A Program of Research on Burnout-Depression Overlap

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In 2013, I teamed up with Renzo Bianchi and Éric Laurent. We began to study the relationship between job-related burnout and depression. A paper published in this newsletter describes how we met (Schonfeld, 2016). Since then Jay Verkuilen of the CUNY Graduate Center began to work with us. We collaborated on a series of empirical studies (enumerated below), as well as conceptual pieces on burnout-depression (Bianchi, Schonfeld, & Laurent, 2018; Schonfeld, Bianchi, & Luehring-Jones, 2017) and commentaries on physician burnout (e.g., Bianchi, Schonfeld, & Laurent, 2017; Schonfeld, 2018). Below is a partial list of our empirical research.

5,575 French schoolteachers (Bianchi, Schonfeld, & Laurent, 2014);
1,386 U.S. teachers (Schonfeld & Bianchi, 2016);
184 New Zealand teachers (Bianchi, Schonfeld, Mayor, & Laurent, 2016);
911 French schoolteachers and other school employees (Bianchi & Schonfeld, 2018);
734 U.S. teachers (Schonfeld, Verkuilen, & Bianchi, 2019);
17,670 individuals in a variety of jobs as part of a meta-analysis of the last ten years of research in up to 15 samples (Schonfeld, Verkuilen, & Bianchi, in press).

According to Maslach, Jackson, and Leiter (2016), burnout is a work-induced syndrome that combines emotional exhaustion (EE, sometimes called just exhaustion), depersonalization (DP, also called cynicism), and a reduced sense of personal accomplishment (PA). EE encompasses feelings that work drained one of one's energy. It is burnout's core. DP involves withdrawal from one's job and detachment from the people connected to it (e.g., students, patients, customers). It is a way of coping with EE. Reduced PA involves a negative self-evaluation of what an individual has accomplished in his or her job. It is a long-term repercussion of EE (Maslach, Schaufeli, & Leiter, 2001).

My colleagues and I obtained several research findings that shed light on the burnout-depression relationship. First, it has been argued that a key difference between burnout and depression is that burnout is caused by adverse working conditions while depression is more global in origin. When individuals experiencing burnout symptoms are asked what they ascribe their symptoms to, fewer than half attribute those symptoms to work (Bianchi & Brisson, 2017). What is called burnout is likely to have several causes, including factors outside of the workplace. In this connection we found that, compared to individuals with low scores on burnout scales, individuals with *very* high scores are more likely to have a history of depressive and anxiety disorders and to be currently taking antidepressant and antianxiety medication (Bianchi et al., 2014; Schonfeld & Bianchi, 2016). Similar findings were obtained by Rössler, Hengartner, Ajdacic-Gross, and Angst (2015). There is also abundant evidence that adverse working conditions lead to increases in depressive symptoms and elevated risk of a depressive disorder (Schonfeld & Chang, 2017).

Second, our research indicates that EE, burnout's core, correlates too highly with depressive symptoms scales to be considered something apart from what depressive symptom scales measure. We obtained findings in which the correlations between [emotional] exhaustion and depressive symptoms were greater than .70, and close to or higher than .80 when measurement error is controlled (Bianchi et al., 2014, 2016; Bianchi & Schonfeld, 2018; Schonfeld & Bianchi, 2016). In research in which we applied confirmatory factor analyses in three different samples (Schonfeld et al., in press) we found that the latent [emotional] exhaustion and latent depression correlated higher than .80.

Third, we note that both depression and burnout have been conceptualized in two different ways. One way is the traditional diagnostic way. A person meets criteria for the diagnosis or does not. Maslach et al. (2016) defined the state of burnout as "a crisis in one's relationship with work" (p. 21). A problem with this approach is that there are no consensual criteria for identifying a "case" or state of burnout (Bianchi et al., 2014; Rotenstein et al., 2018; Schonfeld & Bianchi, 2016). For practical reasons, researchers used cutoff scores on burnout scales to identify cases of burnout. We found that often enough burnout researchers don't use suffi-

ciently high cutoff scores (e.g., the top tercile) to identify cases involving a work-related "crisis." These cutoffs don't differentiate individuals with ordinary, nonpathological fluctuations in fatigue from individuals who are truly suffering (Bianchi, Schonfeld, & Laurent, 2019).

By contrast, there are criteria for identifying cases of major depression. When we have treated burnout categorically/diagnostically based on *very* high cutoff scores, we found that such individuals were likely (probability > .80) to meet criteria for provisional diagnoses of depression (Bianchi et al., 2014, 2016; Schonfeld & Bianchi, 2016).

Fourth, another way of conceptualizing burnout and depression is by treating them as continua (like temperature). Burnout scales such as the subscales of the Maslach Burnout Inventory (MBI) provide EE, DP, and PA scores. The scores reflect the extent to which an individual is affected. Developments in research on psychopathology have indicated that depression may be better conceptualized as reflecting a continuum or a dimension (Caspi et al., 2014; Kotov et al., 2017). Depression and anxiety scales correlate very highly; scores on depression and anxiety scales likely reflect the same underlying dimension of psychopathology. We found that the EE subscale highly correlates with depressive and anxiety symptom scales, suggesting that all three scales reflect the same underlying dimension of psychopathology (Schonfeld et al., 2019, in press).

Fifth, we have also shown that burnout and depression have highly parallel nomological networks. For example, the cognitive features associated with depression include pessimistic attributions, rumination, and dysfunctional attitudes such as perfectionism and a pathological need for approval. We found that those cognitive features are equally associated with burnout (Bianchi & Schonfeld, 2016). We also found that depression and burnout are about equally related to stressful life events occurring outside of work, job adversity, and workplace support (Schonfeld & Bianchi, 2016; Schonfeld et al., 2019).

Sixth, our research has been criticized on two grounds. First, "burnout is an occupationally specific dysphoria that is distinct from depression as a broad based mental illness" (Maslach & Leiter, 2016, p. 107). This criticism falls apart because earlier men-

tioned developments in the psychopathology literature indicate that depression can be satisfactorily conceptualized dimensionally. What Maslach and Leiter in effect do is compare burnout as a dimensional factor to the diagnostic category of depression, which reflects only the high end of the depression continuum. When both EE and depression are treated dimensionally, their correlations are too high to suggest that they reflect different constructs (Bianchi & Brisson, 2017; Bianchi et al., 2014; Schonfeld & Bianchi, 2016; Bianchi & Schonfeld, 2018; Schonfeld et al., in press).

The second part of the criticism is that the "nine-item depression measure (Patient Health Questionnaire, PHQ-9) used in [Schonfeld & Bianchi, 2016] includes five items that refer explicitly to fatigue (lack of interest, trouble sleeping, trouble concentrating, moving slowly, and feeling tired)" (Maslach & Leiter, 2016, p. 107). In other words, the depression scale my colleagues and I have used include items that measure burnout. That is why the correlation is so high.

This second criticism is not justifiable. One could argue the reverse. Why are burnout scales poaching items from the DSM symptoms used to diagnose depression? One reason why is that research on burnout largely developed independently of research in "psychiatry, behavioral psychology, and neurobiology on stress-induced conditions such as depression" (Sconfeld et al., in press). Maslach and Leiter identified "lack of interest" as a symptom of burnout, a symptom that is found on the PHQ-9. Actually, the symptom as written in the PHQ-9, the instrument we have used in the research in question, is "Little interest or pleasure in doing things." Kroenke and Spitzer (2002) included that symptom in the PHQ-9 because it reflects anhedonia. Anhedonia is one of the two cardinal symptoms of major depression. A diagnosis of depression could not be made if both anhedonia and depressed mood are absent. Anhedonia is, thus, a very important symptom of depression. The PHQ-9 was co-developed by Robert Spitzer, the prime mover of the revisions of the DSM that led to the emergence of DSM-III and the DSM's later versions.

Clearly some depressive symptoms have a match in burnout scales. These include the fatigue symptoms (e.g., feeling tired and having sleep problems). According to DSM-5 "often insomnia or fatigue is the presenting complaint" in depression (American Psy-

chiatric Association, 2013, p. 162). Skilled workplace physicians can recognize the underlying depression (Kahn, 2008). Burnout clearly does not have a monopoly on these symptoms.

Seventh, in our efforts to closely examine the relationship between MBI burnout and depression, we created depression scales in which we deliberately deleted fatigue-related items. The correlations between EE and each of two different depression scales barely changed when we dropped fatigue items from the depression scales (from .76 to .74 and from .74 to .71) (Schonfeld et al., 2019). Moreover, when we examined the correlation of EE with an anxiety scale in which there was no item (symptom) content overlap, the EE-anxiety correlation was .69. In every case, the EE-depression and the EE-anxiety correlations were stronger than the correlations between EE and each of the other two dimensions of burnout, DP (.60) and PA (-.44).

This brings me to the eighth point our research leads to. Because burnout is thought to be a syndrome comprising EE, DP, and reduced PA, one would expect that the correlation between EE, burnout's core, with DP and PA to be stronger than the correlation between EE and depressive and anxiety symptoms. That is not the case. The correlations of EE with DP and PA are weaker than the Pearson correlations between EE with depressive symptoms (Schonfeld et al., in press), suggesting that burnout is not a syndrome and is more likely to be a depressive condition. Our findings are not an anomaly. Other researchers have also linked burnout with depression. Ahola, Hakanen, Perhoniemi, and Mutanen (2014) linked burnout to depression in their research on dentists. In their research on physicians, Wurm et al. (2016) also linked burnout to depression.

The upshot is that when a worker complains about suffering from burnout, we should consider the possibility that he or she may be experiencing high levels of depressive symptoms, with all their harmful ramifications (e.g., suicide risk). There are evidence-based treatments for depression that can help such a worker. It is also important to investigate the working conditions to which the individual is exposed. Adverse working conditions such as low levels of decision latitude, effort-reward imbalance, bullying, and the absence of organizational justice can contribute to the emergence of depressive symptoms (Schonfeld & Chang, 2017). It would be helpful to find out what could be done to change depresso-

genic working conditions, if indeed working conditions are problematic.

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Book Announcement
Cyberbullying in Schools Workplaces, and Romantic Relationships: The Many Lenses and Perspectives of Electronic Mistreatment

Edited by Gary W. Giumetti, Quinnipiac University, USA and Robin M. Kowalski, Clemson University, USA

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This is fascinating reading for researchers and upper-level students in social psychology, industrial-organizational psychology, and developmental psychology; as well as educators and administrators.
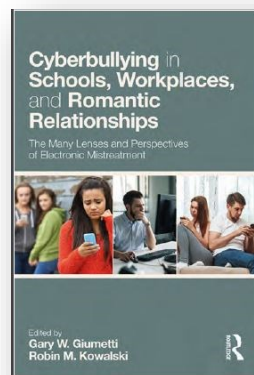
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