

# Understanding the burnout experience: recent research and its implications for psychiatry

Christina Maslach<sup>1</sup>, Michael P. Leiter<sup>2</sup>

<sup>1</sup>Psychology Department, University of California at Berkeley, Berkeley, CA 94720, USA; <sup>2</sup>Centre for Organizational Research & Development, Acadia University, Wolfville, NS B4P 2R6, Canada

*The experience of burnout has been the focus of much research during the past few decades. Measures have been developed, as have various theoretical models, and research studies from many countries have contributed to a better understanding of the causes and consequences of this occupationally-specific dysphoria. The majority of this work has focused on human service occupations, and particularly health care. Research on the burnout experience for psychiatrists mirrors much of the broader literature, in terms of both sources and outcomes of burnout. But it has also identified some of the unique stressors that mental health professionals face when they are dealing with especially difficult or violent clients. Current issues of particular relevance for psychiatry include the links between burnout and mental illness, the attempts to redefine burnout as simply exhaustion, and the relative dearth of evaluative research on potential interventions to treat and/or prevent burnout. Given that the treatment goal for burnout is usually to enable people to return to their job, and to be successful in their work, psychiatry could make an important contribution by identifying the treatment strategies that would be most effective in achieving that goal.*

**Key words:** Burnout, work engagement, psychiatric staff, health care, depression, exhaustion, cynicism, burnout measures, burnout interventions

(*World Psychiatry* 2016;15:103–111)

For many years, burnout has been recognized as an occupational hazard for various people-oriented professions, such as human services, education, and health care. The therapeutic or service relationships that such providers develop with recipients require an ongoing and intense level of personal, emotional contact. Although such relationships can be rewarding and engaging, they can also be quite stressful.

Within such occupations, the prevailing norms are to be selfless and put others' needs first; to work long hours and do whatever it takes to help a client or patient or student; to go the extra mile and to give one's all. Moreover, the organizational environments for these jobs are shaped by various social, political, and economic factors (such as funding cutbacks or policy restrictions) that result in work settings that are high in demands and low in resources. Recently, as other occupations have become more oriented to "high-touch" customer service, the phenomenon of burnout has become relevant for these jobs as well<sup>1</sup>.

## DEFINING BURNOUT

Burnout is a psychological syndrome emerging as a prolonged response to chronic interpersonal stressors on the job. The three key dimensions of this response are an overwhelming exhaustion, feelings of cynicism and detachment from the job, and a sense of ineffectiveness and lack of accomplishment. The significance of this three-dimensional model is that it clearly places the individual stress experience within a social context and involves the person's conception of both self and others.

The initial research on burnout was exploratory and relied primarily on qualitative techniques. Because the earliest researchers came from social and clinical psychology, they gravitated toward

relevant ideas from these fields. The social perspective utilized concepts involving interpersonal relations, i.e. how people perceive and respond to others; these included detached concern, dehumanization in self-defense, and attribution processes. It also brought in concepts of motivation and emotion (and especially coping with emotional arousal). The clinical perspective also dealt with motivation and emotion, but framed these more in terms of psychological disorders, such as depression. Subsequent researchers came from industrial-organizational psychology, and this perspective emphasized work attitudes and behaviors. It was also at this point that burnout was conceptualized as a form of job stress, but the primary focus was on the organizational context and less on the physical characteristics of the experienced stress.

What emerged from this descriptive work were the three dimensions of the burnout experience. The exhaustion dimension was also described as wearing out, loss of energy, depletion, debilitation, and fatigue. The cynicism dimension was originally called depersonalization (given the nature of human services occupations), but was also described as negative or inappropriate attitudes towards clients, irritability, loss of idealism, and withdrawal. The inefficacy dimension was originally called reduced personal accomplishment, and was also described as reduced productivity or capability, low morale, and an inability to cope.

## Assessment of burnout

As the characteristics of burnout became more clearly identified, the next step was to develop measures that could assess them. Various measures were proposed, based on different assumptions about burnout, and many of them relied on the

face validity of the measurement items or statements. The first burnout measure that was based on a comprehensive program of psychometric research was the Maslach Burnout Inventory (MBI)<sup>2,3</sup>. The MBI was specifically designed to assess the three dimensions of the burnout experience which had emerged from the earlier qualitative research. It has been considered the standard tool for research in this field, and has been translated and validated in many languages<sup>4</sup>. In contrast, other initial measures of burnout focused only on the dimension of exhaustion<sup>5,6</sup>.

This distinction between measures that assess several dimensions of burnout, and those that assess the sole dimension of exhaustion, continues to the present day, and reflects different conceptualizations of burnout. For example, the Bergen Burnout Inventory (BBI)<sup>7</sup> assesses three dimensions of burnout: exhaustion at work, cynicism toward the meaning of work, and sense of inadequacy at work. The Oldenburg Burnout Inventory (OLBI)<sup>8</sup> assesses the two dimensions of exhaustion and disengagement from work. Other burnout measures focus on exhaustion alone, although they differentiate between various aspects of exhaustion. For example, the Shirom-Melamed Burnout Measure (SMBM)<sup>9</sup> distinguishes between physical fatigue, emotional exhaustion, and cognitive weariness; and the Copenhagen Burnout Inventory (CBI)<sup>10</sup> makes a distinction between physical and psychological exhaustion.

There have been other changes and modifications of burnout measures over the years. Because the initial concern about burnout emerged from caregiving occupations, such as health care and human services, the measures developed in the 1980s tended to reflect the experience of those professions. Later, however, other occupational groups became interested in the occurrence of burnout, but had some difficulties in adapting the existing measures to their work situation. For the MBI, the solution was the development of a General Survey that could be used within any occupation (MBI-GS)<sup>11</sup>. Not only were various items revised to be more "occupation-neutral", but the dimension of depersonalization (which was more specific to human services) was broadened to refer to a negative detachment from work and was renamed *cynicism*, and the dimension of personal accomplishment was broadened and renamed *professional efficacy*. More recent burnout measures utilized more occupation-neutral wording from the outset.

However, some measures also added some new dimensions to the concept of burnout. For example, the Spanish Burnout Inventory consists of four dimensions: enthusiasm towards the job, psychological exhaustion, indolence, and guilt<sup>12</sup>. Meanwhile, some researchers were concerned that the more neutral wording meant a loss of the specific interpersonal issues for human service workers, so they developed a new measure of interpersonal strain<sup>13</sup>. It remains an open question whether these additional elements are essential components of burnout *per se*, or whether they assess experiences or conditions that often accompany the experience of burnout.

## Engagement

An important development, at the beginning of the 21st century, has been that researchers have tried to broaden their understanding of burnout by extending their attention to its positive antithesis. This positive state has been identified as "engagement". Although there is general agreement that engagement with work represents a productive and fulfilling state within the occupational domain, there are differences in its definition.

For some burnout researchers, engagement is considered to be the opposite of burnout and is defined in terms of the same three dimensions as burnout, but the positive end of those dimensions rather than the negative. From this perspective, engagement consists of a state of high energy, strong involvement, and a sense of efficacy<sup>14</sup>. By implication, engagement is assessed by the opposite pattern of scores on the three MBI dimensions.

However, a different approach has defined work engagement as a persistent, positive affective-motivational state of fulfillment that is characterized by the three components of vigor, dedication, and absorption. In this view, work engagement is an independent and distinct concept, which is not the opposite of burnout (although it is negatively related to it). A new measure, the Utrecht Work Engagement Scale (UWES)<sup>15</sup>, was developed to assess this positive state, and extensive research has been carried out in the last decade<sup>16</sup>.

The relationship between burnout and engagement continues to be debated, however, and a recent approach has been to use dialectical theory to synthesize conflicting views on the two constructs, and to develop an alternate model<sup>17</sup>.

## Conceptual models

There have been various conceptual models about the development of burnout and its subsequent impact. At first, the focus was on the relationship between the three dimensions of burnout, which was often described in sequential stages. Exhaustion was assumed to develop first, in response to high demands and overload, and then this would precipitate detachment and negative reactions to people and the job (depersonalization or cynicism). If this continued, then the next stage would be feelings of inadequacy and failure (reduced personal accomplishment or professional inefficacy).

More recently, burnout models have been based on theories about job stress, and the notion of imbalances leading to strain. The first such model was the transactional one, which served as the conceptual bridge between sequential stages and imbalances<sup>18</sup>. Its three stages are: a) job stressors (an imbalance between work demands and individual resources), b) individual strain (an emotional response of exhaustion and anxiety), and c) defensive coping (changes in attitudes and behavior, such as greater cynicism).

Subsequently, two developmental models of the demands-resources imbalance have emerged: the Job Demands-Resources (JD-R) model and the Conservation of Resources (COR) model. The JD-R model focuses on the notion that burnout arises when individuals experience incessant job demands and have inadequate resources available to address and to reduce those demands<sup>19</sup>. The COR model follows a basic motivational theory assuming that burnout arises as a result of persistent threats to available resources<sup>20</sup>. When individuals perceive that the resources they value are threatened, they strive to maintain those resources. The loss of resources or even the impending loss of resources may aggravate burnout. Both the JD-R and the COR theory of burnout development have received confirmation in research studies.

A different variation of an imbalance model of burnout is the Areas of Worklife (AW) model, which frames job stressors in terms of person-job imbalances, or mismatches, but identifies six key areas in which these imbalances take place: workload, control, reward, community, fairness, and values. Mismatches in these areas affect an individual's level of experienced burnout, which in turn determines various outcomes, such as job performance, social behaviors, and personal wellbeing. The greater is the mismatch between the person and the job, the greater the likelihood of burnout; conversely, the greater the match, the greater the likelihood of engagement. Initial empirical support for the AW model has been provided by both cross-sectional and longitudinal studies<sup>21</sup>.

## CAUSES AND OUTCOMES

Most models of burnout make explicit the causal theorizing that has always been implicit in burnout research: certain factors (both situational and individual) cause people to experience burnout, and once burnout occurs, it causes certain outcomes (both situational and individual). However, these causal assumptions have rarely been tested directly. Most research on burnout has involved cross-sectional designs or studies using statistical causal models. This correlational database has provided support for many of the hypothesized links between burnout and its sources and effects, but it is unable to address the presumed causality of those linkages. The recent increase in longitudinal studies is beginning to provide a better opportunity to test sequential hypotheses, but stronger causal inferences will also require appropriate methodological designs (and these are often difficult to implement in applied settings). One other critical constraint is that many of the variables have been assessed by self-report measures (rather than other indices of behavior or health).

Over two decades of research on burnout have identified a plethora of organizational risk factors across many occupations in various countries<sup>22,23</sup>. Six key domains have been identified, as mentioned earlier: workload, control, reward, community, fairness, and values. The first two areas are reflected in the Demand-Control model of job stress<sup>24</sup>.

Work overload contributes to burnout by depleting the capacity of people to meet the demands of the job. When this kind of overload is a chronic job condition, there is little opportunity to rest, recover, and restore balance. A sustainable and manageable workload, in contrast, provides opportunities to use and refine existing skills as well as to become effective in new areas of activity.

A clear link has been found between a lack of control and burnout. On the contrary, when employees have the perceived capacity to influence decisions that affect their work, to exercise professional autonomy, and to gain access to the resources necessary to do an effective job, they are more likely to experience job engagement.

The area of reward refers to the power of reinforcements to shape behavior. Insufficient recognition and reward (whether financial, institutional, or social) increases people's vulnerability to burnout, because it devalues both the work and the workers, and is closely associated with feelings of inefficacy. In contrast, consistency in the reward dimension between the person and the job means that there are both material rewards and opportunities for intrinsic satisfaction.

The area of community has to do with the ongoing relationships that employees have with other people on the job. When these relationships are characterized by a lack of support and trust, and by unresolved conflict, then there is a greater risk of burnout. On the contrary, when these job-related relationships are working well, there is a great deal of social support, employees have effective means of working out disagreements, and they are more likely to experience job engagement.

The area of fairness emerges from the literature on equity and social justice. Fairness is the extent to which decisions at work are perceived as being fair and equitable. People use the quality of the procedures, and their own treatment during the decision-making process, as an index of their place in the community. Cynicism, anger and hostility are likely to arise when people feel they are not being treated with the appropriate respect.

Finally, the area of values picks up the cognitive-emotional power of job goals and expectations. Values are the ideals and motivations that originally attracted people to their job, and thus they are the motivating connection between the worker and the workplace, which goes beyond the utilitarian exchange of time for money or advancement. When there is a values conflict on the job, and thus a gap between individual and organizational values, employees will find themselves making a trade-off between work they want to do and work they have to do, and this can lead to greater burnout.

In terms of outcomes, burnout has been frequently associated with various forms of negative reactions and job withdrawal, including job dissatisfaction, low organizational commitment, absenteeism, intention to leave the job, and turnover<sup>23</sup>. For example, cynicism has been found to be the pivotal aspect of burnout to predict turnover<sup>25</sup>, and burnout mediates the relationship between being bullied in the workplace and the intention to quit the job<sup>26</sup>. On the other hand, for people who stay

on the job, burnout leads to lower productivity and impaired quality of work. As burnout diminishes opportunities for positive experiences at work, it is associated with decreased job satisfaction and a reduced commitment to the job or the organization.

People who are experiencing burnout can have a negative impact on their colleagues, both by causing greater personal conflict and by disrupting job tasks. Thus, burnout can be “contagious” and perpetuate itself through social interactions on the job<sup>27,28</sup>. The critical importance of social relationships for burnout is underscored by studies that show that burnout increases in work environments characterized by interpersonal aggression<sup>29,30</sup>. Such findings suggest that burnout should be considered as a characteristic of workgroups rather than simply an individual syndrome.

Burnout has a complex pattern of relationships with health, in that poor health contributes to burnout and burnout contributes to poor health<sup>31</sup>. Of the three burnout dimensions, exhaustion is the closest to an orthodox stress variable, and therefore is more predictive of stress-related health outcomes than the other two dimensions. Exhaustion is typically correlated with such stress symptoms as headaches, chronic fatigue, gastrointestinal disorders, muscle tension, hypertension, cold/flu episodes, and sleep disturbances. These physiological correlates mirror those found with other indices of prolonged stress. Parallel findings have been found for the link between burnout and substance abuse<sup>32</sup>.

A ten-year longitudinal study of industrial workers found burnout to predict subsequent hospital admissions for cardiovascular problems<sup>33</sup>. Other research found that a one-unit increase in burnout score was related to a 1.4 unit increase in risk for hospital admission for mental health problems, as well as a one-unit increase in risk for hospital admissions for cardiovascular problems<sup>31</sup>. Other studies have provided a more detailed examination of the link between burnout and cardiovascular disease, noting the role of high-sensitivity C-reactive protein and fibrinogen concentrations in the link<sup>34</sup>.

## BURNOUT IN PSYCHIATRY

To a large extent, the research literature on burnout in psychiatry echoes those previous themes. Workplace variables have been found to be more stressful for psychiatrists than other factors, and thus may be more likely to perpetuate burnout<sup>35</sup>. These variables include too much work, long working hours, chronic staff shortages, an aggressive administrative environment, and lack of support from management. Poor relationships with management and supervisors have also been identified as related to burnout among psychiatry residents<sup>36</sup>. However, research has found mixed results with regard to the role of job satisfaction in burnout, with some studies reporting no relationship<sup>37,38</sup>, and other studies reporting that job satisfaction did play a role<sup>39,40</sup>.

The rate of burnout among those employed in the health care field tends to be reported in the moderate to high levels, and it is generally believed that the burnout risk in health care is higher than in the general working population. Reported burnout rates for psychiatrists are quite similar to this overall trend<sup>41-43</sup>. Some studies have raised the possibility that psychiatrists show an even more negative risk profile for burnout than do other health care employees<sup>36,43,44</sup>. For example, one study found that 89% of psychiatrists had either thought about or experienced a clear threat of severe burnout<sup>45</sup>.

There are other critical risk factors that may be more unique to the field of psychiatry. Chief among these is the working relationship that psychiatrists, and other mental health professionals, have with clients who are experiencing psychological trauma. The challenging demands posed by these and other difficult clients can lead to greater stress and frustration among psychiatrists, which in turn can fuel the exhaustion, cynicism, and inefficacy of burnout. This process has also been described in terms such as compassion fatigue, secondary traumatic stress, and vicarious traumatization<sup>46-48</sup>. The burnout experience can become especially overwhelming when the psychiatrist becomes the target of anger, hatred, and even violence, as a result of negative transference<sup>49</sup>. Violent incidents with patients can be emotionally draining and difficult to manage, and can lead health providers to psychologically distance themselves from their work. The occurrence of violence can also make providers feel that they lack control over their job, and thus challenge their sense of professional efficacy.

Higher levels of burnout are correlated with more negative feelings about patients<sup>50</sup> and a poorer quality of patient care<sup>51</sup>. This link between burnout and poor care is supported by research on how burnout is manifested in psychiatrists, by changes in appearance (e.g., look of fatigue), behavior (e.g., becoming avoidant, making less eye contact), and mood (e.g., becoming more irritable and agitated, communicating poorly). In addition, perfectionist and obsessive traits may perpetuate burnout, particularly when the workload is heavy or stressful<sup>52</sup>.

Working with demanding patients and working with patients' families have been found to be closely associated with psychiatrists' levels of exhaustion and depersonalization<sup>35</sup>. These relationships reflect psychiatrists' frustrations with the limits of their craft. Contact with patients' families intensified these feelings, especially when family members expressed unrealistic expectations for treatment. Psychiatrists are emotionally drained by their inability to meet the strenuous demands they put upon themselves, and the demands inherent in their interactions with patients and patients' families. In contrast, diminished personal accomplishment reflects problematic relationships with superiors and colleagues, rather than demands from patients. Colleagues provide the most relevant source of information regarding one's sense of efficacy in professional life. When those relationships are strained, it is difficult to find meaningful confirmation of one's job performance.

Research on burnout has always recognized a central role for social relationships in the development and resolution of the syndrome. Initially, the research focus was primarily on the therapeutic relationship between the provider and the service recipient. Over time, studies have confirmed that relationships with colleagues and supervisors are equally, if not more, relevant to the potential for providers to experience burnout. For example, recent research on attachment styles found that attachment anxiety was accompanied by more frequent incivility from colleagues, and was associated with more exhaustion and cynicism. Attachment avoidance was linked to fewer instances of positive social encounters at work, and was associated with a greater sense of inefficacy<sup>53</sup>. In sum, negative social interactions seem to drain energy and distance people from their job, and the absence of positive social encounters is discouraging.

## CURRENT ISSUES

There are many interesting questions about burnout and engagement which are being studied in many countries around the world. A few inter-related themes should be of particular significance for the profession of psychiatry. First is the question of the relationship between burnout and mental illness. Second is the question of the value of simplifying the multi-dimensional construct of burnout to the single dimension of exhaustion. And third is the question of how best to ameliorate burnout in terms of treatment and prevention.

### Burnout and mental illness

When the construct of burnout was first proposed in the 1970s, there were arguments that it was not a distinctly different phenomenon, but rather a new label for an already known state – i.e., “old wine in a new bottle”. However, there were a lot of differing opinions about what the “already known state” actually was. These included job dissatisfaction, anomie, job stress, anxiety, anger, depression, or some combination of them<sup>54-56</sup>. For example, one psychoanalytic perspective argued that burnout was not distinguishable from either job stress or depression, but represented a failure to achieve narcissistic satisfaction in the pursuit of ideals<sup>57</sup>. As a result of these critiques, subsequent research often focused on testing the discriminant validity of burnout by assessing whether it could be distinguished from these other phenomena. The results of many studies have established that burnout is indeed a distinct construct<sup>23</sup>.

Much of this prior discussion has focused on depression, thus raising the question of whether burnout is a precipitating factor for depression, and thus is a predictor for it, or whether burnout is the same thing as depression, and thus is itself a mental illness. Research has demonstrated that the two con-

structs are indeed distinct: burnout is job-related and situation-specific, as opposed to depression, which is more general and context-free.

However, a recent article has renewed debate on the distinction between burnout and depression by claiming that at high levels the two states are indistinguishable<sup>58</sup>. This position is in contrast to the view that burnout is an occupationally-specific dysphoria that is distinct from depression as a broadly based mental illness<sup>22</sup>. But close examination of the new research article reveals problems with its argument.

A necessary condition to examine the distinction between burnout and depression is a set of measures that provide a complete and accurate operationalization of each construct, and the new study fell short of this criterion. Specifically, the nine-item depression measure (Patient Health Questionnaire, PHQ-9<sup>59</sup>) used in this study includes five items that refer explicitly to fatigue (lack of interest, trouble sleeping, trouble concentrating, moving slowly, and feeling tired). The other four items include one referring to loss of appetite and three referring to negative thoughts (suicidal thoughts, feeling depressed, negative self-evaluation). The measure produces a single factor score; clearly that factor is heavily weighted towards fatigue (Cronbach alpha of .88). It may be argued that these nine items fail to capture the full complexity of clinical depression. In any case, the depression construct operationalized in this measure is one dominated by fatigue, accompanied by negative thoughts. To measure burnout, the study used the SMBM<sup>9</sup>, which is a one-factor fatigue scale with items referring explicitly to trouble concentrating, feeling tired, and thinking in a slow, unfocused, and unclear manner. Although conceptualized as representing three distinct factors of cognitive, physical, and emotional fatigue, the measure consistently reduces to a single factor of fatigue (Cronbach alpha of .96). Given the overlap in the explicit reference of the two measures to fatigue in the majority of their items, it is not surprising that the two scales are correlated highly ( $r=.77$ )<sup>58</sup>.

The high correspondence of burnout and depression in this new study reflects a large level of concept redundancy between the SMBM and PHQ-9. The two instruments primarily measure exhaustion, leading to a strong correspondence between them, especially at high levels of exhaustion. The correlation was especially high in this study; earlier research that used these identical measures reported correlations at three different times as .51, .53, and .54<sup>60</sup>. These results are consistent with other research that finds that burnout and depression are inter-related conditions.

Research using the MBI departs further from depression measures in its three-component definition of the syndrome as exhaustion, cynicism, and inefficacy. Some studies that have used the MBI and different measures of depression have found the following range of correlations. The Profile of Mood States (POMS) depression scale correlated with the MBI - Human Services Survey (MBI-HSS) exhaustion ( $r=.33$ ), depersonalization ( $r=.30$ ), and personal accomplishment ( $r=-.14$ )<sup>61</sup>. The Depression Anxiety Stress Scale (DASS-21) depression subscale

correlated with the MBI-GS exhaustion ( $r=.37$ ), cynicism ( $r=.47$ ), and efficacy ( $r=-.21$ )<sup>62</sup>. The Beck negative emotions and attitudes subscale correlated with the MBI-GS exhaustion ( $r=.46$ ) and cynicism ( $r=.28$ ), and the Beck performance difficulties and somatic complaints subscale correlated with MBI-GS exhaustion ( $r=.61$ ) and cynicism ( $r=.36$ )<sup>63</sup>.

The wide range of correlations between burnout and depression argues for a complex relationship between the two constructs. Clearly, they are linked to each other. For example, one study found that 90% of the respondents with severe burnout (i.e., daily occurrence of burnout symptoms) reported a physical or mental disease, with musculoskeletal pain and depression as the most common problems<sup>64</sup>. A longitudinal study found that increases in burnout predicted increases in subsequent prescriptions of antidepressant medication<sup>65</sup>.

A new understanding of this linkage comes from a recent longitudinal study in Finland, which found a reciprocal relationship between burnout and depression, with each predicting subsequent developments in the other. It was noteworthy that burnout fully mediated the relationship of workplace strains with depression: when problems at work contribute to depression, experiencing burnout is a step in the process<sup>66</sup>.

These studies confirm that burnout and depression are not independent. Each state has implications for the other. However, that relationship is far from saying that burnout and depression are the same mental illness.

### Single or multiple dimensions

Although the original construct acknowledged exhaustion as a key aspect of burnout, it argued that exhaustion is not the whole story. Indeed, if burnout were solely exhaustion, then the word “burnout” would be unnecessary, as it would not be providing any added value. “Exhaustion” would suffice. To rename “exhaustion” as “burnout” would definitely be inviting the criticism of “putting old wine in new bottles”.

And yet, that simplification of burnout to exhaustion has been taking place not only among researchers, but also among practitioners. The driving force seems to be the goal of establishing a clinical diagnosis for burnout, so that health professionals can then receive reimbursement for treating individuals suffering from that condition.

This shift to defining and diagnosing burnout as an individual disorder or disability has been taking place in Northern Europe, primarily in Sweden and the Netherlands. There, burnout has been likened to neurasthenia or other syndromes with a quality of chronic fatigue. Sweden began using work-related neurasthenia as a burnout diagnosis in 1997; soon, that was within the five most frequent diagnoses<sup>67</sup>. Researchers developed a similar diagnosis in the Netherlands, using clinically validated cut-off scores on the MBI<sup>68</sup>.

To provide more precise diagnostic direction, Sweden in 2005 revised the ICD-10 burnout diagnosis (Z73.0) as a difficulty in life management characterized by “vital exhaustion”.

The signs of vital exhaustion include two weeks of daily experiences of low energy, with difficulties in concentration, irritability, emotional instability, dizziness, and sleep difficulties. Additionally, these symptoms must interfere with the patients’ capacity to perform their work responsibilities.

In the Netherlands, the term *overspannenheid* or “overstrain” is used to indicate burnout. This diagnostic approach estimates burnout prevalence at 3-7% across various occupations, with psychotherapists at 4%<sup>69</sup>. In terms of MBI scores, Dutch researchers recommended that a burnout diagnosis should be connected with very negative scores on exhaustion accompanied by negative scores on one of the other two subscales (cynicism and inefficacy)<sup>70,71</sup>.

The use of burnout as a medical diagnosis implies one-dimensionality, and it is clear that exhaustion has emerged as that single dimension. Moreover, since 1997, the Dutch census bureau has been assessing “burnout” among the working population by using an index of work-related exhaustion (that is based on the MBI) in its annual national survey. As a consequence, public discourse about burnout in the Netherlands is increasingly limited to exhaustion alone. The risk is that a focus on just exhaustion (and its connection to work overload) will miss the distinct quality of burnout as reflecting a crisis of meaning or values. The exhaustion dimension captures the problem of lacking sufficient energy to make a useful and enduring contribution at work. But it is the cynicism dimension that captures the difficulty in dealing with other people and activities in the work world. Furthermore, efficacy captures the core self-evaluation people make regarding the value of their work and the quality of their contribution. To ignore these core aspects of the burnout experience would truly be a “mis-diagnosis” that could have important ramifications for both policy and practice.

It is interesting that North American jurisdictions have been reluctant to recognize burnout as a clinical diagnosis, partially due to concerns about a flood of requests for disability coverage. The lack of an official diagnosis of burnout limits access to treatment, disability coverage, and workplace accommodations. Alternatively, disability applications have referred to depression, neurasthenia, or chronic fatigue. An unfortunate consequence is that inaccurate diagnoses may reduce possibilities for successful recovery and return to work.

New research has begun to focus on an innovative use of the three burnout dimensions, which allows for multiple distinct patterns along the burnout-engagement continuum. In addition to the two standard endpoint patterns of Burnout (high on all three dimensions) and Engagement (low on all three dimensions), this approach can identify people who are only experiencing one of the dimensions, rather than all of them<sup>72</sup>. A particularly relevant comparison is between people with the complete Burnout profile and those with only high exhaustion (the Overextended profile). The research findings show that these two patterns are decidedly different in terms of their workplace experience, so it is clear that exhaustion alone is not a proxy for burnout. Instead, the profile that

comes closer to the negative endpoint of Burnout is the cynicism-only one (Disengaged profile), which suggests that the experience of cynicism may be more of a core part of burnout than exhaustion. Cynicism is more clearly linked to the job environment, in terms of the poor quality of social relationships at work and the lack of critical resources, and that will lead to reduced job satisfaction and poor job performance<sup>73</sup>.

## Treatment and prevention

The personal and organizational costs of burnout have led to proposals for various intervention strategies. Some try to treat burnout after it has occurred, while others focus on how to prevent burnout by promoting engagement. Intervention may occur on the level of the individual, workgroup, or an entire organization. In general, the primary emphasis has been on individual strategies, rather than social or organizational ones, despite the research evidence for the primary role of situational factors.

Many of these individual strategies have been adapted from other work done on stress, coping, and health. The most common recommendations have included: a) changing work patterns (e.g., working less, taking more breaks, avoiding overtime work, balancing work with the rest of one's life); b) developing coping skills (e.g., cognitive restructuring, conflict resolution, time management); c) obtaining social support (both from colleagues and family); d) utilizing relaxation strategies; e) promoting good health and fitness; and f) developing a better self-understanding (via various self-analytic techniques, counseling, or therapy)<sup>74</sup>.

Initiatives to moderate workload demands complemented by improvements in recovery strategies through better sleep, exercise, and nutrition have direct relevance to the exhaustion component of burnout. Cynicism, in contrast, pertains more directly to a sense of community or to the congruence of personal and workplace values. For example, an intervention that improved workplace civility among health care providers showed that cynicism declined as a function of improved civility<sup>75</sup>, and that this change was sustained at a one-year follow-up assessment<sup>76</sup>. A sense of efficacy, in contrast, could be more responsive to improvements in the forms of recognition from colleagues and leaders within an organization or the profession. An alternative proposal has been that people can make various changes in how they do their job (a process known as "job crafting"), and that such job alterations could lead to less burnout<sup>77</sup>.

Unfortunately, there is very little research that has evaluated the efficacy of any of these approaches in reducing the risk of burnout. Especially rare are studies modeled even loosely on randomized control trials. More common are studies with a single intervention group of volunteer participants for whom there are rarely follow-up assessments after treatment has ended<sup>78</sup>. It is not yet clear whether burnout is generally susceptible to a range of strategies or whether it is crucial to

fit the strategy to the specific context of a workplace to be effective.

The same basic points can be made about studies examining interventions specific to psychiatrists. There have been several recommendations about possible interventions, but no thorough research on whether these ideas are viable solutions. One fairly common recommendation emphasizes the importance of various forms of support, such as peer support groups, formal support via regular feedback and performance evaluation, or the use of a community-based approach in the work environment. Interestingly, medical students and residents have also identified support as a critical factor, including support from faculty, peers, outside personal relationships, and counseling services<sup>79</sup>.

Another suggestion involves having psychiatrists evaluate their workload frequently, to ensure they are not putting themselves at additional risk for burnout. A related recommendation is that psychiatrists should develop a more versatile lifestyle, in which they diversify their work (e.g., take on a part-time teaching job, do some writing, or extend one's practice to other types of clients) and/or engage in activities outside of work (such as hobbies and other personal interests).

Mental health professionals who have worked in the areas of trauma and palliative care have made additional recommendations on how to deal with burnout<sup>80,81</sup>. Notably, one approach emphasizes the need to take care of oneself – and not only in terms of personal health and physical fitness, but also in terms of psychological wellbeing. Professionals who deal with trauma survivors are encouraged to work through their own personal traumatic experiences in order to prevent becoming "wounded healers" or secondarily traumatized therapists. Professionals working in hospice and palliative medicine are encouraged to focus on spirituality and human nature, via prayer, meditation, or religious services. Other methods for self-care include taking regular breaks from work, advocating for better social recognition of the difficult work that is being accomplished, and focusing on the positive aspects of life, both at work and home, so that one is not overwhelmed by adversity and misery.

Although various studies have provided excellent ideas to explore as interventions, the logistics of funding, designing, implementing, and evaluating these ideas remain the primary obstacles to better knowledge about the best solutions for burnout. For example, a Swedish group contrasted two therapeutic modalities for people who had been on long-term leave from work with a diagnosis of "work-related depression". They found that both cognitive group therapy and focused psychodynamic group therapy were effective in facilitating their return to work, but found no difference in effectiveness between the two approaches<sup>82</sup>. This study raises two important issues for further research. First, to what extent does "work-related depression" map upon clinical depression, in contrast to mapping upon burnout? Second, what are the common qualities of the two therapeutic modalities that could serve as mechanisms in treatment efficacy?

## CONCLUSIONS

Research to date indicates that the three aspects of burnout do present challenges for psychiatrists. Many of the issues for psychiatrists are similar to those facing other professionals providing human services to people in need of help. But additionally, psychiatric work entails close contact with people in emotional distress, and in some cases the potential for threats from some of these patients. Both of these stressors make demands on psychiatrists' energy, their capacity for involvement with others, and their sense of professional efficacy.

An issue of special significance to psychiatry is the alignment and differentiation of burnout and depression. The concept of workplace depression as a basis for workers' disability coverage in some European countries raises important issues for practitioners, which have extensive implications for employees, employers, and insurance providers. Research and conceptual development that includes multidisciplinary participation is needed for definitive progress.

Psychiatry is in a strong position to contribute to the growth of knowledge regarding burnout. The question of burnout's status as a basis for disability claims requires precise and objective assessment. Further, psychiatric-based treatments may be relevant to burnout, especially regarding return to work for people experiencing severe burnout. Finally, effective research on preventing and alleviating aspects of burnout among psychiatrists requires giving the issue a high priority within the profession.

## REFERENCES

1. Maslach C, Leiter MP. The truth about burnout. San Francisco: Jossey-Bass, 1997.
2. Maslach C, Jackson SE. The measurement of experienced burnout. *J Occupat Behav* 1981;2:99-113.
3. Maslach C, Jackson SE, Leiter MP (eds). *Maslach Burnout Inventory manual*, 3rd ed. Palo Alto: Consulting Psychologists Press, 1996.
4. Maslach C, Leiter MP, Schaufeli WB. Measuring burnout. In: Cooper CL, Cartwright S (eds). *The Oxford handbook of organizational well-being*. Oxford: Oxford University Press, 2009:86-108.
5. Freudenberger HJ, Richelson G. Burn-out: the high cost of high achievement. Garden City: Doubleday, 1980.
6. Pines A, Aronson E, Kafry D. Burnout: from tedium to personal growth. New York: Free Press, 1981.
7. Feldt T, Rantanen J, Hyvonen K et al. The 9-item Bergen Burnout Inventory: factorial validity across organizations and measurements of longitudinal data. *Ind Health* 2014;52:102-12.
8. Halbesleben JBR, Demerouti E. The construct validity of an alternative measure of burnout: investigation of the English translation of the Oldenburg Burnout Inventory. *Work Stress* 2005;19:208-20.
9. Shiron A, Melamed S. A comparison of the construct validity of two burnout measures in two groups of professionals. *Int J Stress Manage* 2006;13:176-200.
10. Kristensen TS, Borritz M, Villadsen E et al. The Copenhagen Burnout Inventory: a new tool for the assessment of burnout. *Work Stress* 2005;19:192-207.
11. Schaufeli WB, Leiter MP, Maslach C et al. Maslach Burnout Inventory – General Survey. In: Maslach C, Jackson SE, Leiter MP (eds). *Maslach Burnout Inventory manual*, 3rd ed. Palo Alto: Consulting Psychologists Press, 1996:19-26.
12. Gil-Monte PR, Figueiredo-Ferraz HH. Psychometric properties of the "Spanish Burnout Inventory" among employees working with people with intellectual disability. *J Intell Disabil Res* 2013;57:959-68.
13. Borgogni L, Consiglio C, Alessandri G et al. "Don't throw the baby out with the bathwater!" Interpersonal strain at work and burnout. *Eur J Work Organizat Psychol* 2012;21:875-98.
14. Maslach C, Leiter MP. Burnout and engagement in the workplace: a contextual analysis. In: Urdan T (ed). *Advances in motivation and achievement*, Vol. 11. Stamford: JAI Press, 1999:275-302.
15. Schaufeli WB, Bakker AB, Salanova M. The measurement of work engagement with a brief questionnaire: a cross-national study. *Educ Psychol Meas* 2006;66:701-16.
16. Bakker AB, Leiter MP (eds). *Work engagement: a handbook of essential theory and research*. New York: Psychology Press, 2010.
17. Leon MR, Halbesleben JRB, Paustian-Underdahl SC. A dialectical perspective on burnout and engagement. *Burnout Res* 2015;2:87-96.
18. Cherniss C. *Staff burnout: job stress in the human services*. Beverly Hills: Sage, 1980.
19. Bakker AB, Demerouti E. The Job Demands-Resources model: state of the art. *J Manag Psychol* 2007;22:309-28.
20. Hobfoll SE, Freedy J. Conservation of resources: a general stress theory applied to burnout. In: Schaufeli WB, Maslach C, Marek T (eds). *Professional burnout: recent developments in theory and research*. New York: Taylor & Francis, 1993:115-29.
21. Leiter MP, Maslach C. Areas of worklife: a structured approach to organizational predictors of job burnout. In: Perrewe PL, Ganster DC (eds). *Research in occupational stress and well-being*, Vol. 3. Oxford: Elsevier, 2004:91-134.
22. Maslach C, Schaufeli WB, Leiter MP. Job burnout. *Annu Rev Psychol* 2001;52:397-422.
23. Schaufeli WB, Enzmann D. *The burnout companion to study and practice: a critical analysis*. London: Taylor & Francis, 1998.
24. Karasek R, Theorell T. *Stress, productivity, and the reconstruction of working life*. New York: Basic Books, 1990.
25. Leiter MP, Maslach C. Nurse turnover: the mediating role of burnout. *J Nurs Manage* 2009;17:331-9.
26. Laschinger H, Wong CA, Grau AL. The influence of authentic leadership on newly graduated nurses' experiences of workplace bullying, burnout and retention outcomes: a cross-sectional study. *Int J Nurs Studies* 2012;49:1266-76.
27. Bakker AB, LeBlanc PM, Schaufeli WB. Burnout contagion among intensive care nurses. *J Advanc Nurs* 2005;51:276-87.
28. González-Morales M, Peiró JM, Rodríguez I et al. Perceived collective burnout: a multilevel explanation of burnout. *Anxiety Stress Coping* 2012;25:43-61.
29. Gascon S, Leiter MP, Andrés E et al. The role of aggression suffered by healthcare workers as predictors of burnout. *J Clin Nurs* 2013;22:3120-9.
30. Savicki V, Cooley E, Gjesvold J. Harassment as a predictor of job burnout in correctional officers. *Crim J Behav* 2003;30:602-19.
31. Ahola K, Hakkanen J. Burnout and health. In: Leiter MP, Bakker AB, Maslach C (eds). *Burnout at work: a psychological perspective*. London: Psychology Press, 2014:10-31.
32. Burke RJ, Shearer J, Deszca G. Burnout among men and women in police work: an examination of the Cherniss model. *J Health Hum Res Admin* 1984;7:162-88.
33. Toppinen-Tanner S, Ahola K, Koskinen A et al. Burnout predicts hospitalization for mental and cardiovascular disorders: 10-year prospective results from industrial sector. *Stress Health* 2009;25:287-96.
34. Toker S, Shirom A, Shapira I et al. The association between burnout, depression, anxiety, and inflammation biomarkers: C-reactive protein and fibrinogen in men and women. *J Occupat Health Psychol* 2005;10:344-62.
35. Bressi C, Porcellana M, Gambini O et al. Burnout among psychiatrists in Milan: a multicenter survey. *Psychiatr Serv* 2009;60:985-8.
36. Dennis NM, Swartz MS. Emergency psychiatry experience, resident burnout, and future plans to treat publicly funded patients. *Psychiatr Serv* 2015;66:892-5.
37. Vaccaro JV, Clark GH Jr. A profile of community mental health centre psychiatrists: results of a national survey. *Community Ment Health J* 1987;23:282-9.
38. Prosser D, Johnson S, Kuipers E et al. Mental health, "burnout" and job satisfaction among hospital and community-based mental health staff. *Br J Psychiatry* 1996;169:334-7.
39. Kumar S, Fischer J, Robinson E et al. Burnout and job satisfaction in New Zealand psychiatrists: a national study. *Int J Soc Psychiatry* 2007;53:306-16.
40. Kumar S, Sinha P, Dutu G. Being satisfied at work does affect burnout among psychiatrists: a national follow-up study from New Zealand. *Int J Soc Psychiatry* 2013;59:460-7.



41. Kumar S. Burnout in psychiatrists. *World Psychiatry* 2007;6:186-9.
42. Ndeti DM, Pizzo M, Maru H et al. Burnout in staff working at the Mathari psychiatric hospital. *Afr J Psychiatry* 2008;11:199-203.
43. Vičentić S, Jovanović A, Dunjić B et al. Professional stress in general practitioners and psychiatrists: the level of psychologic distress and burnout risk. *Vojnosanitetski Pregled* 2010;67:741-6.
44. Martini S, Arfken CL, Churchill MA et al. Burnout comparison among residents in different medical specialties. *Acad Psychiatry* 2004;28:240-2.
45. Korkeila JA, Töyry S, Kumpulainen K et al. Burnout and self-perceived health among Finnish psychiatrists and child psychiatrists: a national survey. *Scand J Publ Health* 2003;31:85-91.
46. Maslach C, Courtois C. Burnout. In: Reyes G, Elhai J, Ford J (eds). *Encyclopedia of psychological trauma*. Hoboken: Wiley, 2009:103-7.
47. Pross C. Burnout, vicarious traumatization, and its prevention. *Torture* 2006;16:1-9.
48. Deighton RM, Gurrin N, Traue H. Factors affecting burnout and compassion fatigue in psychotherapists treating torture survivors: is the therapist's attitude to working through trauma relevant? *J Trauma Stress* 2007;20:63-75.
49. Dal Pai D, Lautert L, Souza SBC et al. Violence, burnout and minor psychiatric disorders in hospital work. *Rev Esc Enferm USP* 2015;49:457-64.
50. Holmqvist R, Jeanneau M. Burnout and psychiatric staff's feelings towards patients. *Psychiatry Res* 2006;145:207-13.
51. Aiken LH, Clarke SP, Sloane DM et al. Hospital nurse staffing and patient mortality, burnout and job dissatisfaction. *JAMA* 2002;288:1987-93.
52. Fischer J, Kumar S, Hatcher S. What makes psychiatry such a stressful profession? A qualitative study. *Australas Psychiatry* 2007;15:417-21.
53. Leiter MP, Day A, Price L. Attachment styles at work: measurement, collegial relationships, and burnout. *Burnout Res* 2015;2:25-35.
54. Firth H, McKeown P, McIntee J et al. Professional depression, "burnout" and personality in longstay nursing. *Int J Nurs Studies* 1987;24:227-37.
55. Meier ST. The construct validity of burnout. *J Occupat Psychol* 1984;57:211-9.
56. Morgan SR, Krehbiel R. The psychological condition of burned-out teachers with a nonhumanistic orientation. *J Human Educat Develop* 1985;24:59-67.
57. Scarfone D. Le syndrome d'épuisement professionnel (burnout): y aurait-il de la fumée sans feu? *Ann Med Psychol* 1985;143:754-61.
58. Schonfeld IS, Bianchi R. Burnout and depression: two entities or one? *J Clin Psychol* 2016;72:22-37.
59. Kroenke K, Spitzer RL. The PHQ-9: a new depression diagnostic and severity measure. *Psychiatr Ann* 2002;32:1-7.
60. Toker S, Biron M. Job burnout and depression: unraveling their temporal relationship and considering the role of physical activity. *J Appl Psychol* 2012;9:699-710.
61. Leiter MP, Durup J. The discriminant validity of burnout and depression: a confirmatory factor analytic study. *Anxiety Stress Coping* 1994;7:357-73.
62. Raedeke TD, Arce C, De Francisco C et al. The construct validity of the Spanish version of the ABQ using a multi-trait/multi-method approach. *Anales de Psicología* 2012;29:693-700.
63. Hakonen JJ, Schaufeli WB. Do burnout and work engagement predict depressive symptoms and life satisfaction? A three-wave seven-year prospective study. *J Affect Disord* 2012;141:415-24.
64. Ahola K. Occupational burnout and health. *People and Work Research Reports* 81. Helsinki: Finnish Institute of Occupational Health, 2007.
65. Leiter MP, Hakonen J, Toppinen-Tanner S et al. Changes in burnout: a 12-year cohort study on organizational predictors and health outcomes. *J Organizat Behav* 2013;34:959-73.
66. Ahola K, Hakonen J. Job strain, burnout, and depressive symptoms: a prospective study among dentists. *J Affect Disord* 2007;104:103-10.
67. Schaufeli WB, Leiter MP, Maslach C. Burnout: 35 years of research and practice. *Career Develop Intern* 2009;14:204-20.
68. Schaufeli WB, Bakker A, Schaap C et al. On the clinical validity of the Maslach Burnout Inventory and the Burnout Measure. *Psychol Health* 2001;16:565-82.
69. Bakker AB, Schaufeli WB, Van Dierendonck D. Burnout: Prevalentie, risicogroepen en risicofactoren. In: Houtman ILD, Schaufeli WB, Taris T (eds). *Psychische vermoedheid en werk: cijfers, trends en analyses*. Alphen a/d Rijn: Samsom, 2000:65-82.
70. Brenninkmeijer V, Van Yperen N. How to conduct research on burnout: advantages and disadvantages of a uni-dimensional approach to burnout. *Occupat Environment Med* 2003;60(Suppl.1):6-21.
71. Roelofs J, Verbraak M, Keijsers GPJ et al. Psychometric properties of a Dutch version of the Maslach Burnout Inventory-General Survey (MBI-GS) in individuals with and without clinical burnout. *Stress Health* 2005;21:17-25.
72. Maslach C, Leiter MP. Early predictors of job burnout and engagement. *J Appl Psychol* 2008;93:498-512.
73. Leiter MP, Maslach C. Burnout profiles: a new approach to understanding the burnout experience. Unpublished manuscript, 2015.
74. Maslach C, Goldberg J. Prevention of burnout: new perspectives. *App Prevent Psychol* 1998;7:63-74.
75. Leiter MP, Laschinger HK, Day A et al. The impact of civility interventions on employee social behavior, distress, and attitudes. *J Appl Psychol* 2011;96:1258-74.
76. Leiter MP, Day A, Gilin-Oore D et al. Getting better and staying better: assessing civility, incivility, distress and job attitudes one year after a civility intervention. *J Occupat Health Psychol* 2012;17:425-34.
77. Demerouti E. Individual strategies to prevent burnout. In: Leiter MP, Bakker AB, Maslach C (eds). *Burnout at work: a psychological perspective*. London: Psychology Press, 2014:32-55.
78. Leiter MP, Maslach C. Interventions to prevent and alleviate burnout. In: Leiter MP, Bakker AB, Maslach C (eds). *Burnout at work: a psychological perspective*. London: Psychology Press, 2014:145-67.
79. Chang E, Eddins-Folensbee F, Coverdale J. Survey of the prevalence of burnout, stress, depression, and the use of supports by medical students at one school. *Acad Psychiatry* 2012;36:177-82.
80. Swetz KM, Harrington SE, Matsuyama RK et al. Strategies for avoiding burnout in hospice and palliative medicine: peer advice for physicians on achieving longevity and fulfillment. *J Palliat Med* 2009;12:773-7.
81. Katsounari I. The road less traveled and beyond: working with severe trauma and preventing burnout. *Burnout Res* 2015;2:115-7.
82. Sandahl C, Lundberg U, Lindgren A et al. Two forms of group therapy and individual treatment of work-related depression: a one-year follow-up study. *Int J Group Psychother* 2011;61:538-55.

DOI:10.1002/wps.20311