

Case report

Burnout in psychiatric practice: a case report

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INTRODUCTION

The association between work conditions and occurrence of physical diseases and mental disorders has been more intensely studied since the second half of the 20th century,¹ but its clinical acknowledgement is still small.² Burnout syndrome has been the focus of many prevalence studies,³ analyses of construct validity,⁴ identification of risk or protection factors,⁵ besides being a topic for press articles. In the medical literature, it has been present in areas other than psychiatry, especially in occupational, psychosomatic medicine and medical clinic.

Prevalence studies involving health professionals showed burnout rates ranging between 30 and 47%.^{6,7} The burnout rate in the population of Finnish workers has reached 27.6%.⁸ In Brazil, its occurrence is around 10%.⁹

Burnout is defined as a condition of work-related psychic suffering. It is associated with physiological changes resulting from stress¹⁰ (higher risk of infections, neuroendocrine changes in the hypothalamic-hypophyseal-adrenal axis, hyperlipidemia, hyperglycemia and increased cardiovascular risk), alcohol and substance abuse,¹¹ risk of suicide¹² and anxiety and depressive disorders,^{13,14} besides socioeconomic implications (absenteeism, specialty dropout, decrease in productivity^{14,15}). Nevertheless, it is not part of any psychiatric classification.

Freudenberger,^{16,17} in 1974, described burnout as an “internal fire” resulting from the tension produced by modern life, negatively affecting the individual’s subjective relationship with work. According to Maslach et al.,¹⁸ burnout is a psychological syndrome resulting from chronic interpersonal stressing factors and is characterized by emotional exhaustion, depersonalization (or cynicism) and reduction in personal accomplishment (or professional efficacy). **Emotional exhaustion** (EE) is characterized by intense fatigue, lack of forces to face a working day and feeling of being demanded more than one’s emotional limits. **Depersonalization** (DE) is characterized by emotional avoidance and indifference toward work or service users. Reduced **personal accomplishment** (PA) is expressed as lack of perspectives for the future, frustration and

feelings of incompetence and failure. Common symptoms are insomnia, anxiety, difficulty in concentrating, changes in appetite, irritability and despondency.

The most used instrument for diagnosing burnout is the Maslach Burnout Inventory (MBI).¹⁹ There are three versions applicable to specific professional categories: MBI-HSS (Human Services Survey), for health areas / human/social caretakers or services; MBI-ES (Educator's Survey), for educators; and MBI-GS (General Survey), for professionals that are not necessarily in direct contact with the target public of the service. It is self-administered and assesses all three burnout dimensions (EE, DE and PA). In Brazil, only adaptations into Portuguese of the MBI-HSS and MBI-ES²⁰ have been published to date.

The personal history of great involvement with work is typical and seen as a life priority or mission. However, the factors related to work organization (work division, shifts, rhythms and duration of work journeys, wages and hierarchic structure)²¹ are considered prevalent in determining the syndrome.²² Recent research projects have stressed the importance of personality and temper as risk factors for burnout.²³

Burnout syndrome is part of the List of Professional and Work-Related Diseases (Brazilian Ministry of Health, Regulation 1339/1999).²⁴ It is classified under code Z73.0 (International Classification of Diseases, 10th Revision – ICD-10) as a **problem** that leads individuals to search for health services.

We report a case that meets the diagnostic criteria for burnout and depression. We then discuss the difference between burnout and depression and the nosological status of the burnout construct.

CASE REPORT

A., 50 years old, married, technician in telecommunications, working for a telephone company for 28 years. His problems started in 1996, after successive administrative changes: he was transferred from his unit twice and took over, without previous consultation, a management

position, increasing his responsibilities, while personnel were being reduced. His new tasks included firing employees. To learn his new job, he started working late on weekends. He started feeling physically exhausted, anxious, tense and insomniac. After the company was privatized, a process of productive restructuring was installed, including mass dismissals and service expansion. New employees were not sufficiently qualified for their jobs, which demanded greater effort in supervising them. There were successive “changes in guidelines” (“they told us to do it in one way, and on the following day that was no longer used, all the work was thrown away”), besides dismissal threats, employees’ demoralization and increasingly higher demands of productivity (“when our goal was not achieved, it’s because we were incompetent; when we managed to achieve it, we should have worked harder to go beyond it”). In addition to physical exhaustion, he felt demanded beyond his emotional limit. Thinking about work made him irritated and impatient, in opposition to what he had always been (he considered work as a priority, source of personal satisfaction and pride). He started presenting, besides anxiety, deep sadness, lack of pleasure in activities, difficulty in taking decisions, loss of appetite and weight (around 14 kg in 7 months), memory “blanks”, hopelessness, feeling of personal devaluation and desire to die. He was then taken away from his work and started psychiatric treatment in 2000. He used many associations: thioridazine 10-30 mg/day, cloxazolam 2 mg/day, sulpiride 300-600 mg/day, biperiden 2-4 mg/day, nortriptyline 25-75 mg/day. He was referred to the Instituto de Psiquiatria da Universidade Federal do Rio de Janeiro (IPUB) after 2 years of private treatment. He was taking oxcarbazepine 600 mg/day, clonazepam 4 mg/day and levomepromazine 50 mg/day, which were then replaced by imipramine 75-150 mg/day, chlorpromazine 100 mg/day and diazepam 10 mg/day (current treatment). He progressed with major improvement in anxiety and insomnia, partial improvement in depressive symptoms and intense difficulty in dealing with work-related situations. He retired due to disability 1 year after being admitted to IPUB.

DISCUSSION

This case presents many factors related to work organization considered by Maslach et al. as determining burnout¹⁸ – overload, insecurity toward tasks, lack of conditions to carry out work, insecurity as to permanence at work, lack of support from team/management, feeling of personal demoralization at work environment, feeling of injustice. Personal factors of work dedication are also present. The emotional symptoms developed by the patient correspond to the three dimensions that are characteristic of burnout syndrome.

The patient also presents depression. Although they are often associated, many studies show that burnout and depression are conceptually different. According to Freudenberger, the “depressive state” present in burnout is temporary and oriented to a precise situation in the person’s life (in this case, work). In addition, the feeling of guilt, characteristic of depression, is not present.¹⁷ Also for Maslach, burnout only affects the professional area, whereas depression affects all areas in the individual’s life.¹⁸ Brenninkmeyer²⁵ systematizes those differences. Compared to depressed individuals, those who have burnout: 1) present more vitality and are more capable of obtaining pleasure in activities; 2) rarely present weight loss, psychomotor retardation or suicidal ideation; 3) have more realistic feelings of guilt, when present; 4) attribute their indecision and inactivity to fatigue (and not to the disease itself); and 5) present early insomnia more frequently, instead of terminal (as in depression). The nature of the burnout/depression association is still not well known: it may be due to common etiological antecedents (linked to chronic stress or personality factors, such as neurotic traits, for example); and burnout can be a stage (or an antecedent) in the development of a depressive disorder.⁸ Iacovides²⁶ suggests that burnout and depression may share many “qualitative” characteristics, especially in the most severe forms of burnout. The author proposes to apply both diagnoses in certain cases, such as those in which there is a higher degree of dysfunction at work than depressive symptoms, dysfunction onset before major depression or the existence of a negative attitude toward the profession that cannot be explained as a manifestation of depression.

Overlapping, in the case reported herein, of burnout and depression leads to two hypotheses:

1) delay in recognizing the problem could influence the development of a complication (depression); or 2) such case is part of a subtype of patients with more vulnerability to the development of burnout that would be associated with more severity and phenotypical similarity with depression (according to the study by Iacovides).²⁷ Ahola et al.⁸ suggest that when “dealing with the population of workers, it is recommended to assess both the existence of burnout and depression.”

This case is an example that burnout seems to be related not only to specific professions, but to the way work is organized, independent of the activity.^{18,28} The crucial determinant seems to be the impossibility found by people deeply committed to achieving an ideal (here represented by work engagement) of achieving such goal, an impossibility that is determined by the characteristics of work organization.

Burnout syndrome is a construct that is still under investigation. According to Maslach, burnout is not a clinical syndrome, but a diagnostic of work situation.¹⁸ Is it possible that the cases that meet the criteria for burnout, according to Maslach’s scale, in psychiatric practice are only cases of depression? If so, how can we establish the relation of such cases with work organization?

A case report cannot answer questions that only prospective studies are able to, but it opens the discussion about burnout syndrome in psychiatric nosology and practice.

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ABSTRACT

The burnout syndrome was first described in the 1970's and is characterized by three dimensions (emotional exhaustion, depersonalization and reduced personal accomplishment).

Burnout is a work organization-related health condition. Nevertheless, it is not part of any

psychiatric classification. This article presents the concept of burnout, establishes its nosological status and introduces a brief discussion on the difference between burnout and depression, based on the report of a clinical case treated at Instituto de Psiquiatria da Universidade Federal do Rio de Janeiro.

Keywords: *Burnout, depression, diagnostic, work organization.*

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