge's organisational setting was quite stressful but not enough to have led to burnout because his tasks were balanced and the climate was characterised by a positive and democratic participative leadership style. When the questionnaire results were discussed with Jorge, he realised he was putting stress on his self and it was not due to the organisational environment. This point was crucial for setting a therapy contract which allowed the client to understand that his fatigue was generated by internal conflicts rather than due to external issues.

The BAC and BAI also contributed to the analysis of Jorge's script system, as show in Table 5.

Treatment goals

The therapeutic process followed Widdowson (2009) guidelines. First, the practitioner focused on reflecting what the client needed to do in order to change, so practitioner and client generated a series of goals (reported in the PQ) considered the priority and central therapeutic task in line with the length of therapy. Second, the practitioner connected Jorge's goals with TA concepts on which they could work in therapy for reaching such changes. These are reported in Table 6 Jorge's first therapy goal was to work on his excessive tendency to do others' work, and the practitioner focused on the redecision of his Please Others driver ("I understand that this is not a part of my job and that I cannot do it for others"), along with the analysis of his drama triangle transactions, in which Jorge entered as a Rescuer ("I told myself that my colleague was very tired and also had a lot of health issues, and so for this reason I had to help her"), but inevitably ended up as a Victim ("I always support and help others solving their job's problems and nobody sees my engagement. I really

think I'm too gentle with people and they take advantage of me").

Jorge's second goal was to change his tendency to do everything alone without considering the possibility to ask for help and the practitioner focused on redeciding his Try Hard driver ("The company is not giving me enough financial and human resources to complete projects, but I tell myself that despite this difficulty I have to go on and show myself and others that I can do it").

His third therapy goal was to be more assertive with his boss, so the practitioner worked on Jorge's internal dialogue between his Critical Parent ("This company is like an old traditional family, you have to respect your father and your mother and to have to be engaged with your spouse and your children") and his Adapted Child ("Yes, I agree, I must be engaged 100%, and if I do not respect this I would understand if I received a punishment").

His last goal was to be able to relax and dedicate time to his leisure activities with his family and friends, so the practitioner worked on Jorge's Adult awareness of when he has to stop working ("Working time has ended, I'm tired, I'll finish it tomorrow. Now I have to go home, take care of my family and do my hobbies: biking and drawing") and when he needs time for himself.

Therapy Process

To help Jorge reach his therapy goals and find relief from his burnout condition, the practitioner focused on the client's drivers, especially Jorge's tendency to Please Others and Try Hard, which made him spend more time at work doing the job of others and trying at his best to be the best performer he could be in a Rescuer-Victim position in the drama triangle. These two drivers learnt during his childhood led Jorge to a predisposition especially to cognitive ("*I am OK only if I help others and I do things perfectly*", "*Others are not OK and need support*"), behavioural ("*If I show that I work extra hours and I do not depend on others, people will have a positive image of me*"), motivational ("*It is not possible to make mistakes, errors are a sign that you do not have control on what you are responsible for*") and relational ("*I have to adapt to others' needs, in this way I will be accepted and considered as a part of the community*") symptoms of burnout in a Script System three-dimensional optic ("*I have to be performing*" and "*Others needs come before mine*"). Working on Jorge's internal dialogue between his Critical Parent that said "*I'm not feeling good and I do not have time for taking care of you (mother)*" and his Adapted Child that answered "*Since nobody can help me and asking for help is shameful, I have to take everything on my shoulders*" helped scale down existential ("*Life*

Jorge's Script System

Script Beliefs and feelings	Expression of scripts	Supporting memories
Beliefs about: 1) Oneself (**Cognitive symptoms**) • I am OK (I feel I can exist) only if I can help • I am OK if I do things perfectly (I make no mistakes) 2) The other (**Cognitive symptoms**) • Others do not understand me • Others are not OK; they need support 3) Life and the world (**Existential symptoms**) • Life has no sense • Life is sacrifice and struggle • Life has to be devoted to others • I do not have to depend on others because I have to be strong Intrapsychic processes (**Emotional symptoms**) • Sadness	1) Observable behaviour (**Behavioural** and **Relational symptoms**) • Working extra hours (more than 12 hours a day – sometimes during the weekend too) • Very adapted to organisation's needs • Justify with others when taking holidays • Hands are as paralysed • No time for leisure activities and family 2) Internal consequences (**Motivational** and **Somatic symptoms**) • Tiredness, heaviness, emptiness, anxiety • Feelings of guilt if he does not do things perfectly • Mood swings and cries 3) Fantasies (**Existential symptoms**) • I will be remembered as the most engaged employee, the one who brought a sense of humanity in the organisation	Emotional memories of script-forming moments (**three-dimensional Script System**) • My father blamed me for not being enough performant at school and in sports • My father gave me heavy punishment when I did not follow family rules • My mother was passive and submitted to my father. • My mother took care of her needs before mine • Game with manager (Kick-me)

Table 5: Jorge's Script System.

Jorge's therapeutic goals in order of priority	TA Concepts
"I want to work on my excessive tendency to do the job for others".	Redecide "Please Others" driver and transactions with the drama triangle (Rescuer-Victim).
"I want to change my way of thinking: 'I have to do everything by myself' and 'I can't ask for help'".	Redecide Try Hard driver.
"I want to be more assertive with my manager".	Analyse the internal dialogue between Critical Parent and Adapted Child, and interrupt it.
"I want to take time to relax and for leisure activities with family and friends".	Reinforce Adult resources to be more aware when it's time to stop working and take time for self.

Table 6 Jorge's therapeutic goals and correlated TA concepts.

is devoted to helping others and I cannot ask for help") symptoms of burnout in his three-dimensional script system ("I have to be performing" and "Others needs come before mine"), allowing Jorge to ask for help if necessary without feeling shameful. Finally, working on his difficulty to give himself some relaxation and dedicate time to leisure activities, family and friends, has been useful for his emotional (sadness) and somatic (tiredness, emptiness) symptoms of burnout.

The evaluation data indicated that the focus needed to be orientated mainly toward motivational, emotional and existential symptoms and it emerged that, without an immediate therapeutic action, Jorge would have fallen into burnout with serious consequences on his physical and psychological health. The loss of meaning about the job, the sense of apathy and disconnection with the company, but paradoxically the incapability to take a break, the uncontrolled mood swings with his colleagues and relatives, and the feeling of emptiness have been evaluated between moderately severe and severe and were considered as the main areas for treatment implications.

Three months after the conclusion of the therapy, Jorge attended a follow-up session, which was based on the CSEP 9/99. The client reported feeling better with a sensation of relief. He asserted to be more conscious about himself and about the injunctions and drivers explored during therapy.

He added that the technique of the internal dialogue based on the ego state model helped him to better manage the unconscious requests from his Critical Parent who pushed him to sacrifice himself in order to feel worthy of his existence and be accepted by others. He also stated that he is better equipped at measuring the burden of tasks at work and the impulse of bringing the job at home is under control. He started delegating, he is less impulsive and more able to control his anxiety. Consequently, also the level of physical fatigue diminished as well as his headache problems and sleep disorder. He referred to feeling more motivated to go to work, and his relationship with peers and direct reports had improved. Delegating impacted positively on his private life – he has more time to spend with friends and family. One aspect that remained was that Jorge reported sometimes feeling disconnection between himself and his job. He experiences this gap between identity and job as a source of frustration, anxiety and feeling of emptiness. In order to better address this topic, the practitioner left the client to decide whether to undertake longer-term treatment.

Jorge's Burnout phases

Jorge came to therapy to prevent a potential burnout syndrome, so we analysed the evolution into phases.

When he started therapy, he was in a condition between the Dehumanisation phase (Phase 4) and the Burnout syndrome (Phase 5). In Table 7 we report his words for each stage, from Honeymoon (Phase 1) to Burnout phase. It is evident that in Phase 1, at the beginning of his career, Jorge was feeling: extremely competent with thought of omnipotence (Cognitive), hyperactive (Behavioural), longing to give more (Motivational), full of energy (Emotional), euphoric with butterflies in his stomach (Somatic) and had loads of group activities (Relational). After two years his condition started degenerating from the Honeymoon to the Suppression phase (Phase 2): he began to doubt his capacities (Cognitive), abandon his hobbies (Motivational), have mood changes (Emotional), gastric problems (Somatic), and group activities were considered less important (Relational). In approximately 15 months these symptoms led Jorge to the Denial phase (Phase 3): he started feeling discouraged (Motivational), anxious (Emotional) which led him to sleep problems (Somatic) and nervous when with others (Relational). After 10-12 months, before beginning therapy, Jorge reduced social contacts (Dehumanisation phase, Phase 4; Behavioural) and lost motivation for his job (Burnout phase, Phase 5; Motivational)

Discussion

The aim of this article is to demonstrate how we have combined systems-psychodynamic, cognitive-behavioural, logotherapy and transactional analysis to create a model for understanding and diagnosing burnout. We have described our processes of development to produce a heptagon with seven dimensions and linked that to the use of the script system. We have developed a Burnout Assessment Chart alongside a semi-structured Burnout Assessment Interview tool.

We have then illustrated the use of these with a case study, which has allowed us to demonstrate how using the proxy measurement tool we have developed provides a basis for identifying the phase and the level of severity of burnout being experienced by a client, so that a practitioner can develop a treatment plan that will facilitate a focus on the key priorities for an individual client.

Limitations

We are conscious that we have developed these ideas between us and have not yet engaged with the wider professional community. We found little on the topic of burnout within the TA literature so the TA concepts we have considered have in our own choices rather than being influenced by many other practitioners. It is likely that others might well be using different TA concepts in their work with clients with burnout indications.

Phase/ Symptoms	1. Honeymoon	2. Suppression	3. Denial	4. Dehumanisation	5. Burnout
Cognitive	"At the beginning I thought that I was the only one who could give the company a truly added value, maybe because of my previous experience in a more structured company".	"At a certain point I started doubting about my capabilities. I could not concentrate at work and the complexity of this project started to become heavy".	"I started having troubles remembering things like important meetings with the board or answering to some important emails. And on the top of it, I was denying the severity of the situation".		
Behavioural	"I wanted to show that there was cohesion between my company and me, in particular with my manager. I wanted to show that I was able to do and manage lot of things at the same moment and in short times. Efficiency was my key word".			"I almost isolated from the others. The only contact I had was with my colleges at work and with my wife at home".	
Motivational	"I used to work a lot and bring home my job. I also worked during the weekend searching for new projects. I was really satisfied about my involvement and commitment".	"I started giving up my hobbies: I've always been interested in drawing and biking, but there was no time for these things anymore".	"I talked to my wife saying that I did not want to go to work. My motivation was decreasing as well as my commitment. I started losing interest in my role, in the project, in the company".		"One morning I could not get out of my bed. I called my wife and told her to call the doctor because I could not move".
Emotional	"It's like I was moved by an internal boost. I was full of energy and motivation".	"My mood changed. I started being irritable with my wife at home".	"The level of anxiety started raising. I was anxious about getting to work late, anxious when reading the emails and when facing with daily problems".		
Somatic	"I had a sense of excitement, like butterflies in my stomach. Which made me think I was in love with my job and the organisation".	"Sometimes I have gastric issues and I cannot sleep very well".	"I wake up at night thinking about my job and in the weekend too. Instead of taking my time for breakfast I start the day checking my emails".		
Relational	"I was involved in a lot of group activities and I really enjoyed it. Teamwork was an asset for me."	"The meetings with my direct reports and my colleagues started losing importance. Even if I participated to all the reports, I found them quite boring and time waste".	"I became nervous with my direct reports and intolerant towards their mistakes that I had to fix. This took time and extra effort".		
Existential	"This job was the one I was looking for since ages. Being at others service in an NGO was my dream".	"I started realising that my values were quite different from the organisation's. I accepted this role of supporting and counselling others, but the board wanted me to have a more strategic position which did not allow me to have a strong contact with the employees of the company".	"I started questioning why I decided to accept that role. What was the sense of all of this? Was it really the job I was looking for"?		

Table 7: Jorge's phases to Burnout in the seven symptom dimensions.

We recognise also the obvious limitations of illustrating the tools we have developed with only one client. We have described a case where burnout had not reached the most severe phase, so that the treatment plan we show did not take into account. We have not developed treatment plans for less severe cases either so that still needs to be done.

Presenting a single case might well give the impression that we expect the use of the tools we have developed to be straightforward and consistent. However, every client is unique and the chart and interview may need considerable amendment to reach a stage where they can be used with a wide variety of presenting cases and at different levels of severity.

Conclusion

Burnout is a syndrome which has recently been recognised within psychiatric pathology, but often dealt with by counsellors and psychotherapists,

educators and work psychologists. It is dominated by serious depressive and somatic symptomatology that can lead to suicide, but it can also be identified in much earlier phases when it is less severe.

We are developing a manual for burnout treatment, where we have brought together systemic-psychodynamic, cognitive-behavioural, logotherapy and transactional analysis perspectives. Through this we have developed a concise version of burnout phases generated a three-dimensional heptagon in which every summit represents a dimension of burnout condition, and linked the dimensions to the script system. We have also created a proxy-rated questionnaire and a semi-structured interview that provides information for tailored treatment planning to suit specific clients.

Although we are presenting here only one case study, we hope that our colleagues within the TA community will use our ideas and tools with their own clients, in different contexts, so that we can develop a broader range of treatment plan options – whilst testing and potentially improving the content of the heptagon.

The authors welcome requests for the blank BAC form.

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Appendix A – Burnout Assessment Chart (BAC)

--------------- **Burnout Assessment Chart (BAC)** ---------------

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Patient's code: 003   Age: 56   Gender: Male   Ethnicity: White

Date of the assessment: 9th May 2018   Pratictioner: GPB

Burnout Symptoms Patterns

With the support of the semi-structured interview and the signs related to symptoms, evaluate if the level of each symptom is severe, moderate or healthy.

Symptom	Signs	Severe	Moderate Severe	Moderate	Mild	Healthy
Cognitive	Suicidal ideas, lack of concentration, laps of memory, difficulty with complicated assignment.	5	4	[3]	2	1
Behavioural	Being extremely active, impulsivity, elevated utilisation of illicit drugs and increased consumption of caffeine, tobacco, alcohol, renunciation of recreational activities, uncontrollable need to criticise, accuse or disapprove.	5	4	[3]	2	1
Motivational	Loss of enthusiasm, giving up, discouragement or apathy.	5	[4]	3	2	1
Emotional	Desolation, mood swings, weepiness, emotional exhaustion, accumulation of stress or apprehension or concerns.	[5]	4	3	2	1
Somatic	Chronic fatigue, nausea, headache, faintness, vertigo, muscle pain, sleep and gastrointestinal disorders.	5	4	[3]	2	1
Relational	Cynics toward others. Withdrawing from society.	5	[4]	3	2	1
Existential	Deficiency in the personal-existential primordial motivation. Alienation.	[5]	4	3	2	1

Treatment Implications:

Working on his capacity to regulate emotions.

Working on his feeling of emptiness, incompleteness.

Working on his excessive self-involvement in the job.

APPENDIX B – Burnout Assessment Interview (BAI)

Semi-structured Interview guide (duration 90 minutes): Basic questions for burnout assessment. For each question **ask also for examples** and if necessary, the level of intensity from the client's point of view explaining the scale from 1 to 5.

I am interested to know a little more about you and about the symptoms that you are experiencing in these last two weeks compared to the last year. The purpose is to better focus and understand which are the most significant signs are you experiencing. This interview and all the therapeutic processes will remain confidential and be used for academic research reasons. If you have any questions feel free to ask during the interview. Also, ask for clarification if you do not understand what I am asking. Probably some events happened a long time ago, so you can take your time to recall them. It is OK if you do not remember or if you do not know an answer and if there are aspects that you do not want to talk about.

Introductory questions

- In order to understand the context, I'll start asking with why you became a Senior HR director.

- Can you describe your development in this position?

Diagnose Cognitive Symptoms

- Do you constantly forget important or little things? Can you give me some examples?

- Do you have difficulties concentrating on one or more task? Can you give me some examples?

- Have you ever had suicidal ideas when you felt drained by your job? Can you give me some examples?

Diagnose Behavioural Symptoms

- How many hours do you generally work per day?

- Have you started using toxic substances or increasing their consumption? Which type of substance have you used and with what frequency?

- Tell me about withdrawing from your hobbies and leisure activities.

Diagnose Motivational Symptoms

- How did you lose enthusiasm about your job? Tell me more about this.

- In which way do you feel discouraged? Can you give me some examples?

- Tell me more about your sense of apathy.

Diagnose Emotional Symptoms

- Are you experiencing a sense of desolation? Tell me more about it.

- How does your mood change? Can you give me some examples?

- How are you accumulating stress and apprehension?

Diagnose Somatic Symptoms

- Are you experiencing a sense of chronic fatigue?

- Are you experiencing somatic distress? For instance, nausea, headache, muscle pain, gastrointestinal disorders, etc.?

Diagnose Relational Symptoms

- Are you withdrawing from others?

- Are you showing a level of cynicism towards others?

Diagnose Existential Symptoms

- How is your job meaningful to you?

- Are you feeling a sense of alienation from your job?

Conclusion of the interview: Thank you for your time for this interview.