EW0106

A person-centered approach to burnout-depression overlap

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Introduction Burnout has widely infiltrated the popular culture and has been extensively studied in both psychiatry and psychology. However, there are currently no consensual or binding diagnostic criteria for burnout. A major obstacle to the elevation of burnout to the status of nosological category is the overlap of burnout with depression.
Objectives We examined whether burnout and depressive symptoms can be distinguished from each other using a person-centered approach.
Methods A total of 1759 French schoolteachers took part in the present study (77% female; mean age: 41; mean length of employment: 15). Burnout symptoms were assessed with the Shirom-Melamed Burnout Measure (14 items) and depressive symptoms with a dedicated module of the Patient Health Questionnaire (9 items). Data were primarily processed using two-step cluster analysis. Correlation analysis and analysis of variance (ANOVA) were additionally carried out.
Results Considered as continuous variables, burnout and depression were found to be closely intertwined ($r = 0.81$; disattenuated correlation: 0.91). Our cluster analysis revealed four different participant profiles, identifiable as "minimal burnout-depression" ($n = 542$; 31%), "low burnout-depression" ($n = 566$; 32%), "medium burnout-depression" ($n = 412$; 23%), and "high burnout-depression" ($n = 239$; 14%). Burnout and depression played equivalently important roles in cluster construction. Our ANOVA confirmed that the four clusters differed from each other in terms of burnout and depressive symptoms.
Conclusions Our findings are consistent with the view that the burnout syndrome is depressive in nature. A diagnostic category dedicated to burnout may therefore not be needed.
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EW0107

Is it time to characterize burnout as a depressive syndrome? A review of recent research

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Introduction More than 40 years after the introduction of the construct in the literature, the status of "burnout" remains unclear. Whether burnout is anything other than a depressive syndrome has been increasingly discussed in recent years.
Objectives We examined the extent to which burnout can be considered distinct from depression.
Methods We reviewed the literature dedicated to burnout-depression overlap over the last decade.
Results Recent research suggests that burnout and depression overlap in terms of (a) etiology, with (chronic) unresolvable stress a common, key causal factor, (b) clinical picture and course, with burnout and depressive manifestations inextricably linked such that they increase or decrease together over time, (c) cognitive biases, with burnout and depressive symptoms similarly predicting increased attention to negative stimuli and decreased attention to positive stimuli, (d) dispositional correlates (e.g, neuroticism, rumination, pessimism), and (e) allostatic load—an index of the biological cost of adaptation to life adversity. Hypocortisolism has been linked to both burnout and depression with atypical features—a highly prevalent form of depression. The often-invoked argument that burnout is singularized by its job-related character is actually invalid given that (a) depression can also be job-related and (b) the "job-relatedness" of a syndrome is not nosologically discriminant in itself.
Conclusions Robust evidence that burnout overlaps with depression has accumulated in recent years. The burnout construct is unlikely to capture a distinct pathological phenomenon. We propose that burnout be characterized as a depressive syndrome for the sake of conceptual parsimony, theoretical clarity, and effective public health policies.
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EW0108

Antidepressants augmented with aripiprazole in the treatment of major depressive disorder

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Introduction Major depressive disorder (MDD) does not consistently respond to any single antidepressant (AD) therapy. Adjunctive therapy with atypical antipsychotics (AA) showed higher response rates compared with AD monotherapy. Aripiprazole, an oral quinolinone, is the first AA agent to be approved in the US as adjunctive treatment in adult patients with MDD.
Aim The aim was to evaluate the efficacy and safety of adjunctive low-dose aripiprazole combined with AD versus AD monotherapy in patients with MDD with minimal improvement after 4 weeks of prior AD monotherapy.
Methods Ten patients with MDD and a history of minimal improvement to 4 weeks of AD monotherapy (escitalopram 10–15 mg/day, sertralin 50–100 mg/day) were included in this study. The patients were randomly assigned to 2 groups: one ($n = 5$) with AD plus aripiprazole 5–7.5 mg/day and the other ($n = 5$) with AD alone. After baseline assessment, the subjects were followed up at weeks 2, and 4. The primary efficacy was the mean change in (HAM-D17) and CGI-I.
Results The aripiprazole group exhibited significantly better efficacy than the AD group in mean total score changes of HAM-D17 and CGI from the baseline to weeks 2, and 4. The item "work and social activities" of HAM-D 17 showed significant improvement at week 4, and the item "somatic symptoms (GI)" showed significant improvement at week 2.
Conclusions Adjunctive aripiprazole therapy significantly improved depressive symptoms in MDD who didn't respond to AD monotherapy. Aripiprazole augmentation is an efficacious, well-tolerated and safe treatment for patients with MDD.
Disclosure of interest The authors have not supplied their declaration of competing interest.

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