

# Defining burnout: What is this syndrome and what sets it apart from other labels?

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*This article is part of a series of articles on doctors' health and wellbeing.*

### Background

Burnout is highly prevalent in the medical profession, yet the term is often used vaguely in both academic and everyday conversation.

### Objective

This article seeks to define burnout and delineate it from similar conditions.

### Discussion

There are multiple theoretical models describing burnout in the literature, identifying various symptoms. A small body of literature has described burnout in doctors. Summarising these bodies of key research indicates that burnout is a late-stage reaction to chronic stress where self-protective psychological mechanisms are invoked to minimise further psychological and physical strain. It comprises five core symptom domains of exhaustion, depersonalisation, reduced sense of achievement, heightened affective reactivity, and cognitive and performance problems. Burnout shows a distinct aetiology and symptom profile from depression, stress and vicarious trauma. Greater understanding of what burnout is will facilitate earlier recognition and more specific intervention to prevent exacerbation.

**BURNOUT** is pervasive within the medical profession.<sup>1-3</sup> This is concerning given the serious consequences associated with burnout, including high levels of distress, functional impairment and even increased risk of suicide.<sup>4,5</sup> However, this prevalence appears to have created vagueness about what 'burnout' means.<sup>1</sup> This conceptual confusion has led to criticisms of burnout, with some arguing that it is not a meaningful term.<sup>6</sup> This article seeks to offer some clarity for clinicians about the nature of burnout, particularly among doctors, by summarising key literature in the field. First, a brief account of how burnout has been conceptualised is offered, followed by a proposal for a more specific definition that incorporates research among doctors and medical trainees. Subsequently, burnout will be distinguished from other related entities of depression, stress and vicarious trauma. Finally, a brief consideration of interventions for individuals to manage burnout is discussed.

### Defining burnout

The term 'burnout' was introduced to the medical literature by Freudenberger in 1974, who defined burnout as becoming 'worn out' from excessive demands.<sup>7</sup> Consistent with this initial conceptualisation, some definitions of burnout view it purely as a state of exhaustion. This exhaustion can manifest itself physically, emotionally and cognitively,<sup>8,9</sup> and is reflected in measurement

tools such as the Copenhagen Burnout Inventory<sup>10</sup> and the Shirom-Melamed Burnout Measure.<sup>11</sup>

Defining burnout purely as a state of exhaustion, however, might seem too simplistic for anyone who has witnessed or experienced burnout. A more elaborated definition comes from the work of Maslach and Schaufeli, who suggested a tridimensional model of burnout. They extended burnout from purely exhaustion (focusing on emotional exhaustion) to also include depersonalisation (acting impersonally towards patients and experiencing reduced motivation) and a lowered sense of personal accomplishment.<sup>12</sup> This model has been popularised through the Maslach Burnout Inventory – the dominant burnout measurement tool.<sup>13</sup> Likewise, the International Classification of Diseases – 11th edition (ICD-11) definition of burnout as an occupational phenomenon (QD85) shows a striking resemblance to the Maslach model.<sup>14</sup>

Yet, further research suggests even this conceptualisation might still be too simplistic. Recent Australian research by Tavella and Parker has supported the symptoms of exhaustion, depersonalisation and reduced personal accomplishment; however, they also found additional symptoms of anxiety and stress, irritability, executive functioning issues and reduced functioning.<sup>15,16</sup> Further research has challenged the notion of burnout as an homogenous syndrome. One model proposes three such subtypes: (1) 'frenetic' burnout,

where individuals overload themselves with work; (2) ‘underchallenged’ burnout, where individuals feel bored, indifferent and stagnant in their professional development; and (3) ‘worn-out’, where individuals neglect their responsibilities, easily become exhausted and feel underappreciated.<sup>17,18</sup> This theoretical variety suggests that the vagueness of what ‘burnout’ means in both everyday and academic conversations might arise from burnout being a highly nuanced syndrome.

Despite the high prevalence of burnout in doctors and medical trainees,<sup>1-3</sup> comparatively minimal focus has been given to documenting the experiences of this group. Among this small body of research, the symptoms described very much align with those documented in the above literature.<sup>19-26</sup> However, research examining doctors’ experiences of burnout remains unconsolidated and has tended not to make clear reference to the burnout theory literature. Although this article does not represent an exhaustive literature review, it aims to summarise key works from these two bodies of literature as an initial step towards their reconciliation.

Given the above evidence, I propose that burnout can be thought of as a late-stage reaction to chronic stress where self-protective psychological mechanisms are invoked to minimise further psychological and physical strain.<sup>21,27</sup> There appear to be five core symptoms of burnout. First, exhaustion spans physical, cognitive and emotional fatigue.<sup>19,21,24-26</sup> Second, depersonalisation involves becoming detached from, and aloof towards, other people.<sup>19,23,24</sup> Two key aspects of depersonalisation include withdrawing from one’s personal and professional relationships,<sup>19,20,22,26</sup> and developing a sense of indifference and demotivation towards one’s work.<sup>19,20,22,23,25,26</sup> The third symptom comprises losing a sense of achievement, lowered self-esteem and neglecting one’s basic physical and psychological needs.<sup>19,23,24</sup> Fourth, doctors experiencing burnout can also find their emotions become heightened,<sup>20-23,25</sup> in particular being more irritable.<sup>20,21,25</sup> Likewise, anxiety and stress levels also increase, fuelling self-doubts and impeding the ability to switch off of work.<sup>19,21,22,24,25</sup> The final symptom domain of burnout concerns reduced cognitive

functioning (eg slower processing speed, poor concentration) and reduced quality of work.<sup>19,21,25</sup>

### Distinguishing burnout from related constructs

#### Depression

There has long been a question as to whether burnout is simply a type of occupational depression.<sup>6,28</sup> Indeed, the symptoms of depersonalisation, exhaustion and lowered sense of accomplishment do resemble low mood, lethargy and diminished self-esteem. However, research has found that although depression symptoms are associated with emotional exhaustion, they tend to show weaker links with depersonalisation and low personal accomplishment.<sup>12</sup> Additionally, where depression is characterised by depressed mood with a sense of *hopelessness* (ie despair), burnout is marked by exhaustion with a sense of *helplessness* (ie feeling ‘stuck’).<sup>29,30</sup> Burnout also shows fewer neurovegetative symptoms than melancholic depression.<sup>29</sup> Individuals who have experienced both depression and burnout distinguish the two in terms of attribution – burnout tends to have a clearly identifiable cause, whereas this is less often the case for depression.<sup>30</sup> These individuals also distinguish the emotional quality of the two, noting that depression involves sadness whereas burnout invokes a sense of emptiness; one can be burnt out but still in a good mood.<sup>30</sup>

#### Stress

A closely related term to burnout is ‘stress’, which is perhaps even more ubiquitous and vague than burnout. Psychological stress has traditionally been defined using a transactional model. This proposes that potentially stressful events trigger two appraisals: first, whether the event represents a threat to oneself and, second, whether one has the capacity to either directly manage the threat or manage the emotions associated with the threat.<sup>31</sup> Two key distinctions can be drawn between stress and burnout. First, stress is a temporary adaptation to a threat, whereas burnout can be viewed as a breakdown in this adaptation after chronically managing stressors.<sup>32</sup> Second, burnout is defined by changes in one’s behaviours and

attitudes, but these changes are not inherent to definitions of stress.<sup>33,34</sup> Accordingly, stress can be viewed as a more acute response to a threat, whereas burnout is a more global response to chronic exposure to stressors. In this way, stress is a precursor to burnout.

#### Vicarious trauma

Clinicians working with patients who have experienced trauma are at risk of experiencing trauma themselves. Termed ‘vicarious trauma’, this is thought to arise in the context of an empathic therapeutic relationship where clinicians are repeatedly exposed to accounts of traumatic experiences.<sup>35,36</sup> Although not directly exposed to the traumatic event itself, clinicians can experience trauma symptoms such as intrusive imagery, arousal, avoidance behaviours and negative changes to cognitions.<sup>36</sup> The symptoms of vicarious trauma do overlap with burnout to an extent (most notably depersonalisation, anxiety and changes in cognitive functioning); however, the symptomatology of burnout is broader. Further, the aetiological mechanisms of the two are quite different, with burnout arising from a broader array of stressors than vicarious trauma. Some have suggested that these aetiological differences indicate that burnout might be more amenable to intervention than vicarious trauma.<sup>36</sup>

### Managing burnout

Knowing what burnout is (and what it is not) enables recognition of this syndrome. However, recognition then requires action. Having a complex aetiology,<sup>37</sup> there is no ‘quick fix’ for burnout that individuals can use; however, the fundamental principle is to identify and remediate its triggers. Oftentimes this will require time away from the stressor (in particular work); this will help one to gain enough distance to identify these triggers and to recover from the effects of burnout.<sup>38,39</sup> Time away from work also provides an opportunity to develop strategies for preventing relapse. This includes psychological strategies and lifestyle changes, which might include how or what work one undertakes. Understanding one’s values also seems to be important.<sup>40</sup> Values can offer a framework to help align one’s personal and professional tasks with what one finds to be

meaningful, thereby buffering against the development of burnout. Further information on the clinical management of burnout has been described by van Dam.<sup>39</sup>

### Conclusion

Perhaps because of its pervasiveness, it seems that burnout means something different to everyone. Despite its nuance, there are some defining characteristics of this syndrome. Burnout can be seen as a late-stage reaction to chronic stress where self-protective psychological mechanisms are invoked to minimise further psychological and physical strain, comprising five core symptom domains. Being clear about what burnout is will help to accurately recognise this syndrome and thereby provide greater direction for how best to address its symptoms (Table 1). In turn, this will facilitate earlier intervention for those in need.

### Key points

- Burnout has become an umbrella term, with confusion about what it refers to.
- Burnout is a late-stage reaction to chronic stress where self-protective psychological mechanisms are invoked to minimise further psychological and physical strain.
- The core symptoms of burnout are exhaustion, depersonalisation, reduced sense of achievement, heightened

affective reactivity, and cognitive and performance problems.

- Burnout is conceptually distinct from, but related to, depression, stress and vicarious trauma.
- Clarity about what burnout is – and is not – can help with recognition of this syndrome and, in turn, implementation of effective changes earlier in its course.

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**Table 1. Distinguishing features of burnout from other constructs**

Construct	Distinctions from burnout	Contrasting features of burnout
Depression	<ul style="list-style-type: none"> <li>• Sense of hopelessness</li> <li>• More neurovegetative symptoms</li> <li>• Cause can be less clear</li> <li>• Greater feeling of sadness</li> </ul>	<ul style="list-style-type: none"> <li>• Sense of helplessness</li> <li>• Fewer neurovegetative symptoms</li> <li>• Causes clearer</li> <li>• Feelings of emptiness</li> </ul>
Stress	<ul style="list-style-type: none"> <li>• Temporary adaptation to a threat</li> <li>• Can include changes to behaviours and attitudes</li> </ul>	<ul style="list-style-type: none"> <li>• Response to a chronic stress experience</li> <li>• Defined by behavioural and attitudinal changes</li> </ul>
Vicarious trauma	<ul style="list-style-type: none"> <li>• More specific symptoms (depersonalisation, anxiety, cognitive changes)</li> <li>• Specific aetiology (arises from chronic exposure to patients’ traumatic experiences)</li> </ul>	<ul style="list-style-type: none"> <li>• Broader symptoms (also includes exhaustion, reduced achievement and additional emotional changes)</li> <li>• Broader array of causes</li> </ul>

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