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Ayurvedic versus conventional dietary and lifestyle counseling for mothers with burnout-syndrome: A randomized controlled pilot study including a qualitative evaluation

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ABSTRACT

Objectives: Ayurveda claims to be effective in the treatment of psychosomatic disorders by means of lifestyle and nutritional counseling.
Design: In a randomized controlled study mothers with burnout were randomized into two groups: Ayurvedic nutritional counseling (according to tradition), and conventional nutritional counseling (following the recommendations of a family doctor). Patients received five counseling sessions over twelve weeks.
Main outcome measures: Outcomes included levels of burnout, quality of life, sleep, stress, depression/anxiety, and spirituality at three and six months. It also included a qualitative evaluation of the communication processes.
Results: We randomized thirty four patients; twenty three participants were included in the per protocol analysis. No significant differences were observed between the groups. However, significant and clinically relevant intra-group mean changes for the primary outcome burnout, and secondary outcomes sleep, stress, depression and mental health were only found in the Ayurveda group. The qualitative part of the study identified different conversational styles and counseling techniques between the two study groups. In conventional consultations questions tended to be category bound, while counseling-advice was predominantly admonitory. The Ayurvedic practitioner used open-ended interrogative forms, devices for displaying understanding, and positive re-evaluation more frequently, leading to an overall less asymmetrical interaction.
Conclusions: We found positive effects for both groups, which however were more pronounced in the Ayurvedic group. The conversational and counseling techniques in the Ayurvedic group offered more opportunities for problem description by patients as well as patient-centered practice and resource-oriented recommendations by the physician.
Trial Registration: NCT01797887.

1. Introduction

Burnout seems to have become a relevant societal and health-economic factor in Western countries during the last decades; the European Agency for Safety and Health at Work estimates the economic costs of burnout in the European Union at around twenty billion Euros per year.[1] In contrast, health insurance companies, e.g. in Germany, recently reported a drop in the numbers of sickleave due to burnout and suggested that its significance is being overestimated.[2] Issues related to medical relevance, social impact and in particular to clear definitions of burnout remain controversial and are being debated globally.[3]

Burnout is most commonly defined as a state of work-related exhaustion, cynicism, and inefficacy with reduced work performance and/or reduced interest in work.[4] It can be described as a result of a dynamic process, which may start as enthusiasm and, via frustration, disillusionment and apathy, may eventually lead to psychosomatic disorders, depression, fatigue, anxiety, aggressive tendencies and an increased risk of addiction.[5] As it bears similarities to depressive

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disorders, and several studies have noted that it may in fact be a form of depression,[6–8] burnout has not been classified as a distinct diagnosis by the 5th edition of the Diagnostic and Statistical manual of Mental Disorders (DSM-5).[9] However, it is included in the ICD-10 and is defined as a state of exhaustion (Z73). According to this classification burnout is an additional Z-diagnosis and not a treatment diagnosis that allows health-insurance reimbursable hospitalization in Germany.[10]

Available treatment options for burnout include treatment of somatic disorders (if existent), basic physical activities, relaxation exercises, psychotherapy and pharmacotherapy.[11] The evaluation of burnout prevention and multimodal treatment programs are still in the beginning, for example one review evaluated the effectiveness of intervention programs aimed at preventing burnout,[12] by including therapies like cognitive behavioral training, psychotherapy, social support and relaxation exercises. 80 percent of all programs led to a reduction in burnout, however, these interventions are cost-intensive due to their multimodal approaches and comparatively high personnel demand.

The traditional Indian medicinal practice known as Ayurveda is widely used in Asia and recognized by the WHO as a medical science.[13] In Europe, Ayurvedic medicine has become increasingly popular and recognized over the last years, particularly in the treatment of chronic[14,15] and psychosomatic[14,16] diseases. Multi-component and individualized Ayurvedic treatment strategies for burnout-syndrome include various non-pharmacological measures and are based on the assumption that combinations of various treatment elements may exert synergistic therapeutic effects.[17–19] As a whole medical system Ayurveda offers complex diagnostic procedures and complex treatment approaches. Ayurvedic treatment is based on Ayurvedic diagnosis and traditionally has a focus on tailored lifestyle- and nutritional counseling, based on the individual constitution of the patient. Ayurvedic counseling can easily be followed by the patients in their day-to-day life and thus is a comparatively inexpensive method of self-care. In Ayurveda lifestyle- and nutritional counseling is often used for the treatment of burnout-syndrome. However, no systematic data is available on its effectiveness in comparison to conventional diet and lifestyle counseling for burnout patients, particularly not for mothers, where burnout symptoms are frequently being reported.[20–24]

The aim of this study was to evaluate the effectiveness of Ayurvedic nutritional and lifestyle counseling compared to conventional nutritional and lifestyle counseling in outpatient mothers with burnout-syndrome due to career and family responsibilities. This trial examined, whether elements of Ayurvedic burnout therapy, which patients are able to perform independently by themselves in their domestic environment, can exert sustainable therapeutic effects.

The qualitative part of this study, using the methods of Conversation Analysis[25] and participant observation,[26] examines the meaning of communication processes in both treatment groups. Empirical research in linguistics and sociology has demonstrated “how insufficient attention to patient-relevant issues results in a lower quality of doctor-patient-communication, and lower satisfaction of patients and doctors”.[27] Gülich noted the significance of the conversational process, precise wording and phrasing, when taking into account the subjective experience in doctor-patient-interaction.[28] Peräkylä, a conversation analytical and psychoanalytical researcher, demonstrated how medically relevant biographies of patients are negotiated and produced in doctor-patient interactions.[29] Ruusuvuori[30] compared homeopathic and general practice consultations and examined the phase of problem presentation, “discovering the reason for the patient‘s attendance”.[31] She demonstrated the consequences of this crucial phase in terms of the outcome of the consultations and showed how “in homeopathy, professionals worked to realize the patient-centered ideal to let patients speak in their own words, to elicit their own formulation of the problem”.[30] Considering these empirical studies and based on the conversation analysis approach, the aim of this study was to focus on differences in conversational styles and counseling techniques between Ayurveda and conventional nutritional counseling and their specific relevance in the treatment process.

2. Methods

2.1. Study design

In a two-armed randomized controlled trial mothers suffering from burnout syndrome were allocated to two treatment groups: (1) Ayurvedic lifestyle- and nutritional counseling and (2) conventional lifestyle- and nutritional counseling.

The study protocol was reviewed and approved by the ethics committee of the Charité-University Medical Center, Berlin, Germany. The trial was registered at Clinical Trials (registration number: NCT01797887, acronym: VEDA-trial). Trained study personnel performed collection of data at Immanuel Hospital Berlin, Department of Internal and Complementary Medicine, Berlin, Germany.

2.2. Participants

Female volunteers, who lived in the community, were recruited from local newspaper advertisements and flyers that offered mothers with burnout-syndrome cost-free Ayurvedic or conventional lifestyle- and nutritional counseling. Subjects were included if they (1) were female and aged 18–50 years, (2) were mothers of at least one biological child (twelve years of age or less), (3) had an employment with at least 20 h workload per week or the equivalent time spent on education, training, studies, etc., (4) had a subjective feeling of physical and mental exhaustion of at least 3 months prior to entry into the study, and (5) scored two or more on the MBI subscale “emotional exhaustion” at screening visit. Subjects were excluded if they (1) had started or modified a psychotropic drug medication therapy during six weeks preceding the study entry, (2) were pregnant or breastfeeding at the time of their screening visit, (3) had a previously diagnosed depression episode, (4) had an acute psychotic illness, (5) had an ongoing treatment with psychotropic drugs, opioids and/or sleeping medication, (6) had severe acute somatic diseases, (7) had severe chronic co-morbidities, (8) were undergoing application processes for pension or retirement or disability and (9) participated in another clinical trial or had participated in another clinical trial within the last six months prior to study entry.

After signing informed consent and collection of baseline data, subjects were randomized to either (1) Ayurvedic lifestyle- and nutritional counseling (n = 16) or (2) conventional lifestyle- and nutritional counseling (n = 18).

2.3. Outcomes and measurements

All subjects were asked to complete standardized validated questionnaires at the onset of the study (baseline), at three months (visit 2) and at a six months follow-up (visit 3). The primary outcome was the change of the mean score of the validated German version of the Maslach Burnout Inventory (MBI-D) at three months.[32] The MBI-D includes four subscales with twenty five items, three of them were adopted from the US version: (1) emotional exhaustion, (2) depersonalization, and (3) personal accomplishment. The MBI-D includes an additional scale “involvement” (e.g. empathy and dedication). Higher scores for emotional exhaustion, depersonalization and involvement indicate more intense burnout symptoms; lower scores for personal accomplishment indicate a higher degree of burnout. The items can be rated from zero (never) to six (very often).

Pre-specified secondary outcomes included the following validated questionnaires in German:

1. Maslach Burnout Inventory (MBI-D) at six months.
2. Cohen Perceived Stress Scale (CPSS) at three and six months. The