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Who deals with occupational burnout?

A qualitative study among (para-)medical and non-medical professionals in Switzerland

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Summary

Background: There is still a gap of knowledge in the detection and treatment of occupational burnout because it is not recognized as a disease and there are no standard criteria for its detection. We conducted a qualitative study to: (1) identify the different types of professionals who intervene in occupational burnout detection, treatment, prevention or administrative management; (2) describe their respective roles, intervention levels and professional interactions; (3) describe the types of interventions and modalities available; and (4) conceptualize the main models of care currently in use in Switzerland.

Methods: We conducted in-depth semi-structural interviews with Swiss (para-)medical and non-medical professionals that deal with occupational burnout. Data were analyzed following the grounded theory principles.

Results: A total of 42 professionals were interviewed from different professional fields (e.g., physicians, nurses, psychologists, human resources, professionals working in insurance, politics, or private consulting) and from all regions of Switzerland. Three main care models for occupational burnout (Support, Extractor, and Systemic) were proposed, based on the categorization of the most cited intervention modalities used by the interviewed professionals.

Conclusions: Based on the preliminary findings of this study, the need for collaboration between medical and non-medical professionals appeared to be the most important requirement to ensure the treatment of and recovery from occupational burnout.

Keywords: Burnout; care; diagnosis; intervention; professionals

Background

A large body of scientific literature shows that occupational burnout has become a widespread phenomenon in the last 20 years [1–3]. According to the World Health Organization (WHO), occupational burnout is not recognized as a disease, but as a syndrome resulting from chronic work-related stress [4]. Symptoms vary by stage, but most are also found in other disorders (e.g., depression) [5]. Many different definitions of occupational burnout have been proposed, whereas a harmonized definition has only recently been published [6]. This harmonized definition describes it as a state of physical and emotional exhaustion that results from prolonged exposure to work-related problems. In practice, some countries recognize occupational burnout as an occupational disease, whereas in others, it is not an official diagnosis [7, 8]. Given the economic consequences of occupational burnout (e.g., work incapacity with long-lasting sick leave and possibly a lay-off, its negative impact on colleagues and the organization, and the loss of productivity) social and economic actors entered the field of occupational burnout in parallel to the healthcare system. Undoubtedly, health professionals also needed to take action, as more and more patients are turning to healthcare providers for care and assistance due to symptoms occupational burnout. However, how can and do physicians and other healthcare providers treat a problem that is not a disease? What can they offer to respond to the growing demand, taking into account the status of occupational burnout? To answer these questions, we conducted a qualitative research aiming to describe how medical and non-medical professionals in Switzerland manage occupational burnout in their patients and how they are working together. The specific objectives of this study were to: (1) identify the different types of professionals who intervene in the prevention, detection, treatment or administrative management of occupational burnout; (2) describe their respective roles, le-

vels of intervention, and professional interactions; (3) describe their action types and modalities; and (4) conceptualize the main models of care and preventive interventions currently used in Switzerland.

Methods

This study was authorized by "La Commission cantonale d'éthique de la recherche sur l'être humain (CERVD)" of the Swiss Association of Research Ethics Committees (Swissetics), Vaud county section (2021-01089). All participants provided their consent when accepting the invitation for the face-to face interview.

Study design

We applied a sociological approach, inspired by the data production and interpretation operations from the qualitative methods [9]. The study is built on the process of inquiry through iteration or "permanent and mutual rearrangement of the interpretative framework and the empirical elements" [10]. This specific configuration allowed us to adapt our research by reframing the interview questions while analyzing the data (supplementary file S1 in the appendix). Thus, the relevance of the emerging occupational burnout dimensions could be investigated in real time. Moreover, the iteration process involves the recruitment of participants by snowball sampling. The latter refers to a procedure "where each individual in the population is asked to name k different individuals" [11] and thus promotes the study of existing networks of inter-acquaintances (or "local social circuits") [10].

Study participants

The eligibility criterion was to have professional experience related to occupational burnout prevention, detection, treatment, or administrative management. According to snowball sampling [12], the researchers used their own professional networks to begin interviews. Initially, we contacted occupational psychologists and physicians specialized in general medicine, occupational medicine, and psychiatry. As the interviews progressed and participants made recommendations, additional participants were contacted. In a second step, further professionals such as occupational nurses, human resources (HR) professionals, case managers, and politicians were recruited for the interview. We recruited participants until the saturation of data [13].

Semi-structured interviews

Interviews with participants were semi-structured through the use of an interview grid. The first grid was inspired by Droz and Wahlen [14]. As the qualitative study progressed, the grid was adapted. The grid created for interviewing healthcare professionals covered six topics: definition and etiology of occupational burnout; diagnostic strategies; therapeutics; efficacy criteria of the treatment; individual risk factors and profiles; interactions with other professionals. The grid for interviews with non-medical professionals included additional topics: management of work absenteeism; management of in-company risk factors and occupational exposures; workplace design and adaptation; prevention, including early detection; role of insurers. These topics were queried differently depending on the participant. New questions were added depending on when some topics reached saturation and how the interviews progressed. Interviews were conducted by two interviewers, usually the study sociologist pair (S.B. and O.T.) or a sociologist and an epidemiologist (S.B. and I.G.C.), and lasted between 1 and 1.5 hours. Because of the COVID-19 pandemic, participants were interviewed by video call.

Data analysis

We applied two levels of analysis. The first level analysis allowed us to classify the different professionals according to their interventions.

The second level of data analysis consisted in a systematic analysis following grounded theory principles [15]. The latter constitutes an iterative approach whose results are close to the empirical data thanks to a systematic coding process. The coding process consists of the "creation of analytic codes and categories developed from data", without a preconceived hypothesis [16]. Hence, each interview was recorded, transcribed, and, when necessary, translated from German into French for analysis. Two sociologists reviewed the transcripts and independently coded the data, which generated a primary number of codes (noted in the margin of the documents). According to their occurrence in the interviews, these codes were selected and tabulated to describe the professionals and their practices. For more details regarding the coding and analysis, please see supplementary file S2 in the appendix.

Intermediary assessment

About midway through the study, we organized a workshop to present and discuss the preliminary results. Participants and members of the project's scientific advisory board were invited via videoconference to comment on the qualitative results (mapping of professionals (fig. S1, in the file "supplementary material"), codes (table S1, ibid.) and care models (table 2)) and to make suggestions for new dimensions that merit investigation.

Results

A total of 42 professionals agreed to participate in this study and were interviewed. They came from different professional fields from all regions of Switzerland. We chose to split the professionals in two parts: the medical and paramedical professionals; the non-medical professionals (table 1, parts A and B, respectively). We described the diversity of professionals' practices and provided examples of interventions in patients with occupational burnout in supplementary file S3.

Professionals intervening on occupational burnout

Psychiatrists

The majority of the interviewed psychiatrists did not consider occupational burnout as a disease with a differential diagnosis. Some considered it a risk factor for psychiatric and somatic disorders whereas others considered that it falls under mood, anxiety, or adjustment disorders. However, for some psychiatrists, occupational burnout can be a disease "I see it as a pathology because people have a set of emotional, cognitive and somatic symptoms that are substantial. So to say that it's not a disease... This is pure hypocrisy. It's perfectly dishonest." All psychiatrists considered occupational burnout as chronic stress that is related to work. Most interviewed psychiatrists used the operationalized criteria of Maslach and Jackson [17] for the definition of occupational burnout. For some, occupational burnout is the exhaustion from the Maslach burnout inventory with demotivation mainly in the context of a helping profession; for example, physicians who are very demanding or have high ideals are at risk of occupational burnout. Whereas for others, there are emotional aspects and cognitive difficulties that can be described in burned-out patients, with the biological aspects which are "Executive function deficits": "When you do the neuropsychological tests and you see that the person has a decline in his cognitive abilities, that's burnout. People can't count on their fingers anymore, they can't concentrate." Among the other views that were reported: "burnout does not exist, occupational burnout is constant chronic stress" but here depression and anxiety are also questioned. The "mirror neurons theory" was cited with advice to "energize the individuals". Most psychiatrists believe there is an overlap between occupational burnout and depression. Most interviewed psychiatrists stated that they can differentiate the stages of occupational burnout. For one psychiatrist, the answer to the question "Would you like a work cessation?" defines the stage of occupational burnout. None of the psychiatrists mentioned that

Table 1: Professionals and their practices related to burnout

Code	Type of profession (n = number of interviews*)	Professional setting	Intervention target	Type of intervention	Modalities of intervention	Interaction with other professionals	Most frequently detected stage of OB
Part A = Medical and paramedical professionals and their practices related to burnout							
1	Primary care physician General practitioner (n = 3)	Ambulatory	Individual	Treatment	• Diagnostics including anamnesis, clinical examinations and biological tests • Medical treatment, including medication and worktime reduction/temporary work cessation • Regular or occasional consultations	2,6,7** – therapeutic coordination***	Advanced
		Ambulatory	Individual	Case management	• Workplace design and adaptation • Correspondence with health specialists and employer • Fill declaration documents (medical and insurance records)	3,9,12,13, – administrative coordination	Intermediate to advanced
2	Physician specialized in psychiatry (psychotherapy) (n = 5)	Ambulatory	Individual	Treatment	• Diagnosis of mental/psychological dysfunction • Treatment including psychotherapy, psycho-education and medication • Recommend group psychotherapies	1,6,7 – therapeutic coordination	Advanced to highly advanced
3	Occupational physician (n = 4)	Private practice; inner- or outer-company occupational health service/ consultation	Individual	Health assessment	• Diagnosis (medical history) • Individual coaching • Work stoppage prescription • Regular meetings with the patient • Referral to other health specialists	1,2,6,7 – therapeutic coordination	Advanced
		Private practice or salaried	Individual	Case management	• Workplace design and adaptation • Report patient status to employer • Coordinate with health specialists and employer	9,12,13 – case reintegration coordination	Advanced
		Inner- or outer-company occupational health service/ consultation	Collective	Workplace assessment	• On-site examinations • Compliance with health and safety standards checkups • Reports to the company • Implement preventive health measures	5,9 – contractual relations	All stages
4	Insurance physician (n = 2)	Insurance company	Individual	Individual mental and physical capacities evaluation	• Evaluation of the reports and medical records • Health and mental status assessment (without consultations) • Workplace assessment • Statement about the right time to return to work	12 – case reintegration coordination	Highly advanced
5	Nurse specialized in occupational health (n = 4)	Inner- company occupational health service/ nursery	Individual	Health assessment	• Individual coaching • Regular medical checkups (including mental health) • Referral to health specialists	1,2,6,7 – therapeutic coordination	Intermediate to advanced
		Inner- company occupational health service/ nursery	Individual	Case management	• Workplace investigations • Coordinate with health specialists, person and employer • Workplace design and adaptation	3,9 – case reintegration coordination	Advanced
		Inner- or outer-company occupational health service/ nursery	Collective	Prevention	• Vaccination to workers • Blood donation campaign • Health promotion • Raise awareness of the individual risks and resources	9 – contractual relations	No stage
		Inner- or outer-company occupational health service/ nursery	Collective	Exposure assessment	• Compliance with health and safety standards checkups & risks management guidelines • Regular health checkups • Collaboration with occupational physician on implementing preventing health measures	3,9 – contractual relations	All stages
6	Psychologist§ (n = 9)	Private practice Partnerships with companies	Individual, Collective	Therapy, Prevention	• Mental health tests • Patient empowerment • Energy boosting • Breathing tools • Individual coaching • Consultations with workers • Training sessions • Work-climate analysis	1,2,7 – therapeutic coordination 9 – contractual relations	Intermediate to advanced

Table 1: Professionals and their practices related to burnout (continued)

7	Personal coach (n = 3)	Private practice	Individual	Therapy	• Individual coaching (e.g., archery, mindfulness meditation, etc.) • Personal development • Motivate physical and mental activity	1, 2, 6 – therapeutic coordination	Intermediate to advanced
8	Medical manager in healthcare settings (n = 1)	Hospitals and clinics	Collective	Prevention	• Colloquia • Integration and training sessions • Team management & supervision • Individual risks and Resource-Awareness	9 – management coordination	All stages
Part B = Non-medical professionals and their practices related to burnout							
9	(Director) Human Resources (n = 5)	Private companies and/or public institutions	Individual	Case management	• Workplace design and adaptation • Correspondence with health specialists • Dashboard maintenance • Correspondence with insurance company • Correspondence with employees with OB	1, 3, 5, 8, 11, 12, 13 – reintegration coordination	Advanced
		Private companies and/or public institutions	Collective	Prevention	• Organization of preventive campaigns • Awareness raising on the risks and resources • Implementation of occupational health programs • Day-to-day workforce management	3, 5, 8, 15, 16, 17 – teamwork	Any
10	Information Technology (IT) tools developer (n = 2)	Private companies and/or R&D institutions	Individual	Information	• Health data collection (e.g., sport activity, heart variability, etc.) • Calculation of health scores and risk scores • Referral to health specialists • Support health specialists/companies with collected data	1, 2, 6 – support diagnosis	All stages
11	Trust person (n = 1)	Partnerships with companies	Individual	Case management	• Workplace assessment • Workplace adaptation • Correspondence with person with OB. Individual coaching • Correspondence with health specialists and employer	1,6,7,9 – reintegration coordination	Intermediate to advanced
		Partnerships with companies	Collective	Prevention	• Team meetings • Information about the employee's health risks and resources in the workplace • Training sessions	9 – contractual relations	Any
12	Reintegration counsellor (n = 1)	Insurance company	Individual	Individual mental and physical capacities evaluation	. Evaluation of the reports and medical records . Individual coaching . Workplace layout . Correspondence with employer . Individual preparation to return to work . Fill work ability/disability certificate	1, 2, 12, 6, 7 – reintegration coordination	Highly advanced
13	Private consultant (n = 4)	Partnerships with companies	Individual	Case management	• Individual coaching • Psychological and clinical care • Correspondence with employer and trade unions • Workplace layout • Mediation services • Referral to health specialists • Debriefing interviews	1, 3, 6, 9 – reintegration coordination (on contractual relations)	Intermediate to advanced
		Partnerships with companies	Collective	Information and prevention	• Training sessions • Prevention campaigns • Climate analysis • Conflict analysis and resolution	9 – contractual relations	Any
14	Union (n = 1)	Private practice	Collective	Legal assistance and political action	• Evaluation on work contracts • Individual and company guidance on legal rights and obligations • Surveys • Motions to Parliament • Lobbying	13, 18, 19 – lobbying and/or teamwork	Any
15	Work and organizational psychologist (n = 5)	Private practice	Collective	Work climate analysis	• Interviews with workers • Observations of the work environment • Questionnaires/audits • Workplace assessment • Training sessions	9 – contractual relations	Intermediate to advanced
16	Occupational health inspector (n = 2)	Public administrations (at federal, cantonal and city levels)	Collective	Inspection	• On-site inspection • Assessment compliance of health & safety work standards • Correspondence with federal institution and company	9 – contractual relations	Any

Table 1: Professionals and their practices related to burnout (continued)

17	Ergonomist (n = 2)	On mandates for private companies and/or public institutions	Collective	Work organization and ergonomics	• Workplace assessment • Training sessions • Field approach • Focus on revealing tensions and the company's resources	9 - contractual relations	Any
18	Specialist in labor law (n = 2)	Federal institutions	Contextual	Legal counselling	• Collaboration with jurists, etc. • Federal health & safety coordination committees • Financial assistance • Legal-political discourses statement	14,19 – teamwork	Any
19	Parliamentarian (n = 1)	Federal and cantonal institutions	Contextual	Political action	• Motions • Statement about the recognition of the disease within the Swiss system • Postulations • Measure the accuracy & compliance of the issue relating to the system	14,18 – teamwork	Any
20	Researcher (n = 2)	Universities	Contextual	Generate and disseminate knowledge	• Analysis of phenomena and big data • Observational, exploratory & interventional studies and systematic studies • Etiology and definition recognition • Consensus building • Result dissemination via publications and communication at congresses and through the media	All	Any

* when interviews were conducted with professionals who have more than one specialization, each one is reported individually. ** the numbers represent the professional related to it in the table. *** type of interaction the professional maintain. § Psychologists summed under code 6 are: psychologists and psychotherapist (n=2), developmental psychologists (n=1), work and organizational psychologists (n=4) and ergonomists (n=2).

burned-out workers can not recover. Additionally, few psychiatrists mentioned a return to work as an indicator of recovery from occupational burnout based on their clinical observations. However, the assessment of the indicator of a return to work is very individualistic. Even if the psychiatrist determines that the burned-out workers' state permits them to return to work, this still does not ensure that they can work and at which work percentage. It is noteworthy to mention that occupational burnout is not an official diagnosis in Switzerland, therefore another diagnosis is usually assigned (such as depression or adjustment disorder), with occupational burnout sometimes mentioned as a secondary diagnosis.

Primary care practitioners

We interviewed three primary care practitioners who highlighted the fact that they are medical professionals who interact directly with patients with occupational burnout in outpatient and inpatient settings and only at the individual level. The analyses of these three interviews showed that whenever a patient with occupational burnout consults the primary care practitioner, his/her intervention becomes a so-called case management intervention along with a therapeutic intervention (tab. 1). In this study, case management refers to the monitoring of the individual's health status (which does not necessarily include healthcare practices), along with the ability to manage and/or adjust the return to work. This intervention can be delivered through three main modalities: correspondence with other healthcare professionals and with the employer (fig. S1, in the file "supplementary material"), requesting a specific workplace adjustment, and filling out documents for various requirements (e.g., medical certificates). Other healthcare professionals contact the primary care practitioner with their patients/clients when a work cessation prescription or extension appears necessary. As primary care practitioners are positioned in the frontline of primary care and at the intersection of medical and administrative coordination of the treatment, they can easily interact with other professionals. However, they indicated in their interviews that, apart from working with a professional within the organization (e.g., human resources professionals, trusted persons or occupational psychologists) to detect occupational burnout at a relatively early stage, in their usual practice, primary care practitioners mainly detect intermediate to advanced cases of burnout. In this case, the primary care practitioner is the first professional consulted by a patient with burnout who attends medical appointments with a doctor. It was highlighted that the contact of the employer to adjust the workplace or working conditions depends on the patient's approval and decision.

Occupational physicians and nurses

Occupational physicians and nurses' interventions have a dual perspective: on the worker as a person (from an individual level), and the organization with its entire workforce (from a collective level), its managers and its directorate. However, their intervention on the collective level does not necessarily lead to individual care for health problems. It may be limited to the prevention of occupational burnout, or consist of a broader mental health protection campaign, or a onetime assessment of working conditions (tab. 1, S1, in the file "supplementary material"). When the interventions are combined at the collective and individual levels, they benefit from an overall view of the organizational context. The latter includes organizational or managerial dysfunctions, the available resources, and the employee's working conditions and health. In the case of employee illness or psychological distress, occupational physicians and/or nurses can intervene individually, sometimes in the frame of specific mandates from organizations. This also allows them to interact with a large number of other (para-)medical professionals as well as the employer, particularly to ensure good coordination between them (fig. S1, in the file "supplementary material"). Among the interviewed occupational physicians, we have noticed different points of view regarding the definition of occupational burnout. Some consider it a disease because people are sick although it is associated strongly with chronic stress and chronic stress makes people vulnerable to burnout. It was also mentioned that people who highly invest in their work and those who love their work are more susceptible to occupational burnout. Other psychiatrists mentioned that occupational burnout is a process not a state and that is how it can differ from depression, which is a diagnostic state. One point of view was that burnout happens after accu-

Table 2: Care models for occupational burnout in Switzerland

Care model	Model 1 "Support"	Model 2 "Extractor"	Model 3 "Systemic"
Conception of Occupational Burnout (OB)	• Phenomenon to be understood independently • Specialized treatment • Possible recovery	• Continuum with depression • Differential diagnosis • Generalized treatment	• Consequences of poor personnel management in companies • Disorder that can be minimized
Logic of action	*In situ* • Valuation of on-the-job treatment (short work cessation or no cessation) • Equipping the individual to deal with stress • Active empowerment	*Curative* • Work cessation (± long term) • Close and individualized therapeutic monitoring • Valued introspection	*Advice* • Acting early on in the company • Identifying areas of work-related issues • Focus on the community • Involving and raising awareness in the company • Internalizing the problems in the company
Criteria for effective care	• "Brake-accelerator" balance • Sustainability of accompaniment at the workplace (ideally at the same)	• Treatment of potentially traumatizing work experiences • Reconstruction of the self • Physical and mental abilities restored to normal	• Employer satisfaction • Minimization of Psychosocial risks (PSRs) • Implementation of the proposed courses of action
Stakeholder's needs	• To recognize OB as an illness	• More dialogue and collaboration with employers	• Raising awareness of PSRs for better company involvement

mulated physical stress: "the cortisol in the blood that rises, and the neurotoxins that invade our body when we are under stress", and depression can be an end stage of it.

Insurance physicians

Insurance physicians have a unique role in that they take a medical view of the occupational context (i.e., workplace). These professionals interact with the medical specialists (physicians assigned by the insurance to examine the patient's medical records) to determine the health status of a person with occupational burnout based on their records. Therefore, the insurance physician has almost no contact with other groups of professionals interviewed for this study, except for the vocational rehabilitation counsellor, when sharing relevant information or decisions about the individual's health status and ability to work.

Medical team managers

In some hospitals and private clinics, medical team managers have the possibility of "identifying and verbalizing the disorder" in an employee with occupational burnout within their teams. This intervention allows the employee's awareness to be raised, helps with burnout management (e.g., by suggesting a few days off to rest, reducing pressure to perform, and rearranging their work schedule) and observes "how they recover at their workplace". Like insurance physicians, medical team managers do not provide care per se. Notwithstanding, their role is central in that they assess, from a medical perspective, along with the administrative process, the conditions for the person's continuation and/or return to work with or after occupational burnout. Conversely, the medical team manager does not need to assign a formal diagnosis, but rather verbally refers directly to the presence of burnout when discussing it with employees working under his/her direct or indirect supervision.

Thanks to their training in psychosocial risks, prevention and experience in managing the medical workforce on the one hand, and hierarchical position on the other, medical team managers are an important resource for the detection and secondary prevention of burnout in medical units in hospitals and clinics. Furthermore, medical team managers have very few connections with (para-)medical professionals. Contacts are effective when the primary care practitioner takes the initiative to call the medical team manager to inform them of the patient's health status or adjust working conditions. If not, it remains mainly administrative cooperation with human resources professionals or the directorate.

Human resources professionals, private consultants and the trusted persons

Non-medical professionals were identified as intervening in occupational burnout outside the Swiss healthcare system, sometimes in close interaction with the latter, depending on whether they intervene at the individual or contextual level (table 1, part B). Three of the identified non-medical professionals appear to benefit from a dual perspective: HR professionals, private counsellors (coaches) and the trusted person in the organization. Like occupational physicians, nurses and psychologists, these professionals can intervene at both the collective and individual level. In the interviews, these professionals often mentioned their extensive knowledge of the work environment as an advantage. In addition, they are in close contact with the employer. When cases of occupational burnout occur within the organization, they indicated that this dual focus allows them to take care of the problem more globally and efficiently. Indeed, they have the ability to modulate the workplace based on the information from (para-)medical professionals. Unlike human resources professionals, the roles of private counsellors and trusted persons usually correspond to the need to embody a "neutral" party who represents both the employer and the employee: "Sometimes we just try to be the mediating link between what the employee expects and what they can give. We try to understand the perspective of both parties and be as neutral as possible."

It should be noted that private counsellors and trusted persons usually become mandated when the person has already been on sick leave for several months, corresponding to a highly advanced stage of burnout.

Work and organizational psychologists

A commonality in the practice of these professionals is that they do not aim to cure a person of occupational burnout but tend to analyze the context in which this problem originates. In principle, they have no contact with (para-)

medical professionals. A significant number of Swiss work and organizational psychologists work in the organization or on a mandate, and they have an individual follow-up role in the organization, meaning they have a dual perspective from both individual and collective levels. They are experts in assessing occupational risk factors, particularly psychosocial risks within an organization and report them to human resources professionals and/or directorate/employer, depending on who mandated them. It is difficult to specify the stage of burnout that they would most often encounter among employees, but since they are most often mandated to intervene when several persons with occupational burnout or other mental/ somatic health problems have already been reported in the organization, it is reasonable to assume that the burnout is at an advanced stage among these persons. However, psychologists permanently working in the organization may be involved since an early stage of burnout development and interact with employees on the individual level as well (table 1, fig. S1, in the file "supplementary material"). Psychologists defined burnout as exhaustion, fatigue, or a depressive state. Some identified symptoms that are linked to depression such as a negative mood, sleep problems, or suicidal thoughts. Other psychologists diagnose burnout based on the state of sleep; if sleep disturbances are important, it is burnout. Among the psychologists, several think that there is an overlap between burnout and depression, either burnout is a depression in the work context or sometimes it can be an "early depression" or they think that the symptoms can not be differentiated easily. However, few psychologists think that burned-out people suffer from anxiety, not depression; "When they think about going to work, they have a panic attack, for example, but they are not depressed. They get up in the morning, and at home, they are perfectly fine."

Information technology tool developers

The IT tool developers interviewed in this study are developing screening instruments that measure or predict the individual risk of occupational burnout, based on either a self-reported questionnaire or the person's overall health status. Some IT tools may be useful in assessing the severity of occupational burnout as defined by Swiss (para-)medical professionals who distinguish three burnout stages. Some of the IT tools are sold to organizations that want to get information about the health and productivity of their employees or want to strengthen prevention and use these tools as a support for risk monitoring by the human resources department. In this situation, IT developers work directly with the employer or human resources. By collecting individual health and stress data, IT developers gather extensive information across many organizations. In terms of IT tools advancement, IT tool developers and users have a common need to objectively estimate the incidence and/or prevalence of occupational burnout among an organization's workforce, despite the lack of standardized diagnostic criteria.

Professionals from the legal, political and academic fields

Experts in labor law explore the relevance of social issues related to occupational burnout within the Swiss context (e.g., "In terms of legal policy, it means taking a position on the discourses, improving the situation more concretely, and framing burnout"). Thus, they are in a position to determine whether (and how) the law should be changed, and who will be affected by these changes. Other professionals, such as parliamentarians, have a duty to comment on whether or not occupational burnout should be recognized as a disease at the federal level, taking into account the actual economic and societal consequences. Political and legal professionals that intervene in relation to burnout are therefore central to this study, in the sense that the regulation and development of the global situation depend significantly on their decisions. They are able to examine the viewpoints of the various professional groups, assess the consequences and design future investigative approaches that will provide them with an overview of the problems associated with occupational burnout in the Swiss context. In essence, they bring federal concerns to the debate on the recognition of occupational burnout as a disease, and as an occupational disease in particular. Professional networks and triggers of inter-professional interactions.

Some professionals conceptualized occupational burnout as a continuum between the state of wellbeing and the state of complete exhaustion and inability to work. However, the suggested categorization of burnout severity according to the stage of its natural progression may help to emphasize the specificity of professionals' interventions and inter-professional interactions. One example from the interviews is the so-called "early intervention" of a vocational rehabilitation counsellor who intervenes when the person has been out of work for at least 30 days and aims to arrange a return to work. Another example is primary care practitioners who would intervene at the intermediate stage, considering that a person may consult a doctor once he/she feels sufficiently affected by burnout symptoms. In addition, some professionals noted that practices can be combined according to the stage at which they intervene. This means that existing practices may address the entire spectrum of occupational burnout problems from early to (highly) advanced stages. These professionals clearly expressed the existence of collaborations among themselves (table 1). Although collaborations rarely follow a uniform pattern, particularly the collaboration between the (para) medical and the medical professionals for workplace layout purposes, we identified some common features (supplementary fig. S1, A, and B, in the file «supplementary material»). For instance, once the person is on a long-term work cessation, coordination occurs between the non-medical professionals and the (para-) medical ones. Human resources and health insurance professionals, along with hierarchical managers contact the person's therapist (e.g., primary care practitioners, psychiatrists and/ or psychologists). Therapists also mentioned this cooperation as essential. This collaboration, when it takes the form of a meeting, was mentioned in some interviews as the most successful and efficient method to help the person to recover and return to work. It is noteworthy that some groups of professionals have collaborative activities in their portfolio and therefore tend to create and promote inter-professional interactions (tab. 1, fig. S1). In other words, occupational physicians and nurses, trusted persons, and some private counsellors and work and organizational psychologists, all have the distinction of encouraging connections between the employer and the employee with burnout. The aforementioned professionals have a good knowledge of the internal work climate, conditions, and potential concerns. They could also intervene directly with persons with OB to refer them to other professionals. These professionals have the ability to "bring the different professionals to the same table" and guide dialogues. During the interviews, several professionals recognized that this strategy increases the chances of recovery and/or of return to work: "The effectiveness of care can also be judged by the quality of the network in place, whether it is medical or professional. It is the willingness and readiness of each person in the support network that counts a lot". Hence, the collaboration between both spheres (medical and non-medical) of professionals is essential. Key professionals as occupational nurses can activate this network. Yet, there are very few companies implementing health services that hire this type of professional. In general, our results indicate that collaboration may be motivated more by employer distress than by therapeutic or preventive purposes.

Care models

We found that most participants distinguished several stages of burnout severity according to its development, we thus added this categorization to the analysis of practices. Three main stages of occupational burnout were retained from our interviews with (para-) medical professionals: the early stage, the intermediate stage, and the advanced stage. Additionally, three conceptual care models emerged from our analysis (tab. 2), each corresponding to a singular interventional scheme. All three models are conceptualized by four dimensions (i.e., s conception of occupational burnout, a logic of action, criteria for effective care, and stakeholder's needs) that cannot be removed or interchanged unless their relevance is compromised.

Support model

The first model is named the "Support model" because it provides treatment while the patient is still engaged in occupational activities to support him/her. Within this model, occupational burnout is perceived as an independent condition that can be treated, provided that healthcare professionals' intervention can immediately take place. Professionals (e.g., counsellors and psychologists) who refer to this model have developed burnout-oriented care practices. The specificity of this model is based on the analysis of the working conditions and the position that the person occupies in the organization to find and maintain the balance between the person's well-being and work capacity /productivity. Extractor model The "Extractor model" is committed to the idea that the person must be removed from his/her work environment. To recover, a distance from the workplace and occupational activity must be ensured. This allows for in-depth individual introspection, addressing one by one the problems that have made the individual ill. The main goal of this model is to understand how the work environment and a person's behavior affect his/ her health. Hence, the person will return to work once he/she is physically and mentally healthy. Psychiatrists and primary care practitioners are typical professionals assigned to the Extractor model. Thus, in this model, occupational burnout is defined as a pathological health condition reinforced by individual risk factors.

Systemic model

Several professionals identified occupational burnout as a problem resulting from poor human resources and work management and conditions, as well as one of the psychosocial risks at work. Notably, this is also how the Swiss Office of Statistics classifies occupational exhaustion [18]. From this perspective, we propose a third model called the "Systemic model", which emphasizes that burnout can be addressed through improvements implanted in the work environment. By providing advice on how to create a healthy work environment, professionals in this model (e.g., ergonomists, occupational nurses and occupational psychologists) help organizations to prevent occupational burnout in their employees.

Discussion

Main findings

The present study provided insights into the diversity of practices related to occupational burnout among Swiss (para-)medical and non-medical professionals. We found that professionals within and beyond the healthcare system have managed to develop interventions to take care of persons with occupational burnout, even though it is not recognized as a disease. Throughout the interviews, the need for collaboration between medical and non-medical professionals appeared to be the most important requirement to ensure treatment and recovery. While (para-)medical professionals take care of a person's health condition, non-medical professionals are able to manage social issues such as workplace and insurance demands. Thus, the collaboration between (para-)medical and nonmedical professionals locates occupational burnout at the intersection between social and health fields and facilitates the return to work (which is commonly identified as the first – but not only – criterion of recovery).

The particularity of the Swiss context

Inter-professional relationships

The study showed that occupational physicians, nurses, psychologists and some non-medical professionals are particularly inclined to collaborate. However, it is worth noting that these are relatively new specialties in Switzerland, which are still insufficiently known/ contacted by the other professional groups. Swiss occupational physicians are insufficiently supported by the healthcare system (e.g., no specific pricing exists for their interventions) and their number is very limited [19, 20]. Many occupational physicians work for health insurance companies, most notably the Swiss National Accident Insurance Fund (SUVA) and cease to perform their valuable dual role described above. In this context, the role of primary care practitioners in occupational burnout care is crucial for patients, as they act as frontline therapists. However, Swiss primary care practitioners are considered insufficiently trained in occupational health [19,21], as well as not always able to detect or effectively treat suffering at work and burnout promptly. In addition, the lack of interaction with occupational physicians (often not available near the practice/occupational network or overwhelmed with work) may attenuate the primary care practitioner's attention to the occupational origin of a patient's health condition and delay patient referral to a mental health specialist [22]. Given that the collaboration between primary care practitioners and psychiatrists has been shown to be effective and necessary [23], its absence or delay would worsen the stage of occupational burnout and hinder therapeutic success. Moreover, in the absence of interdisciplinary collaboration, prescribing work cessation by primary care practitioners would remain the most accessible intervention for occupational burnout, although not always effective.

Current status of occupational burnout

Occupational burnout forms a complex problem, with overlapping medical, social, political, and legal dimensions, which we attempt to simplify in the following. Currently, diagnosis of occupational burnout is not officially possible as its status (as a disease) remains unclear. Consequently, estimation of its prevalence, incidence, and burden at the national level is challenging. The ignorance of these public health indicators delays public decisions and preventive interventions to reduce the burden of occupational burnout. The same holds for all mental disorders that are not part of the Swiss list of occupational diseases [19] and thus are outside the prevention and surveillance scope of SUVA. Occupational burnout rather falls within the remit of the Swiss State Secretariat for Economic Affairs (SECO), which intervenes via legislation on aspects of work organization (e.g., working hours, breaks) and labor inspections to monitor compliance with regulations. The fact that so many non-medical professionals established their economic and professional interests in the occupational burnout "market" that have emerged (sustained by the increasing demand from persons with burnout), confirms that the social recognition of occupational burnout precedes the medical and legal ones and that its medicalization is essentially consumer-driven [1]. The hesitation of the healthcare system concerning the recognition of occupational burnout is obvious even at the WHO level [24]. This is likely due to the work-related (social) origin of burnout and the need for a long and interdisciplinary treatment, involving psychotherapy and workplace adaptation. Instead, maintaining the status quo, and diagnosing occupational burnout as a work-related depression, anxiety

or undetermined somatic symptom disorder, justifies the prescription of antidepressant and anxiolytic medication, which can be easier to manage than psychotherapy and beneficial for the pharmaceutical industry.

Finding consistency

In analyzing the complexity of the inter-professional network and interactions, we sought to understand how these interactions evolve according to the three stages of occupational burnout development and severity. Study participants almost unanimously considered these stages as consistent with the natural course of burnout. The recent literature confirms their relevance, particularly in identifying the advanced stage as "clinical burnout" [25–27]. Thus, as these studies indicate, viewing occupational burnout in light of multiple- stage development could help us to understand how individuals move from a healthy state to a clinically severe burned-out state. Moreover, our findings support this perspective by showing how professionals are organized into a logical system of preventive and therapeutic practices according to these stages. This dynamic of professional collaboration according to the occupational burnout stage was also observed by Kanayama et al. [28].

The care models that we conceptualized to understand how professionals care for their patients/clients with occupational burnout are original and should be tested and validated. They represent in a simplified way the three main patterns of burnout treatment in Switzerland, based on the coherence between stage, origin and intervention modalities. Nonetheless, these models could contribute to a better understanding of patterns of care for mental health issues in primary care, urged by several authors [29, 30].

Finally, regarding the heterogeneity and the lack of consensus in practices of dealing with occupational burnout in Switzerland, the Swiss Network of Burnout Experts published practical recommendations to treat burnout in 2016 [31,32]. However, none of the interviewed professionals especially the (para-)medical ones mentioned these recommendations. It was not clear whether these professionals are not aware of these recommendations, or they simply do not follow them.

Study limitations

The results of our study cannot be generalized to other countries or types of intervention. For the purpose of the study, we focused on existing networks of professionals in Switzerland to map their position in the system and their relationships. The representativeness of our study might be limited to the profiles of participants whom we interviewed and/or some representatives may not reflect the general trend in the discipline, although our sample size was pretty large (42 participants) and balanced with respect to professionals' specialties. Due to snowball sampling, it is possible that we missed some groups of professionals. We followed the Consolidated Criteria for Reporting Qualitative research (COREQ) [33], but we did not fulfill two items out of the 32 mentioned in the checklist. First, we did not report a coding tree, because it is not required within the grounded theory approach. Secondly, we could not send the transcripts of the interviews back to the participants because the participants were professionals with busy schedules and could not have validated the results, especially the translated English version. Therefore, the results presented in this study are preliminary and should be interpreted with caution.

Conclusions

The main contribution of this study is the discovery of a wide variety of professionals involved in occupational burnout in Switzerland. This study suggests that recovery from occupational burnout is faster and more efficient when specific professionals (e.g., work and organizational psychologists, private consultants, and occupational physicians and nurses) mediate the interactions between the non-medical and the (para-)medical professionals who intervene in burnout treatment and administrative management. Finally, three models of occupational burnout care were proposed based on the categorization of the most frequently cited intervention modalities. However, evidence of successful interventions and care models is clearly needed, meriting further research to improve prevention, detection, treatment, and administrative management.

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Availability of data and material

All data generated or analyzed during this study are included in this published article and its appendix, available online at http://doi.org/10.4414/sanp.2023.03277.

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Potential competing interests

No potential conflict of interest relevant to this article was reported.

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