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On the Depressive Nature of the "Burnout Syndrome": A Clarification

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Viewpoint

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"...although severe stressors have been generally linked to increased risk of depression, chronic stressors and events characterized by perceived (a) lack of control, (b) inability to escape or resolve the aversive situation (e.g., entrapment), or (c) loss of status (e.g., humiliation) appear to be particularly depressogenic..."
Diego A. Pizzagalli (2014, p. 406)

The "burnout syndrome" has become popularly known since it was described in the 1970s and is today an emblem of work-related ill-health [1,2]. Its phenomenological and nosological status, however, remains strongly debated [3]. In this viewpoint article, we defend the controversial position that burnout is a depressive syndrome. Our objective is to provide the psychiatry community with a different reading of burnout, a syndrome that in recent years has elicited increasing interest among psychiatrists.

1. Burnout: definition and assessment

Burnout has been defined as a combination of emotional exhaustion, depersonalization (unconcern regarding recipients and withdrawal from work), and poor personal accomplishment (reduced professional efficacy and fulfillment from work) [1,2]. Burnout is thought to develop out of chronic exposure to uncontrollable job stressors. Because the stressors cannot be neutralized, individuals are condemned to endure the stressors' harmful effects resignedly: "First and foremost, the burned-out professional feels helpless, hopeless, and powerless" (p. 25) [2].

The three dimensions of burnout come from, and are assessed with, the Maslach Burnout Inventory (MBI), a self-administered questionnaire [1]. The MBI has been developed inductively by factor-analyzing "a rather arbitrary set of items" [2] (p. 188), designed on the basis of exploratory interviews and field observations. Central to burnout research, the MBI has been severely criticized because its development implied no systematic clinical work and was not theory-driven [1,2].

In more than 40 years, no binding, consensual criteria for diagnosing burnout have been established [1]. It is thus unclear where clinical burnout begins (onset) and ends (recovery) or what constitutes a case of burnout. As a corollary, the prevalence of burnout cannot be estimated – although many researchers have intended to do so. Given its nosological vagueness, the use of the burnout construct has been argued to be confusing for occupational medicine professionals and public health decision-makers.

Importantly, pioneers of burnout research suggested that burnout should be viewed as a social, rather than an individual, problem [1,2]. This perspective led them to reject a diagnostic approach to burnout, perceived as stigmatizing and implying a risk of "blaming the victim" [2]. It is worth noting, however, that regardless of whether or not one favors a social perspective, burnout is in the end experienced by people. Because burnout is individually embodied, individual diagnosis and individualized assistance are required if we are to help sufferers recover. Tackling the question of stigma to the detriment of the concern for diagnosis is therefore not a solution.

2. Is burnout expected to be anything other than a depressive syndrome?

As previously mentioned, burnout is not a clinically-grounded or theory-based construct; it is the product of a "grassroots" field approach to stress and health [1,2]. Furthermore, the burnout construct was introduced in the literature in the absence of any comprehensive review of already-described stress-related syndromes (e.g., depressive syndromes), that is, without any explicit justification of its added value. Given this context, whether there was any reason to a priori assume that burnout is something other than a depressive syndrome is a central question. In this respect, a focus on the etiology of burnout is informative.

Burnout is thought to result from unresolvable stress. As long evidenced by research conducted in psychiatry, behavioral psychology, and neurobiology, depressive symptoms constitute basic responses to unresolvable stress in homosapiens, as in many other species [4–8]. Unmanageable adversity, in any life domain valued by the individual (e.g., work), is fundamentally depressogenic [1,5]. On this basis, burnout is expected to overlap with (a) transient depressive manifestations or subclinical forms of depression at low and intermediate points on the burnout continuum and (b) clinical depression at the high end of the burnout continuum. Put differently, in a dimensional approach to psychopathology, burnout as a process is expected to be a depressive process and, in a categorical approach to psychopathology, burnout as a clinical state is expected to be a depressive clinical state [1,9]. The presupposition that burnout is not a depressive phenomenon thus appears theoretically incongruous.

3. Empirical evidence for burnout-depression overlap

Burnout has in fact been associated with all the "classical" symptoms of depression, including the most severe (e.g., anhedonia,

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depressed mood, suicidal ideation) [1,2]. Among numerous studies suggesting that burnout and depressive symptoms are inextricably linked [1], a three-wave, seven-year study by Ahola et al. [10] is of particular interest. These authors examined both within- and between-individual symptom variations in 3255 Finnish professionals. The study showed that burnout and depressive symptoms increased and decreased commensurately over time, with low, intermediate, and high levels of burnout symptoms being respectively accompanied by low, intermediate, and high levels of depressive symptoms. The authors concluded that "burnout could be used as an equivalent to depressive symptoms in work life" (p. 35) [10]. Thinking in terms of burnout-depression co-development or co-morbidity might be tempting; giving in to this temptation, however, would be misguided given that the distinctiveness of burnout, precisely, has not been established [1,2].

4. Moving from burnout to job-induced depression

Despite its limitations, burnout research contributed to the spotlighting of the link between work and health. Arguably the "social focus" of burnout research helped draw researchers' attention to the supra-individual factors influencing occupational health (e.g., organizational factors) [3]. Recognizing the depressive nature of the burnout phenomenon does not imply any neglect of such factors or step backward in this matter.

In research settings, the relationship between work and depression can be explored by examining (a) the variance in depression associated with occupational and non-occupational stressors and/or (b) the extent to which affected individuals attribute their depressive symptoms to their job. In clinical settings, the anamnesis of the depressed patient offers clues to the etiological relationship between the individual's job and his/her depressive symptoms. Based on the anamnesis, the practitioner can specify, if relevant, a diagnosis of job-induced depression. Should the patient's workplace be identified as depressogenic, then job-centered measures can be implemented in order to help the individual recover.

We plead for a multiscale approach to occupational health, in which individual/dispositional and organizational/environmental factors are taken into account relationally [11]. Doing so, we warn investigators against the risk of ideologically favoring one level of explanation (e.g., individual) over another (e.g., organizational), by acting as if the answers to job stress research questions lay either exclusively in internal, individual-related factors or exclusively in external, organization-related factors.

5. Conclusion

Key theoretical arguments and empirical findings converge to suggest that the burnout construct captures a depressive phenomenon. The reluctance to consider burnout a depressive condition may be due to (a) a neglect of the stress–depression relationship and (b) a difficulty coordinating dimensional and categorical approaches to psychopathology in burnout research. Regarding this latter point, it is worth underlining that dimensions and categories constitute two ways of describing (psychopathological) phenomena. Thus, dimensions and categories should be heuristically combined [9] rather than opposed: burnout and depression can be studied both as "processes" or "end-states". Clarifying what burnout actually is matters in terms of conceptual parsimony, theoretical integration, nosological consistency, interventional effectiveness, and public health policy-making. Understanding burnout as a depressive condition is in our estimation a critical step toward clarification.

Disclosure of interest

The authors declare that they have no competing interest.

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