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Research report

The relationship between burnout and depressive symptoms in patients with depressive disorders

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ABSTRACT

Background: Burnout – physical or psychological fatigue in the personal, work and client-related work domains – appears to share numerous overlapping characteristics with major depressive episodes. However, whether burnout and depression are in fact separate conditions is still ambiguous. Our aim was to examine burnout in a clinically depressed patient sample.
Methods: Outpatients with a DSM-IV depressive episode (major depressive episode and dysthymic disorder) completed the Copenhagen Burnout Inventory (CBI) and the Quick Inventory for Depressive Symptomatology, Self-Rated (QIDS-SR). The relationship between CBI-defined burnout and depressive symptoms was examined using correlation and hierarchical multiple regression analyses.
Results: Depressed patients had high rates of CBI-defined burnout as well as significant correlations between burnout scores and overall depression severity scores. Individual depressive symptoms were significantly higher between patients with and without burnout, and significantly correlated with burnout scores, with the exception of guilt/worthlessness. Multiple regression analysis identified changes in sleep and fatigue as significant predictors of burnout.
Limitations: The main limitations of the study were the sample size, the broad definition of depression, and the cross-sectional design.
Conclusions: The high burnout scores and correlations between burnout and depression severity observed in this study highlight the importance of understanding burnout in depressed patients. Despite the significant overlap between burnout and depression, the relationship between these two concepts still requires further clarification.

1. Introduction

Major Depressive Disorder (MDD) is a highly prevalent psychiatric condition with heterogenous presentations. Common symptoms of depression include low mood, anhedonia, fatigue, psychomotor retardation, and sleep disturbances. Several of these symptoms overlap with burnout, which is a syndrome that manifests as fatigue, sleep changes, headaches, hopelessness/helplessness, anxiety, reduced self-esteem, behavioral changes and interpersonal disturbances in individuals whose emotional resources become depleted under the burdens of his/her work (Freudenberger, 1974; Seti, 2008). In fact, Freudenberger (1974), who first coined the term in 1974, described a burned-out worker as somebody who "looks, acts and seems depressed". Initially identified in human services sector workers, burnout has since been observed in numerous other occupations (Schutte et al., 2000). The burnout syndrome is etiologically complex, with work environments, personalities, motivation and personal attitudes all contributing to various degrees towards the development of symptoms as well as the subsequent personal, occupational and socioeconomic fallout (Iacovides et al., 2003).

Despite the widely accepted view that some type of connection exists between burnout and depression, efforts to further clarify and empirically define this relationship have been met with conflicting findings and diverging views. Burnout and depression are usually regarded as separate constructs in spite of the significant similarities. Burnout is generally thought of as a strictly work-related phenomenon whereas depression is thought of as pervasive and context-independent (Bakker et al., 2000; Maslach et al., 2001). It is possible that burnout and depression result from similar processes that occur in different contexts. Burnout and depression are both related to a lack of reciprocity, but in occupational domains and in intimate relationships, respectively (Bakker et al., 2000). It has also been suggested that burnout is a prodromal phase in the development of a Major Depressive Disorder (Ahola et al., 2005; Iacovides et al., 2003). A cross-sectional study using the data from the Finnish

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Health 2000 Study demonstrated that 52.9% of those with severe burnout had a depressive disorder, and that recent depressive episodes (in the past month) are correlated with a higher prevalence of severe burnout. The authors concluded from these data that burnout and depression are related but separate concepts (Ahola et al., 2005). Other studies have also supported similar views, identifying a moderate correlation and shared variances of around 20% between the two conditions, possibly due to co-development (Iacovides et al., 2003).

However, a more recent study demonstrated that the symptomatology of depression and burnout are virtually indistinguishable on both the overall depression score and the scores on the nine criteria-defining symptoms of depression (Bianchi et al., 2013). Moreover, symptoms that are pervasive and affect the subjects' experiences outside the workplace – sleep changes, cognitive impairment, and suicidal ideation – have been observed in people with burnout (Bianchi et al., 2013; Sandstrom et al., 2005). In addition, burnout has also been correlated with general traumatic life events (Mather et al., 2014). These findings challenge the notion that burnout and depression are separate entities that develop from experiences in different spheres of life, and highlight the need to further examine the extent to and the manner in which burnout and depression are related.

To date, the majority of the research on depression and burnout has studied populations who are in specific occupations and who have relatively low prevalence of depression and burnout. Very few have specifically examined the phenomenon of burnout in populations with clinical depression. Therefore, our study aims to explore the extent to which depression symptoms are correlated with and explain burnout in a sample of subjects with clinically established depressive symptoms from all types of occupational backgrounds. We conducted our study within the framework of burnout as a state of general, work-related, and client work-related exhaustion and fatigue, using the Copenhagen Burnout Inventory.

2. Methods

2.1. Study participants

This chart review study was approved by the Clinical Research Ethics Board of the University of British Columbia. Participants were taken from consecutive patients ($N=127$) referred by family physicians and psychiatrists to the UBC Mood Disorders Outpatient Clinic. Diagnoses were made by board-certified psychiatrists using clinical interviews supplemented by symptom and criteria checklists. Only subjects who fulfilled the following inclusion criteria ($N=77$) were part of the analysis: 1) completed QIDS-SR and CBI questionnaires, 2) provided information about occupational status, and 3) had clinically significant depression, defined as a diagnosis of Major Depressive Disorder, dysthymic disorder or Bipolar Disorder, depressed, and/or a QIDS-SR total score of 11 or higher. Table 1 summarizes the characteristics of the participants. Mean age of the participants was 41.6 (SD = 13.4) years.

Table 1
Characteristics of the participants ($N=77$).

Characteristic	*N* (%)
Sex	
Male	30 (39)
Female	47 (61)
Primary diagnosis	
Major Depressive Disorder	56 (72.7)
Bipolar Disorder, depressed	12 (15.6)
Dysthymic disorder	2 (2.6)
Other	7 (9.1)
Medications	
Antidepressants	46 (59.7)
Mood stabilizers	14 (18.2)
Atypical antipsychotics	15 (19.5)
Occupations	
Unemployed/disability/retired	17 (22.1)
Student	1 (1.3)
Executive/administrative	3 (3.9)
Professional	8 (10.4)
Technical support	7 (9.1)
Sales	5 (6.5)
Clerical/administrative support	11 (14.3)
Service	5 (6.5)
Precision production/crafts	3 (3.9)
Operator/laborer	6 (7.8)
Other	11 (14.3)
Client-based occupations	
Yes	33 (55.9)
No	26 (44.1)
Unknown	5 (8.9)

2.2. Questionnaires

Participants completed the Copenhagen Burnout Inventory (CBI) and the Quick Inventory of Depressive Symptomatology, Self-Rated (QIDS-SR) as a part of their initial clinical assessment at the outpatient Mood Disorders Clinic.

2.2.1. QIDS-SR

The QIDS-SR is a self-rated scale used to determine the profile and severity of depressive symptoms (Rush et al., 2003). It has been validated and widely used as a clinical symptom rating tool. There are 16 questions that assess the nine criterion symptoms of depression – depressed mood/irritability, decreased interest/pleasure, change in weight/appetite, change in sleep, change in activity, fatigue/low energy, feelings of worthlessness/guilt, reduced concentration and suicidality. Scores of 0–10 indicate normal or mild depression; 11–15 indicate moderate depression; 16–20 indicate severe depression; ≥ 21 indicate very severe depression. The QIDS-insomnia score is calculated from the first four items while the QIDS-atypical symptoms score is calculated from items 4, 7, 9 and 15.

2.2.2. The Copenhagen Burnout Inventory (CBI)

The Copenhagen Burnout Inventory (CBI) was developed using the data from the Danish PUMA study on burnout among human service workers in Copenhagen, and includes 19 questions categorized into three subscales (Kristensen et al., 2005). The CBI is based on the idea that burnout is primarily a condition of personal and work-related exhaustion. The Personal burnout subscale contains 10 questions that assess the level of fatigue or exhaustion regardless of occupational status. It includes questions such as "How often do you feel tired?" and "How often do you think: I can't take it anymore?". The second subscale measures Work-related burnout, which is defined as "the degree of physical and psychological fatigue and exhaustion that is perceived by the person as related to his/her work". The third subscale measures Client-related burnout, which is defined as "the degree of physical and psychological fatigue and exhaustion that is perceived by the person as related to his/her work with clients" (Kristensen et al., 2005). All questions, except for "Do you have enough energy for family and friends during leisure time?", are keyed in the same direction. Responses for each item are rated as "never/almost never", "seldom", "sometimes", "often" or "always". The labels are recoded in increments of 25, with 0 being the equivalent of "never/almost never" and 100 being the equivalent of "always".