Burnout

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Contributor: Lindsey Nadon, Leon De Beer, Alexandre Morin

Maslach et al. initially conceptualized burnout as a psychological state encompassing exhaustion, depersonalization (or cynicism), and a reduced sense of professional efficacy. However, Schaufeli et al. recently proposed an improved definition of burnout, as a syndrome reflecting: “a work-related state of exhaustion that occurs among employees, which is characterized by extreme tiredness, reduced ability to regulate cognitive and emotional processes, and mental distancing” (p. 4). This new definition excludes the professional efficacy component, which has been empirically found to be distinct from burnout. More generally, burnout seems to be primarily characterized by a state of work-related exhaustion and is generally acknowledged by researchers, clinicians, and the public as a pervasive occupational difficulty. However, and despite this widespread recognition, longstanding debates remain within the scientific community regarding the appropriateness of classifying burnout as its own pathological entity.

Keywords: burnout ; mental disorder ; syndrome ; diagnostic

1. Introduction

Described as a modern affliction [1] of epidemic proportions [2], burnout has evolved from being uniquely associated with human services employees to being considered as a relevant phenomenon across all occupational groups [3]. First defined in the 1970s as a state of exhaustion resulting from excessive job demands [4][5], burnout has since gained global traction as a psychosocial adaptation problem recognized by researchers, professionals, and the public at large [6]. Along with this joint recognition, widespread public discourse, and extensive publications, a debate remains regarding what burnout really is and whether it should be considered a distinct psychopathological entity [7][8][9]. For instance, some position burnout as a clearly defined mental disorder and report prevalence estimates reaching as high as 67% among medical populations [10]. Others, however, actively dispute the notion that burnout forms a distinctive mental disorder, insisting that burnout is not a diagnosable condition and, therefore, that any prevalence estimates are nonsensical [11][12]. Indeed, without clear diagnostic criteria, prevalence estimates remain doubtful. In line with this second perspective, psychology researchers have criticized burnout for its shaky theoretical roots, measurement problems, and lack of clinical utility [13]. Despite these criticisms, burnout research has remained widespread, and burnout itself is now, in some countries, close to becoming a legitimate medical diagnosis [14].

2. Evidence Supporting the Distinctive Nature of Burnout

Despite the aforementioned criticisms, many still consider burnout to be meaningfully distinct from depression. For instance, Epstein and Privitera [15] argued that, although evidence supports the presence of substantial overlap between both constructs, workers do not always simultaneously experience burnout and depression. They further highlight that, relative to depression, burnout cannot be considered a purely individual syndrome because it is intimately related to a “breakdown in the relationship between people and their work” [15] (p. 1). From a practical perspective, they note that conceptualizing burnout as depression would stigmatize the struggles of many employees from occupational groups particularly affected by burnout (e.g., physicians) as an individual issue, rather than properly contextualizing their distress within a problematic systemic or institutional setting [15]. To address these concerns, Bianchi et al. [16] noted that the reliance on a measure of depression specific to work would make it possible to retain these contextual considerations. However, this recommendation relies on the assumption that burnout and depression are empirically indistinguishable phenomena.

In a meta-analysis of research published between 2007 and 2018 to examine the overlap between burnout, depression, and anxiety, Koutsimani et al. [17] noted that, although there was indeed evidence of overlap between burnout, depression, and anxiety, the bulk of the results still supported the distinctive nature of these three psychological states. Interestingly, they also found that studies using the Maslach Burnout Inventory (MBI) tended to demonstrate cleaner distinctions between the constructs relative to those relying on other measures of burnout. The distinction between burnout and

depression has also been supported by various factor analytic studies supporting the idea that both constructs retain a meaningful amount of specificity once their common core is considered [18][19][20]. There is also qualitative evidence for the distinctive nature of burnout and depression. For instance, Tavella and Parker [21] recruited 1019 workers who self-reported having experienced both depression and burnout. These workers completed an open-ended questionnaire recording the symptoms they attributed to burnout, the main cause of their symptoms, and how they differentiated between burnout and depression symptoms. Their qualitative analyses revealed that several themes contributed to differentiate burnout from depression. Thus, whereas participants were able to ascribe a clear external cause to their symptoms of burnout, they had a more challenging time identifying the causes of their depression, which seemed to be more intrinsically rooted. Participants also reported that burnout was associated with higher functioning, greater self-esteem, less suicidal ideation, and more hope than depression. Additionally, participants reported that burnout felt more like an anxious and activated state than depression, which was characterized by feelings of heaviness and slowness. The presence of anhedonia in depression, but not in burnout, was another major distinction. Finally, approximately one-fifth of the participants could not distinguish depression from burnout, with some noting that their experience of burnout led to depression.

Lastly, in a recent longitudinal investigation of the reciprocal associations between burnout and depression, Tóth-Király et al. [22] found evidence supporting the discriminant validity of both constructs. First, they demonstrated that while burnout was an inherently multidimensional construct, depression was better conceptualized as a unidimensional phenomenon. Second, although both constructs were found to be reciprocally related both within and over time, their associations remained moderate in magnitude, consistent with the presence of variability uniquely associated with both constructs. Lastly, they found evidence that both constructs shared a well-differentiated pattern of association with a series of theoretically relevant covariates.

3. Burnout as a Diagnostic Category

To summarize the previous discussion, current theoretical considerations and empirical results can be leveraged to support both the notion that burnout is distinct from depression and that these two psychological phenomena share substantial conceptual overlap. Based on this conflicting evidence, some researchers argue that burnout is simply work-specific depression and should be studied as such [13][23][24][25], whereas other argue that both represent theoretically and empirically distinct psychological constructs [17][22][26][27]. Nonetheless, while the burnout–depression debate is an important and pervasive one, it is not the only consideration from a diagnostic perspective. To determine whether burnout should or could conceivably be characterized as a mental disorder, burnout must also be evaluated within the context of current diagnostic classification models. This examination might help to devise the next steps in a research program that could also prove helpful in clarifying the burnout–depression debate.

In and of itself, the debate surrounding the classification of burnout as a diagnosable condition is not new. Though no universally agreed-upon definition of burnout exists and though burnout has not yet been formally incorporated in any existing diagnostic classification systems, researchers and clinicians have been classifying and “diagnosing” burnout as a syndrome for years [28]. This may be related, at least in part, to the fact that in the early days of burnout research, Maslach et al. [29] included cut-off scores in the MBI test manual to help identify clinically significant levels of burnout. Thus, although the MBI was explicitly designed as a continuous measure of burnout severity, these cut-off scores sparked a surge of studies in which employees were classified based on the severity of their symptoms. Additionally, because accumulated research evidence supports the clinical validity and utility of the MBI, some researchers have concluded that it was therefore suitable as a diagnostic tool [30][31]. However, measures of burnout rely predominantly, if not exclusively, on self-report. This is, and has always been, a considerable limitation of psychological or psychiatric diagnoses, which cannot be established in the absence of additional signs of health and behavior typically collected via clinical interviews [32]. One last consideration comes from the more practical considerations of health professionals, whose clinical services are typically more easily reimbursed by governmental agencies or insurance companies when there are linked to diagnosable medical conditions [3].

Nowadays, several European countries acknowledge burnout as a legitimate mental disorder. Lastovkova et al. [14] and Guseva Canu et al. [33] contrasted burnout classifications and found that it is acknowledged as an occupational disease in 14 European countries but is only officially listed as an occupational disease in Latvia. In five European countries, it is common practice to grant workers suffering from burnout with financial compensation. In Iceland, the Netherlands, and Sweden, if one can prove causality related to work conditions, any illness or injury can be classified as an occupational disease, including burnout [14][33]. The Netherlands is currently the only country using the MBI as a clinically validated diagnostic tool, issued by the Royal Dutch Medical Association as a strategy to manage stress-related disorders [34]. Diagnostic criteria vary widely by country, with most criteria derived from regional or national committees [14][33]. Thus,

although burnout is a common diagnosis in Europe, there is currently no consensus surrounding financial compensation, diagnostic criteria or protocols, and the role of work-related and individual determinants in the etiology of burnout [33].

3.1. Primary Classification Systems

Turning the attention to primary diagnostic systems, the Diagnostic and Statistical Manual for Mental Disorders (DSM-5; APA, 2013) and the International Classification of Diseases [35] are currently the most frequently used diagnostic classification systems internationally. They define mental disorders as the presence of significant impairments in functioning across contexts in the areas of cognition, emotion regulation, and/or behavior [36][35]. Both systems seek to provide a common vocabulary to improve diagnostic accuracy, public understanding, and treatment accessibility [36][35][37]. To be diagnosed with any mental disorder, one must exhibit a particular set of symptoms. Such criteria are determined by committees comprised of researchers and mental health professionals, who iteratively make decisions based on evidence derived from empirical studies and clinical trials [36][34][35].

Burnout is not currently characterized as a mental disorder or medical condition in the DSM-5 [36]. However, the World Health Organization recognizes burnout as an important occupational phenomenon under the category of “factors influencing health status or contact with health services” in the ICD-11 [35]. The ICD-11 defines burnout as a syndrome resulting from chronic work stress, in a way that matches Maslach’s original conceptualization [38]. The ICD-11 also states that burnout should not be identified in the presence of adjustment, stress-related, anxiety, or mood disorders.

To be included in these primary diagnostic systems, in alignment with the medical model which underpins them, one must be able to demonstrate that new disorders can be linked to consistent etiological risk factors, pathological processes, symptom patterns, concurrent validators, and comorbidities, while accounting for a variety of cultural, social, psychological, and developmental considerations [36][37][39]. Clark et al. [37] identified four key issues related to the classification of mental disorders. First, the drive to find clear causes for mental disorders, in the same manner as physical health conditions, is complicated by the fact that psychopathologies are typically influenced by a complex pattern of interaction among a variety of biological, behavioral, psychosocial, and cultural factors, making their etiology more complex to uncover than that of purely physiological medial conditions. Second, the categorical nature of these systems oversimplifies the fact that mental disorders involve complex combinations of dimensional problems (i.e., varying in terms of severity rather than in terms of presence or absence) that are often transdiagnostic (i.e., play a role in many mental disorders). Third, because mental disorders are typically multidimensional (i.e., entailing a combination of behavioral, cognitive, emotional, and physical manifestations), setting diagnostic thresholds, and making decisions regarding the clinical significance of symptoms tends to be very difficult in practice. Finally, categorical classification systems face the problem of artifactual versus actual comorbidity. In other words, patients often display symptoms associated with various disorders, thus decreasing diagnostic accuracy and clinical utility [37]. Incorporating new disorders into these primary diagnostic systems thus entails years of research focusing on these complex considerations [39].

3.2. Evaluation and Future Directions

Based on the aforementioned considerations, characterizing burnout as a mental disorder within these existing classification systems does not currently seem appropriate. First, the rigorous empirical evaluation of burnout required for diagnostic classification is muddied by various longstanding conceptual and measurement issues/inconsistencies [13]. Without a clear definition anchored in a consensual set of symptoms, it remains impossible to establish reliable prevalence rates or properly compare etiological and outcome-related findings across studies [6][12]. Determining clear etiology for mental disorders is complicated in general [37][39] and even more so when phenomena lack a clear definition to begin with [12]. Thus, before considering burnout for inclusion in any existing diagnostic classification systems, conceptual inconsistencies must be clarified, and consensus must be reached regarding how to define and measure burnout. While efforts to arrive at a consensus have historically triggered more research using the MBI [13], thus reifying the same conceptual definition in a way that some have described as circular, the development and emerging evidence of validity associated with the BAT offers some promise in this area.

Second, the medicalization of burnout would entail a shift away from a continuous (i.e., varying in terms of severity) toward a dichotomous (i.e., burned out or not burned out) or categorical (i.e., cut-off scores for low, medium, and high levels of burnout) conceptualization of burnout [6]. On the one hand, insisting that burnout is best defined as a multidimensional continuous phenomenon is inherently incompatible with the current categorical diagnostic systems. On the other hand, there is currently no standard definition of what being “burned out” truly means from a dichotomous or categorical perspective. Though it is often reduced to exhaustion alone [40][41][42][43], Schaufeli [9] contends that the core of burnout entails both the inability (exhaustion) and unwillingness (mental distance) to work. Thus, for burnout to be

integrated into an existing diagnostic system as a separate diagnosis, researchers first need to reach a consensus on this matter.

Third, researchers also currently lack consensus regarding which specific symptoms should be used to define burnout and on how these symptoms differ from those of other well-understood mental disorders. As noted previously, there is a great degree of heterogeneity in the burnout symptoms identified in the current research literature [28], and many of these symptoms share a substantial degree of overlap with those of depression [3][38][44][45][36][46]. As such, an important step would be to develop clear and widely agreed-upon set of diagnostic criteria (i.e., symptoms), diagnostic thresholds, and differential diagnostic criteria. Additionally, researchers will need to determine whether the high comorbidity typically reported between depression and burnout is artifactual (i.e., burnout is simply work-related depression) or whether they represent meaningfully distinct constructs that constitute different diagnostic categories. Longitudinal investigations, such as that conducted by Tóth-Király et al. [22], would be helpful in this regard, making it possible to systematically assess the nature of the overlap between both phenomena, as well as the similarities and differences in their etiology and implications. Likewise, person-centered analyses [47] would also help to systematically capture subpopulations of individuals presenting overlapping and non-overlapping conditions.

Fourth, research evaluating burnout's neural, biological, genetic, and cognitive correlates remains underdeveloped [8], which represents an important obstacle to positioning burnout as a distinct diagnostic category within a medically inspired classification system. In this regard, Bayes et al.'s [48] systematic literature review revealed that burnout was potentially associated with autonomic nervous system activation, changes in cortisol levels, immune functions, and endocrine functions. However, the lack of consensus related to burnout definition and measurement, variability in results across distinct populations, and the predominantly cross-sectional nature of the studies made it difficult to draw any firm conclusions [48]. Homogenous clinical samples and longitudinal studies would be needed to determine biomarkers able to differentiate burnout from other well-established mental disorders [49].

Lastly, the relevance of positioning burnout as a mental disorder should ideally be investigated from a transdisciplinary angle that includes both clinical and social psychologists, as well as non-academic stakeholders. Currently, it appears that research is being conducted in isolation, raising questions about possible confirmation biases. Similarly, although burnout is not currently categorized as a mental disorder and has no clear diagnostic criteria, individuals in some countries are still being classified as suffering from burnout and treated for their condition. Research has shown that it is difficult to objectively compare burnout interventions as they vary considerably but that individual-focused interventions are not necessarily sufficient [50][51]. In this regard, combination therapy may be an effective avenue to addressing both the individual (e.g., coping-related) and environmental (e.g., job demands and social support) origins of 'burnout'.

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