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Commentary

Is Burn-Out Syndrome Preventable?

Vesselin Tenev*

Clinical Assistant Professor, Department of Psychiatry, University of Iowa, USA

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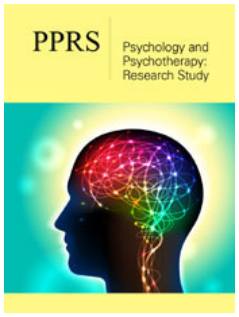

***Corresponding author:** Vesselin Tenev, Clinical Assistant Professor, Department of Psychiatry, University of Iowa, USA

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Introduction

From "the Great resignation", to the "quiet quitting" we had all been inundated with headlines describing what essentially is a mild depression – burnout syndrome. It is hard to estimate the real prevalence of the condition, since there are different methodologies in reporting, different occupation fields, different various models of interpretation. According to WHO definition for this phenomenon, Burnout consists of three dimensions: 1) feelings of energy depletion or exhaustion, 2) increased mental distance from one's job, or feelings of negativism or cynicism related to one's job, and 3) reduced professional efficacy; all occurring within occupational context and not being experienced in other areas of life (WHO, 2019, ICD-11).

Burnout syndrome had been assessed by many instruments. One – dimensional scales focus mostly on exhaustion, such as Burnout Measure (BM), Shirom Melamed Burnout Measure (SMBM), Copenhagen Burnout Inventory (CBI). Multidimensional scales, such as the Maslach Burnout Inventory (MBI) and its' generalized version, valid across different professions (MBI-GS), containing three factors: emotional exhaustion, depersonalization/ cynicism/ distancing from the job, reduced personal accomplishment/reduced efficacy. MBI-GS has its companion Area of Work life Survey, assessing the occupational factors impact on psychological reactions, such as Workload, Control, Reward, Community, Fairness, Values. Other multidimensional scales are Link Burnout Questionnaire, which also assess the disillusionment with existential expectations, sense of professional inefficacy, related to evaluation of employee's own professional competences; and one of the most complex ones - the Burnout Assessment Tool (BAT) with core symptoms of exhaustion, mental distance, cognitive impairment, emotional impairment. It is interesting that the conceptualization of burn – out syndrome includes more and more symptoms that overlap with some depressive disorder, diagnostic criteria: low mood, fatigue, low motivation. Some symptoms could be also interpreted as dissociative experiences. The key difference remains that the symptoms (dimensions) of burn-out syndrome are triggered and are experienced exclusively in the context of a working environment.

The causal relationship between environmental factors and individual response to them is still difficult to interpret in most aspects of human psychology and psychopathology. The variables triggering, shaping and defining burnout syndrome are even more complex and elusive. Occupational environment keeps changing faster than ever, standards and requirements evolve exponentially together with the ever-accelerating intricacies of software development, workspace ethics, norms and expectations.

AI contributes further to overwhelming sense of job insecurity. Economic realities with structural unemployment, transformation of the economic vectors, policies can create further sentiment of instability. The need for constant adaptation pushes the limits of personal coping strategies, behavioural patterns and biological predisposition for resistance to stress. Despite that some principles regarding attitude towards work – related stress remains universally

true. Such is the Karasek "Demand Control" model. It posits that the higher level of responsibility coupled with the lowest control, lead to the worst stress experienced.

Loss of personal sense of achievement, accomplishment combined with loss of control over one's professional trajectory could trigger depressive symptoms. The overwhelming experience of inadequacy in our job performance can resemble bereavement for the lost aspirations of a career, that we erroneously believed would elevate our self-esteem, our sense of purpose. This can be too much to handle psychologically for anyone. It can lead to dissociative experiences, derealization, depersonalization, eg "Imposter syndrome". They can be diagnosed as a dissociative disorder, or could be assessed as prodromes of depression, or acute stress reaction. The experience of loss can be compared sometimes to a grieving reaction – another condition without unanimous diagnostic classification place of belonging.

Burn-out syndrome is a clinical challenge equally for mental health providers (therapists, prescribers) and for HR specialists. How to predict burn-out, how to prevent it becomes a focal point of multidisciplinary efforts. However, the multiple approaches focus way more on the here and now assessment, rather than taking into account the timeline of the presentation. When dealing with burn-out syndrome, it might seem that immediate help consists of risk evaluation for specific behaviours of employees, such as quitting, verbal or physical aggression. Is it possible to make prognosis about such behaviours after the work environment is changed? Would anyone suggest, recommend or observe for follow ups for employees behaviours after they'd be laid off? Even if employer arranges for a therapy intake interview after the employee is not on the team anymore, how long would it take, before they start having therapy outside of their job?

It is worth noting that employee can continue to exhibit burn-out symptoms even after his work environment had changed, even after they had switched to a different employer. It is vastly unclear, if such people would seek treatment at all, being in-between jobs, insurance plans. Would a burn-out syndrome escalate to severe, full blown depressive episode, regardless of the employment outcome? Would they need intense therapy, or medication or both. None of these questions can be answered currently with any certainty.

Any sign in psychology and psychopathology has to have two dimensionality - 1) cross section, here and now description (intensity, context), and 2) timeline – duration. While there is duration criteria for all forms of depressive disorders in ICD 10, ICD 11, DSM 5.0, most burnout assessment questionnaires do not necessarily address the timeline aspect (it is confined to the answers never, rarely, sometimes, often or always). Some of the symptoms that can occur, or become visible during the job assignments, they can continue after the discontinuation of the job contract, especially of the person is not being observed, falls through the cracks. The nosologic entity of Acute stress reaction, that by itself could resemble burn-out is 3 months. How long does a burnout continue? The longest duration of a condition that could be part of the differential of burn-out syndrome, dysthymia could be years.

I'd humbly propose for discussion several items to better detect increased risk of burn-out syndrome, or higher likelihood of such condition to escalate into a depressive episode. In order to predict better who would be in need for therapy and possibly med management, we might need to consider the following:

A. presence of negative emotional content – low mood, exhaustion, distress, distancing from the job requirements, lack of motivation to follow through with requirements – for longer than 2 weeks;

B. worsening of cognitive performance – longer than a month;

C. presence of above symptoms not only at work, but also in other aspects of life;

D. repetitiveness of these symptoms in different work environments, different career, while employed, and unemployed;

E. unexplained somatic symptoms;

This list could be longer. We would need a better cooperation and communication between providers in the field of occupational psychology, psychiatry and HR in order to respond to the ever-growing demand for revaluation, redefining burn-out, anxiety and depressive disorders. This will facilitate a better diagnostic process, more successful treatment and prevention of this condition. It is possible. Especially if we work together.