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When We Say 'Physician Burnout,' We Really Mean Depression

Irvin Sam Schonfeld
CUNY Graduate Center

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In a recent commentary on Medscape ("[Is Burnout a Form of Depression?](#)"), Michael R. Privitera, MD, MS, cited a review article on which I served as one of the coauthors.^[1] This review, the conclusions of which Dr Privitera disputes, finds that there is substantial overlap in what some writers call burnout with depression.

Although I agree with Dr Privitera that the conditions under which many physicians work need to be improved, I disagree with his view that burnout and depression are separate entities. I have a number of reasons for advancing the view that burnout is not something separate from a depressive condition.

Why Depression Isn't Separate

First, Dr Privitera observes that a physician may face career barriers if he or she admits to being depressed. Although true in many instances, such a situation does not support the view that burnout and depression are separate entities. Rather, the situation represents serious discrimination. It is preferable to implement enlightened, effective, and discrete ways to help a physician who is depressed. We want enlightened, effective, and discrete ways to help a teacher or a social worker or any other person who works but is also depressed.

Second, the work-related causes of burnout and depression are essentially the same.^[2] Toxic work environments featuring constricted autonomy and excessive psychological workloads are implicated in both. This is not to say that depression cannot develop out of serious problems in other life domains. But adverse working conditions are indeed implicated in the development of depression.^[3]

Third, the evidence that Dr Privitera cites involves some conflation of how burnout and depression are conceptualized. Dr Privitera conceives of burnout as both categorical/nosological and dimensional.

Burnout is ordinarily measured dimensionally with a questionnaire, either self-administered or administered by an interviewer. Scores on the three reputed dimensions of burnout (emotional exhaustion, depersonalization, and reduced personal accomplishment) are obtained. Although measures such as the commonly used Maslach Burnout Inventory are not diagnostic instruments, when researchers treat burnout categorically/nosologically, they ordinarily operationalize "clinical" burnout by arbitrarily identifying individuals with a score on one of its three burnout dimensions at or above some threshold, often merely the top tercile.

Of course, depression has been treated nosologically for a long time, which is how Dr Privitera primarily treats this condition. However, a relatively new generation of research on psychopathology indicates that depression may be better conceptualized as a dimensional phenomenon—that is, on a continuum.^[4,5] To summarize, both burnout and depression can be treated categorically/nosologically (although questionable in the case of burnout) or dimensionally. This will clarify what I have to say next.

Burnout's Core: Emotional Exhaustion

Fourth, emotional exhaustion is considered the core of burnout.^[6] When emotional exhaustion and depression are treated dimensionally, their correlations, when corrected for measurement error, equal or exceed .80.^[7,8] This is a very high correlation, suggesting substantial overlap.

Fifth, the above cited studies indicate that emotional exhaustion correlates with depressive symptom scales more highly than emotional exhaustion correlates with depersonalization or reduced personal accomplishment, the other two putative dimensions of burnout.

The implication is that if burnout is a syndrome, it should embrace emotional exhaustion and depression. In other words, depression is at burnout's heart. Moreover, the symptom items on Maslach's emotional

exhaustion scale map onto fatigue symptoms used to diagnose depression. The reader should also bear in mind that fatigue is often the presenting problem when an individual seeks help from a clinician for depression.^[9]

Understanding the Overlap

Sixth, when burnout and depression are treated categorically/nosologically, there is also substantial overlap. More than 80% of individuals with high burnout scores meet criteria for provisional diagnoses of depression.^[6,10]

Seventh, Dr Privitera cites the work of Wurm and colleagues^[11] and Ahola and colleagues^[12] as part of his case supporting the view that burnout and depression are different. Those studies, if anything, suggest the reverse—namely, that of burnout-depression overlap.

Wurm and colleagues show that with increasing burnout symptoms, the risk for depression monotonically increases. For example, the odds ratio that depression is present in individuals with very high burnout scores exceeds 93.

Ahola and colleagues found that burnout and depression symptoms cluster together and change synchronously over time. These authors wrote, "On the basis of the present results, burnout could be used as an equivalent to depressive symptoms in work life."

Finally, Dr Privitera mentioned that burnout is associated with alexithymia. But that association underlines burnout's link to depression, which is also associated with alexithymia.^[13]

Towards Better Care for Clinicians

Freudenberger,^[14] the investigator who published the first paper in a social science journal on burnout, wrote that the burned-out individual "looks, acts and seems depressed." That is because he or she probably is depressed.

Once depression is recognized, we know that there are effective psychotherapeutic and pharmacotherapeutic treatments. However, this does not relieve us of the obligation to make work environments less depressogenic. Medical societies, senior physicians, and healthcare administrators operating in the healthcare field need to take steps to modify workloads for residents and more junior members of the staff when those workloads are excessive, compromise work-family balance, and increase the risk for errors.

[A recent Medscape article](#) reported that a medical student and resident who were at the same major medical center committed suicide within the same week. Dr Privitera noted the risk for suicide in physicians and linked it to depression. He also noted that sometimes suicide occurs impulsively outside of a depressive episode but never explicitly linked suicide to burnout. We don't want any more suicides among medical students, residents, or senior doctors.

As Dr Privitera observed, becoming depressed can evoke a sense of shame in physicians, increasing the burden they already carry. I think it is time to say, "Enough!" We need efforts to eliminate that sense of shame by offering help to an affected physician in a discreet manner that isn't trumpeted across the healthcare setting. We need to recognize that when we talk about physician burnout, we're really talking about something very serious: depression.

Research on the efficacy of treatments for depression has been of higher quality than similar research for burnout.^[7] There are effective treatments for depression; by contrast, the best treatments for burnout are unclear. (A vacation? The half-life of the effect of a vacation is less than 2 weeks.^[15])

When we recognize that some physicians may be suffering from depression, we can make thoughtful progress in helping them with evidence-based treatments. Of course, helping an affected physician obtain the appropriate treatment does not release us from the

responsibility for modifying the adverse working conditions that contribute to serious mental health problems.

References

1. Bianchi R, Schonfeld IS, Laurent E. Burnout-depression overlap: a review. *Clin Psychol Rev.* 2015;36:28-41. [Abstract](#)
2. Schonfeld IS, Chang C-H. *Occupational health psychology: work, stress, and health.* New York, NY: Springer Publishing Company; 2017.
3. Tennant C. Work-related stress and depressive disorders. *J Psychosom Res.* 2001;51:697-704. [Abstract](#)
4. Caspi A, Houts R, Moffitt T, et al. The p factor: one general psychopathology factor in the structure of psychiatric disorders? *Clin Psychol Sci.* 2014;2:119-137. [Abstract](#)
5. Kotov R, Krueger R, Zimmerman M, et al. The Hierarchical Taxonomy of Psychopathology (HiTOP): a dimensional alternative to traditional nosologies. *J Abnorm Psychol.* 2017;126:454-477. [Abstract](#)
6. Maslach C, Schaufeli WB, Leiter MP. Job burnout. *Ann Rev Psychol.* 2001;52:397-422.
7. Schonfeld IS, Bianchi R. Burnout and depression: two entities or one. *J Clin Psychol.* 2016;72:22-37. [Abstract](#)
8. Schonfeld IS, Verkuilen J, Bianchi R. Confirmatory factor analysis of burnout and depressive symptoms. Program and abstracts of the 12th International Conference on Work, Stress, and Health; June 7-10, 2017; Minneapolis, Minnesota.
9. American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders.* 5th ed. Arlington, VA: American Psychiatric Association; 2013.
10. Bianchi R, Schonfeld IS, Laurent E. Is burnout a depressive disorder? A reexamination with special focus on atypical depression. *Int J Stress Manag.* 2014;21:307-324.
11. Wurm W, Vogel K, Holl A, et al. Depression-burnout overlap in physicians. *PLoS One.* 2016;11:e0159913.
12. Ahola K, Hakanen J, Perhoniemi R, Mutanen P. Relationship between burnout and depressive symptoms: a study using the person-centered approach. *Burn Res.* 2014;1:29-37.
13. Kim JH, Lee SJ, Rim HD, et al. The relationship between alexithymia and general symptoms of patients with depressive disorders. *Psychiatry Investig.* 2008;5:179-85. [Abstract](#)
14. Freudenberger HJ. Staff burnout. *J Soc Issues.* 1974;30:159-165.
15. Westman M, Eden D. Effects of a respite from work on burnout: vacation relief and fade-out. *J Appl Psychol.* 1997;82:516-527. [Abstract](#)