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ORIGINAL PAPER

Burnout: From Popular Culture to Psychiatric Diagnosis in Sweden

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Abstract This article aims to understand how burn-out became an object of thought, through the study of certain processes of legitimization. It traces the genealogy of the burn-out concept from the initial article from 1974, via its confirmation as a "disease" in the 1980s, to its appearance as a legitimate diagnosis in Sweden in 1997. The theoretical framework is that of applied metaphysics, which means a study on how a specific phenomenon came into being. Consequently, I take departure from ontology in motion with an approach that concerns the legitimization processes. The conclusion will show the underlying processes of legitimization in relation to the making of a psychiatric object of thought in Swedish society.

Keywords Burnout · Legitimization · Object of thought · Psychiatric diagnosis · Sweden

Introduction

This article concerns the processes through which a popular conception of burnout became a psychiatric diagnosis and then an object of public health policy. More specifically, it traces the American development of the concept from its initial introduction in Herbert J. Freudenberger's article in 1974 through the appearance of burnout as a legitimate diagnosis in Sweden. At first glance it appears that burnout has two separated national histories without any clear point of contact. I argue, however, that these two histories are clearly interrelated when it comes to the emergence of a diagnosis as an object of thought. The emergence of a diagnosis occurs within complex sociohistorical networks of science and policy (Hacking 2002b; Showalter 1998; Young 1995). By following the two interrelated histories it

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becomes possible to reach a better understanding of the relationship among emerging social problems, policy and medicine, as an important task within the anthropological and sociological medicalization literatures and frameworks (Conrad 2007; Furedi 2003; Lock 2002; Szasz 2003).

My theoretical point of departure is the edited volume *Biographies of Scientific Objects* (Daston 2000), an anthology of 11 essays on various scientific phenomena from physics, economics, psychology, biology, anthropology, demography, medicine, sociology and mechanics. The common denominator of these essays is, according to the editor, Lorraine Daston, an applied metaphysic. By studying the dynamic world, all the authors focus on how a specific phenomenon comes into being and gradually passes away as an object of scientific study. In this context, applied metaphysic is contrasted to pure metaphysic, that is, distinguished from an antidynamic God's-eye viewpoint that leaves no account for explanations of various processes. However, a study of dynamics and processes does not mean a disavowal of existing reality. The reality of a specific phenomenon becomes real the more it is "woven into scientific thought and practice" (Daston 2000, p. 1). It follows that the intention behind the book is to strive beyond the never-ending debate between realism–constructionism and discovery–invention. This means that the object of science simultaneously can be real and historical. To maintain such an integrated idea of reality and history, Daston argues for ontology in motion. This is much the same foucauldian ontology that the philosopher Ian Hacking has made use of in relation to his philosophically historically studies of science (cf. Hacking 2002a, p. 11): an epistemological position that I share with them (Friberg 2006). In relation to this kind of ontology, Daston discusses an overall framework with four overlapping "principal approaches to the history of scientific objects: salience, emergence, productivity, embeddedness" (Daston 2000, p. 6). The approach of *salience* means a study of how an unpretentious phenomenon—such as dreams, personal identity or monsters—attracts systematic attention and thereby changes into a scientific object. It is all about how science intensifies the reality of the specific phenomenon. The second approach is about the *emergence* of scientific objects: an analysis of the development of the scientific object at a certain time in a specific place. The next course of action is a study of how the scientific object reaches an ontological status through the *production* of results, explanations, connections and manipulation: as something contemporarily useful or valuable for future problematic encounters. The final approach, *embeddedness*, means an investigation of how local, material and practical networks function as a principle for the reality of the object. The reality of the scientific object thus depends on its embeddedness in various organized systems of techniques and instruments. In the light of the four principal approaches, I would like to add a fifth, that is, the study of legitimization processes. Here, I argue, the concept of legitimacy seems to be a fruitful organizing principle in the explanation of various social phenomenon. Legitimacy is an analytic concept to be found in the midst of ideology, justice and intergroups (Major and Jost 2001) as well as in relation to power (Beetham 1991). Conspicuous by its absence, however, is how a psychiatric diagnosis becomes an object of thought in everyday life in a specific society. Is this just another example of cultural constructivism? A close reading of Atwood Gaines's "Introduction," in *Ethnopsychiatry: The Cultural*

Construction of Professional and Folk Psychiatries, reveals the main difference between Daston's approach and cultural constructivism. While the cultural constructivist "provides the basis for important critiques of Western beliefs, practices, and institutions" (Gaines 1992, p. 18), the applied metaphysician is principally interested in descriptive explanations. This means that the latter approach operates primarily at an explanatory level rather than on achieving a specific policy goal. Instead of proposing how knowledge should be made, on a political basis, this article focuses on an empirical understanding of the development of knowledge (Dear 2001).

I first give an account of how Freudenberger made use of the burnout concept to describe his personal experiences while working at a free clinic. This is followed by a description of how Freudenberger systematized the relevant symptoms into the concept of burnout, as described in work later published in the *Journal of Social Issues*, the scientific goal of which was to enlighten people about the phenomenon. Next I describe the work of Christina Maslach, who developed Freudenberger's ideas with the help of empirical data. By studying her publications we are able to observe how she statistically legitimizes the burnout phenomena. Once it was legitimate, she was soon able to create burnout data, working together with her colleague Susan E. Jackson. These two scholars developed a scale measuring the experience of burnout, which meant that one could measure burnout in a scientific manner. By eventually developing the Maslach Burnout inventory (MBI) to assess burnout, I contend, they confirmed that there is a "disease" that is called burnout. In contrast to historical accounts of the emergence of the burnout diagnosis (Schaufeli and Enzmann 1998), this article focuses on how a hypothesis becomes a scientific fact when scholars distance it from its condition of production: this process of reification is most important in understanding the legitimization of the burnout diagnosis. Following this, I discuss how the burnout diagnosis came to Sweden through the translation of the *International Statistical Classification of Diseases and Related Health Problems, Tenth Revision* (ICD-10). This volume, published by the World Health Organization (WHO), provides guidelines for physicians to use in making diagnoses—it is the sacrosanct objective home for any diagnosis. It is from this respected location that a diagnosis can interact with the real world and real people. The subsequent section illustrates how burnout became a policy issue in Sweden. It presents a study of how various Swedish policymakers frequently problematized the new uncertain and emotionally insecure experiences articulated via the burnout diagnosis. Policymakers—those politicians and decision-makers who sketch out guiding principles—are seen here as physicians, social caseworkers, politicians and burnout researchers. The consequence of these interrelated processes, acted out in the arenas of medicine, social insurance offices, party-political struggles and academia, is the creation of burnout as a legitimate diagnosis. In a European context, the Swedish case is extraordinary in the sense that the burnout diagnosis obtained a strong foothold within a short period of time. As we shall see, Sweden is an excellent example of a rapid career of a psychiatric diagnosis. In a report by the Swedish Psychiatric Association, the authors write that burnout has been a problem in Holland for some years, which can be compared to the Swedish circumstances. Contrary to the situation in Sweden, however, the physicians in Holland have made use of a neurasthenia diagnosis with the addition

"work related" (Björkman et al. 2001, p. 3). Cultural specificity is reflected in the use of different diagnoses for similar symptoms. Another example is that of the German physician Marcus Beland and his encounter with the Swedish medical service in 1997. After taking up his duties as a fully qualified physician in Sweden, Beland described his encounters with some unfamiliar and infrequent diagnoses, such as fibromyalgia, whiplash injury and burnout. Since these diagnoses had not attracted the same attention in Germany as in Sweden, they were to him perplexing phenomenon. About burnout he wrote: "To my knowledge there is no similar burnout epidemic in other countries" (Beland 2003, p. 3999). According to a report about mental health in the European Union (EU), burnout is still an unknown concept in certain EU countries. Such is the case with France, where there are no reports of illness attribute to burnout (Rydén 2004).

The Making of a Legitimate Foundation

A diagnosis, as a concept, must enter the scientific world before it obtains its own legitimacy in the social arena. I analyze here how certain symptoms, as such, were systematized into a medical concept before being published with the goal of enlightening people.

The Father and Free Clinics

Freudenberger is considered the "father" of the burnout concept (42Online 2004). He was the first to publish an article on burnout, in the 1974 issue of the *Journal of Social Issues*. Holding a Ph.D. in Clinical Psychology, Freudenberger was trained as a psychoanalyst. According to Schaufeli and Enzmann, the reason for publishing his work in a journal of social problems, rather than in one from the field of psychiatry proper, was that burnout first emerged as a social problem, as a discovery that something was "in the air," rather than as a scholarly construct (Schaufeli and Enzmann 1998, p. 6). In the introduction to the article, Freudenberger explains that he would like to communicate his own experience from working in the free clinic movement: therapeutic communities, hot lines, crisis intervention centers, women's clinics, gay centers and runaway shelters. Already in 1973, he had warned free clinic staff of the "burnout syndrome" (Freudenberger 1973, p. 56).

St. Mark's Free Clinic in the East Village, New York City, is the place where Freudenberger himself burned out. Considering this background, it can be seen that most of his articles about burnout are more or less autobiographical. He tells the story of how the free clinic was tightly packed with young people who came in with a variety of illnesses and diseases. Even after working a full day, from eight in the morning to six in the evening, he still took care of his regular practice before heading home. These circumstances resulted in irritation towards his wife (Freudenberger 1971a, p. 171, 1971b, p. 39; Freudenberger and Richelson 1980, p. xviii). Working virtually around the clock each day, while simultaneously shifting his role model conception to get inside the perspective of the patient, eventually led to an emotional collapse. He writes:

> I continued to deny that anything was wrong despite my lingering cold, my fatigue, and my constant irritability. During the Christmas holiday my wife insisted that we take a vacation with the children, and much as I hated to be away from the clinic, I felt I should go to make up for all the time I had spent away from home. My wife made the hotel and plane reservations. All I had to do the night before we left was pack my own clothes, but when I dragged myself through the door at 2 A.M., I was too exhausted to do anything except fall into bed. I told my wife that I would pack into the morning, but in the morning I couldn't get up. We never got to the airport. I slept for two solid days and ruined the family vacation. On the third day, I was still not able to get out of the bed, but I *was* able to begin reflecting on how I had been behaving. (Freudenberger and Richelson 1980, p. xix)

Despite his devotion to free care, he and many other professional volunteers found themselves in an emotional state or condition they called burnout. This state of health was the main thing to be explained in the first article he wrote in 1974. In his definition of burnout, Freudenberger uses an ordinary dictionary, unreferenced in the footnotes or bibliography, from which he describes burnout as "to fail, wear out, or become exhausted by making excessive demand on energy, strength, or resources" (Freudenberger 1974, p. 159). This is called bricolage, meaning that Freudenberger has taken a definition, a meaning, from another meaning system and context and placed it in the context of a therapeutic community. Even though the article's purpose is supposed to be scientific, it focuses on Freudenberger's own experiences. The article lacks a well-founded argument in a social scientific or psychiatric sense. He had not collected data especially to show the reader a new medical diagnosis. This is also the case in the second article, from 1975, where his main goal was to make the burnout phenomenon visible (Freudenberger 1975, p. 81).

At the time he developed symptoms of burnout, he talked about his experiences into a tape recorder. The purpose of this was to see what he could learn by repeatedly talking each day and then listening to it the following day. Listening to his own voice, he writes, revealed many emotions that he had not noticed earlier. He remained away from work for a period of time in order to regain balance, and for part of that time he continued to analyze the tapes. The results were presented in the first article about burnout. This self-analysis allowed Freudenberger to be able to distinguish those signs that show that a person is burned out. He divides them into three categories: physical signs, behavioral signs, and psychological signs. The first-mentioned category includes weight loss, sleeplessness, being unable to shake a cold, feeling physically run down, having head and stomach problems, experiencing shortness of breath and being depressed. The second group includes anger, irritation and frustration responses. The third group of signs includes feelings of exhaustion, boredom, resentfulness, disenchantment, discouragement and confusion. This indicates Freudenberger's concern with informing his readers about the strains found in the circumstances he discusses (Freudenberger 1975, pp. 78–79).

The Symptom of Imbalance

When Freudenberger writes about the problem of helping other people and at the same time helping himself, he illustrates the tension of giving. Giving is duality. The demands of helping other people with their problems are so great that one forgets to help oneself. This understanding of giving has little to do with Marcel Mauss' gift-giving theory (Mauss 2006). For Mauss, giving is a social relationship; it is not about helping others or the motivations underlying helping others. For Freudenberger giving is giving of one's self on a psychological level. His argument, however, raises the following question: Why does one's own self need help? The answer seems to lie in the fact that if there are no rewards at a basic psychological level, then illness will follow. This is the same as saying that the opposite of burnout is self-fulfillment. When totally engulfed by the other, you are unable to achieve self-realization. Freudenberger writes about the reciprocal relationship in terms of the self (within) and others (outside) from the point of view of guilt: "We feel a pressure from within to work and help and we feel a pressure from the outside to give.… His guilt may then prompt him to even further giving and ultimate exhaustion" (Freudenberger 1974, p. 161). It seems that *guilt* produces pressure on an individual that can be reduced through his or her work: here, by helping others.

For Freudenberger, a human must be able to *balance*, in the helping situation, between the self and others in order to avoid becoming burned out. One cannot help the rest of the world without taking care of oneself first. On the basis of this reasoning, I argue that Freudenberger's thoughts about burnout are related to humoral theory. As one of the most persistent medical models throughout history, humoral theory was developed in Greek and Arabic traditions according to which the body was considered to be a microcosmos of the world (Blaxter 2004, pp. 32–33). Ill health of the body and soul is thus caused by a disturbance of the proper balance among the four fluids of the body: blood, phlegm, yellow bile and black bile. By restoring equilibrium, one can cure ill health. The normal state of the body is order, which means that disorder (a system under attack) causes ill health. The physician Ludwik Fleck's reasoning concerning primeval ideas as guidelines for the development of knowledge is relevant here. Accordingly, there is a historical continuity from Hippocrates' (ca. 2400 BP) collected medical works to Freudenberger's articles on burnout—with the idea of balance as the common denominator. Following Fleck, there is "a harmony of illusion" when primeval ideas become accepted concepts (Fleck 1997, p. 39). With this in mind, it is through the symptoms of imbalance, in line with humoral theory, that Freudenberger is able to establish a legitimate foundation in the mediation of his personal experience.

After Freudenberger

Christina Maslach, Ph.D., Assistant Professor of Psychology at the University of California, Berkeley, was the first to follow Freudenberger. Her first article on the

subject, published in 1976, was "Burned-out," in *Human Behavior: The Newsmagazine of the Social Sciences*. The publication in a popular magazine rather than in a scientific journal is explained by Schaufeli and Enzmann in terms of the character of Maslach′s data, which were of an anecdotal character (Schaufeli and Enzmann 1998, p. 7). Since burnout was "the language of the people," it was most often dismissed, according to Maslach, as pseudoscientific jargon without substance—denigrated by journal editors as "pop psychology" (Maslach and Jackson 1984, pp. 138–139; Maslach et al. 2001, p. 398). Within a few years, however, Maslach became one of the most distinguished researchers in the field. The turning point in her career was the publication of the influential article, "The Measurement of Experienced Burnout," written with her colleague Susan E. Jackson, in 1981. Wider recognition was achieved when they published the manual *MBI: Maslach Burnout Inventory (Human Services Survey)* that same year. By turning anecdotal experiences into measurement, they converted the experience of burnout into a diagnosis. From burned-out persons they created the legitimate burnout disease.

My purpose here is to elucidate how Maslach and Jackson refined and legitimized burnout within the scientific field. Burnout thus becomes a product that can be measured and assessed according to seemingly objective criteria.

Refinement

Maslach's first article, "Burned-out," was an attempt to discover what happens to people who work intensely with clients in distress. In the article Maslach refers to research done with co-workers at the University of California, Berkeley. Together they observed, conducted interviews with and collected questionnaire data from 200 professionals at work: poverty lawyers, clinical psychologists, prison personnel, social welfare workers, clinical psychologists and psychiatrists at a mental hospital, child-care workers and psychiatric nurses. Burnout as a phenomenon is, according to Maslach, found in different professions under different names. She mentions law enforcement groups, who refer to suppressed emotions as the "John Wayne syndrome." When in such an emotional state, the workers use certain techniques to detach themselves from clients and patients. As a result, the client becomes less human and more like an object (the poor, my caseload, my docket and animals). Many professionals lack control over what they do at their jobs because of an increasing caseload of clients, and it is underlined by Maslach that there is further need for special training for health and social service professionals. She suggests the need for training professionals so that they can be more aware of the significance of their own psychological states. Here, referring to Freudenberger, she notes that it is important for social service personnel to understand their own motivation while working with other people (Maslach 1976, p. 22). By becoming aware of their own motivation, they can help themselves avoid becoming burned out. Such a statement is close to Freudenberger's because he mentions that a loss of ideals (motivation) leads to illness. The main difference is that Maslach possesses empirical data to support her arguments.

In the article "The Client Role in Staff Burnout," published in 1978, it is possible to read about the further development of Maslach's ideas. Primarily she discusses

the increased growth in the human service sector, which has led to the emotional exhaustion syndrome of burnout for professional staff. In a manner similar to Freudenberger's, she emphasizes that, instead of relying on family and friends, one turns to trained professionals within an institutional setting. Her arguments here imply that a state of normality exists when people turn to their family or friends when they are having problems. In this way, Maslach describes a changing society, that is, a societal inversion where institutions have an increasingly prominent role. Even though an increasing number of people seek help within institutions, this does not mean that they are happy about those institutions. On the contrary, this inversion has led to increased criticism since the clients complain of being ill treated and dehumanized. Much in line with Freudenberger's argument about transforming society in a moral way, Maslach writes about the negative consequences of these social changes. Accordingly, she describes how trained professionals suffer from burnout while their clients are unable to achieve positive changes of their own situations. This is not only bad for staff personnel, who lose the positive feelings, respect and sympathy of clients, but also negative for the client, who is categorized as a "bad person." The whole process of institutionalization within a society involved in transformation has led, according to Maslach, to the destruction of the normal exchange situation that arises between humans when they meet. While Freudenberger focuses mainly on the professional side of the staff-client relationship, Maslach concentrates on both sides. She views the two participants as actors who potentially dehumanize each other in an exchange situation (Maslach 1978, p. 123).

Legitimization

Working at Berkeley, Maslach and Jackson wrote the influential article "The Measurement of Experienced Burnout" in 1981 (Maslach and Jackson 1981b). In the introduction to this article, they write that professional staff at human service institutions run the risk of being burned out. They mention three key aspects of burnout. The first includes increased feelings of emotional exhaustion. The second, depersonalization, concerns the development of negative, cynical attitudes and feelings about the client. The third aspect, lack of personal accomplishment, is a tendency to evaluate oneself negatively. These three characteristics originate from Maslach's burnout articles in 1976 and 1978, as discussed above. The purpose of the 1981 article is to attempt the construction of a way of measuring experienced burnout, that is, an attempt to measure emotional exhaustion, depersonalization and lack of personal accomplishment in a quantitative way. The measuring instrument in question goes by the name "the Maslach Burnout Inventory" (MBI). The material for the article is from the authors' interviews and questionnaire data. The population used in the study consisted of 605 people, of whom 56 percent were male and 45 percent female. These were chosen from health and service occupations: police, counselors, teachers, nurses, social workers, psychiatrists, psychologists, attorneys, physicians and agency administrators.

As a reader of the article, one easily notices that the rhetoric of the piece follows a scientific ideal in a Popperian spirit. That is, Maslach and Jackson

subject their hypotheses to an open critical test. This lays the ground for the statement that the test is valid in a scientific sense. But what does this mean, and what consequences can be drawn from their article? I contend that the consequences are twofold: on one hand, a confirmation of Maslach's previous articles and, on the other, an authentication of the MBI. Consequently, the past and the present are connected and confirmed through references in the historical literature. These are important elements in establishing the legitimacy of the concept of burnout. Hence, it follows that the hypothesis becomes a fact when it is used in a later phase, when it has been distanced from its conditions of production. Thanks to the validation of the hypothesis, the MBI article is recognized as a useful and reliable measurement of burnout. Also, largely because of the MBI article, it is possible to say that Maslach and Jackson stake out a space for burnout, a new niche, so to speak. This is clear when they write:

> Further evidence of the validity of the MBI was obtained by distinguishing it from measures of other psychological constructs that might be presumed to be confounded with burnout. (Maslach and Jackson 1981b, p. 109)

Carving out such a niche by distinguishing their disease from others is, of course, a conventional strategy within the academic arena. Sociologist Pierre Bourdieu, who has dealt with autonomy of science, wrote that the "battle over frontiers are often over the monopoly of a name, with all kinds of consequences, budget lines, posts, grants, etc." (Bourdieu 2004, p. 50).

It is, however, possible to say that the real breakthrough for burnout came when Maslach and Jackson published their manual *MBI: Maslach Burnout Inventory (Human Services Survey)* (Maslach and Jackson 1981a). In this manual they develop five codes of conduct for the examiner. The point I wish to make here is that the manual is of great importance for the legitimization of burnout. The manual follows the norms of a positivistic science since it presents an object that can be measured. According to Maslach and Jackson, this is to be done by extracting each individual's knowledge and separating it from a social setting, by concealing the true meaning of the test from the participants and by exercising control over those being examined. These codes of conduct are a positivistic method whereby people become replaceable objects. This implies a belief that if the examiner simply follows the rules, measurements of different individuals can be made on the same basis. Any individual can consequently represent any other, since all individuals (objects) are the same according to the chosen method. These codes of conduct also satisfy an ideal of validity that states that one must follow certain rules when studying reality. Avoiding such rules produces not objective science but subjective nonsense, according to Maslach and Jackson. The discussion of validity also implies a belief that a correct measuring instrument can be identified and improved on. In this sense, the test itself is a confirmation that there is a "disease" called burnout. Without successful measurement, there can be no disease, only a set of symptoms.

Historical Texts Discussing the Success of the Maslach Burnout Inventory

As a reader of the history of the MBI, within the field of burnout research, one is immediately immersed in a positivistic conceptual world (See Schaufeli and Enzmann 1998; Schaufeli et al. 1993). The success of the MBI is seen in terms of its superior reliability and validity. These words, expressed as psychometric qualities, seem to be the "objective" guidelines when explaining and testing the best measurement. The MBI is contrasted with several other kinds of instruments for measuring burnout, from the 1980s onward. The "alternative measures of burnout" mentioned are a structured interview to assess the level of burnout, projective drawings and a validity study of an overall self-assessment of burnout (Schaufeli et al. 1993, p. 201). These alternative measures are, however, on positivistic grounds, most often dismissed because they lack an empirical basis, according to leading burnout researchers such as Schaufeli, Enzmann and Girault. In this context, it is possible to observe a strong belief in an empiricism that places stress on people's experiences rather than on the researcher's theoretical approach—that is, most burnout researchers prefer an inductive approach when developing a measurement for burnout:

> It is important to note that the three dimensions of burnout [emotional exhaustion, depersonalization, and lack of personal accomplishment] have not been deduced theoretically before the proper test construction of the MBI commenced. Instead, they were labeled *after* a factor analysis of an initial set of 47 items in a heterogeneous human service sample. Accordingly, an inductive, rather than a deductive, approach was deployed. (Schaufeli et al. 1993, pp. 207–208)

The quotation above demonstrates a belief in an autonomous researcher free of any theoretical speculation or factors when observing the data—the existing social world. This is a belief we today call naïve empiricism, and it has, I argue, mainly given the MBI its authority within the social field of burnout research. As an example of this, we are able to observe how the MBI has been confirmed in several studies by other burnout researchers (see Schaufeli et al. 1993, p. 209).

The New Product

Maslach developed Freudenberger's ideas with the help of empirical data. She also made a point of focusing on the exchange situation by discussing the two parties in the staff–client contact, while Freudenberger had mainly focused on the professionals and the symptoms. A process followed via which Maslach and Jackson transformed burnout from a set of vague symptoms into a measurable scientific entity. They created ways to measure burnout and also inserted the MBI into the academic arena by constructing distinct boundaries with other psychological measurements. This was done by following a tradition of positivism, according to which an incontestable norm is understood to be an objective test (manual). Maslach and Jackson were successful in spreading the message of burnout because the MBI

test soon became the most widely used instrument by many business firms and scholars. Evidently, "to date, the MBI is almost universally used as *the* instrument to assess burnout" (Schaufeli and Enzmann 1998, p. 50).

Burnout Comes to Sweden

Although Maslach and Jackson had refined and legitimized burnout through their writings, it had to overcome a new barrier. To be considered legitimate as a diagnosis, it first had to be included in the latest version of *The International Statistical Classification of Diseases and Related Health Problems*, published by the WHO. Burnout was introduced into this big blue book in 1992. The volume contains a hierarchical system of classification for grouping diseases and related health problems, and the intention is to revise the book every tenth year. The latest version, today the tenth (ICD-10), is accepted as a universal standard of classification. The volume was translated into Swedish as *Klassifikation av sjukdomar och hälsoproblem 1997* (KSH97), which should be seen as its formal introduction to Sweden (Socialstyrelsen 2002). It is from the Swedish version of the ICD-10 that the concept, as a diagnosis, first could interact with the real world, with real humans in Sweden. The KSH97 is not just an abstract set of categories. It is, in fact, integrated into the Swedish social security system, which is based on various classifications of illness and disease that are then used to qualify a person for specific types of treatment or compensatory payments. To be classified as unhealthy, and to receive economic compensation from a social insurance office, a patient must first have a legitimate diagnosis based on the KSH97. It is within this social milieu that burnout becomes a policy issue.

Burnout as a Policy Issue in Sweden

Hence, the burnout diagnosis came to Sweden through the ICD-10. As we shall see, its entry into a rapidly changing society created various fields of interaction, including the physician's diagnosis, the social insurance response, policy debate and academic debate. As burnout spread in Sweden, new ways to articulate experience, new diagnostic categories, new bureaucratic procedures and new academic debates became localized. Within these fields, various Swedish policymakers—seen here as physicians, social caseworkers, politicians and burnout researchers—frequently problematize uncertainties and experiences of emotional insecurity. As we shall see, the unsettled time in Sweden demands that the policymakers give an answer that can explain the contemporary situation that goes along with certain unusual behaviors. For this reason, the new behavior is partly to be classified as burnout. This means that the burnout diagnosis becomes more and more legitimate, despite the debates about it, in Swedish society. The following Swedish story is in line with what Michel Foucault would mention as "the history of an answer … to a certain situation" (see Pearson 2001, p. 173).

Sickness Allowance Claims

During the 1990s, when Sweden was undergoing a periodical radical shift, people began to increasingly articulate their new, vague experiences via a diagnosis of burnout, while physicians many times accepted it as a reasonable explanation. Qualitative study has shown that physicians lack specific criteria to follow when making a burnout diagnosis. Instead of following specific criteria, as is the case with depression, physicians most often take their departure from vague criteria concerning work, achievement, personality and the working environment (Ursjö 2001). Critics therefore mean that it has been too easy to claim sickness allowance since physicians lack a framework to follow (cf. Eriksson 2002; Lindskog 2003, p. 19). As such, the diagnosis of burnout has drawn attention. Today we can observe a recent trend in social security offices since they now refuse to accept sickness allowance claims based on burnout if that diagnosis has been issued by a general practitioner. Since 2005, burnout victims must apply to psychiatric specialists if they wish to continue receiving government sick benefits (Keller 2005). For a better understanding of this problem, let us take a closer look at the accompanying political process.

"A Great Problem for Society"

Sweden's social insurance system has come under pressure to be both more financially responsible and socially aware. People in general have been reporting more illness and disease, and physicians and patients have attributed this to increased workloads on the job. The Swedish government has called long-term sickness "a great problem for society" and has selected Jan Rydh as a special investigator to work out a plan of action to deal with the issue. As an indication of this problem, scholars and politicians often mention that the number of people registered as ill for longer than 365 days, between 1997 and 2001, increased from 75,000 to 120,000. It is primarily the stress-related diagnosis to which these numbers refer (RFV 2002). According to the National Social Insurance Board (Riksförsäkringsverket), which is responsible for the greater part of society's financial safety net, 26 percent of long-term illnesses are related to mental health (RFV 2001). Politicians and scholars are calling for more knowledge about the "new" diseases and illnesses. In contemporary Sweden, burnout is often mentioned as a national disease (*Folksjukdom*) (Krauklis and Schenström 2003; Palmer 2004). After being classified and statistically observed, burnout became one of the five most common diagnoses, and it was that state of ill health that increased the most, especially within the public sector in the year 2002. During that period, burnout was calculated to be an "expensive" diagnosis. In contrast to average diagnoses, which represented a cost of 32,700 SEK, burnout was estimated to cost, on average, 55,000 SEK. This cost calculation includes a contrast between long periods of sick leave for burned-out persons with a high income *and* short-term sick leave for people with a lower income (Ljungberg 2002). Against the background of its being a socially and economically problematic diagnosis, burnout became an issue during the 2002 elections as part of a general discussion of long-term illness and work (Johansson

2002). This can be illustrated via an Internet survey presented to Swedish politicians that asked them, "How can we stop burnout?" The main points can be summarized as follows.

> Gudrun Schyman, leader of the Socialist-Left party, writes that her party wishes to reduce working hours—by changing the norm of full-time work. As a result, more people would have greater strength for both work and leisure time. It is also important to increase workers' influence in the workplace.
> Lars Stjernkvist, party secretary of the Social Democrats, writes that his party wants to reduce the stress of working life and improve support for people stricken by illness. Other demands include increased rights of participation in decision-making and the employment of more people. Moreover, greater demands should be made on employers with respect to workplace health.
> Maria Wetterstand, spokeswoman for the Green Party, writes that their party wants to reduce working time and give people more leisure time.
> Lars Leijonborg, leader of the Liberal Party, writes that people need increased power in their daily life to be able to avoid burnout. He wants to give people greater power over their own working conditions, working hours, and competence development.
> Maud Olofsson, leader of the Center Party, writes that their party wishes to create a working life suitable to increasing the possibility of combining work and family life. Also, increased rehabilitation for those at risk of being burned-out.
> Bo Lundgren, leader of the Moderate Party, writes that their party wants to increase the possibility of a good working environment, increase workplace influence, and provide better salaries. By means of tax reduction people should be able to control their daily life better since they can then avoid working overtime and simultaneously gain more leisure time.
> Alf Svensson, leader of the Christian Democratic Party, writes that his party wants parents to have the right and the opportunity to choose among forms of child welfare and to be able to reduce their working time. They also support increased influence at the work place and the introduction of rehabilitation insurance to enable a return to working life (Östersund 2002).

Even though these politicians differ somewhat in their answers, they all see the burnout syndrome as being caused by too much work and the cure as being a reduction of the number of working hours. These politicians are there able to manifest their respective ideologies by discussing what to do about the set of problems concerning burnout. Instead of calling burnout itself into question, they use it as a vehicle to promote their political ideas.

As burnout became part of the emergent discussion surrounding long-term illness, it also became a political issue that had to be dealt with: not least because the disease now was statistically observed—understood as an objective social problem. These processes, I argue, ought to be seen as a way of legitimizing the burnout diagnosis. People seem to have a common point of reference—the burnout diagnosis—when explaining societal and individual phenomena.

An Increasingly Menacing Situation

Against this background of long-term illness and the political debate, the government has pumped a lot of economic resources into different institutions to try to solve the problem. In the year 2002, the social insurance offices spent 565 million SEK to send patients for diagnostic tests and active rehabilitation. In 2003 this cost increased to 803 million SEK, which further increased in 2004, to 818 million SEK (Försäkringskassan 2005). Rehabilitation seems to have become a word with very positive connotations, along with the idea that more and better rehabilitation would help individual Swedes as well as society as whole (SOU 2002, p. 407). As leading scholars (physicians, professors and associate professors at the WHO Collaborating Center for Neurotraumatologic Prevention, Treatment and Rehabilitation) write:

> Rehabilitation is thus a measure required for dealing with numerous conditions of ill-health. Diseases that lead to long-term ill-health are expensive, for the employer and the individual. To this one should add a loss of quality of life. The number of instances of long term of ill-health in Sweden has never been present on such a large scale as is the case today, during the entire history of health insurance. Authorities, employers, and many individuals feel worried about this development, and many activities have been initiated in a search to understand and cope with this increasingly menacing situation (SOU 2002, p. 407).

The belief and economic investment in rehabilitation has also meant that case officers at social security offices have begun to purchase more rehabilitation services for the victims of burnout (SOU 2002, p. 544). This was necessary because psychiatric diagnoses (depression, stress reaction and burnout) surpassed in number back and muscular pain as the most common leading causes of sick leave (SOU 2002, p. 442). Hard work is no longer a physical problem but a mental one, with occasional physical manifestations such as exhaustion, fibromyalgia and burnout. As a result, suppliers of rehabilitation treatments have changed or adjusted their rehabilitation centers from those dealing with physical illness to those treating mental health symptoms (SOU 2002, p. 581). This was a process that involved both already established and new rehabilitation centers.

In a report from the Swedish Council on Technology Assessment in Health Care (*Statens offentliga utredningar*), one can read that there is a great lack of knowledge about psychiatric diagnoses. As the scholars write in their summary: “More research is needed. And better!” (SBU 2003, p. 17). The report in question is a meta-analysis of the scientific literature, with a special focus on the three most common domains of diagnoses (psychological problems, back and neck problems, heart and circulatory problems) in relation to early retirement pension and sick leave. In one part of the report, the authors speculate about inadequate opportunities for treatment of psychiatric disorders. Consequently, this is one of the causes of increasing costs for the social insurance system (SBU 2003, p. 293). The scientific community in Sweden today has a deep desire to assess the effects of rehabilitation. Many scientists and politicians want to know what measures should be taken to

enable individuals to achieve maximum efficiency (SOU 2002, p. 538). Unfortunately, there seems to be no research with reliable results regarding burnout and similar diagnosis (SBU 2003, p. 311). This means that there are almost no scientific guidelines to follow, which has led to a more free-floating situation regarding the choice of burnout treatment methods. In another report, from the National Board of Health and Welfare (*Socialstyrelsen*), one can read that there is a great range of treatments regarding burnout and that certain of these treatments, while not proven effective, can nevertheless generate positive effects. This, however, needs to be evaluated on scientific grounds by means of randomized control studies (Socialstyrelsen 2003). Many of these randomized control studies are done in Stockholm at the Karolinska Institute, the country's leading medical research facility. In the year 2000, scholars received 40 million SEK for a research project concerning burnout and depression (Psykoterapicentrum 2000). In 2005 they received an additional 28 million SEK to continue research that will end in the year 2008. The goal of the project is to obtain scientific knowledge and develop a methodology for the efficient rehabilitation of depressed and burned-out victims (AFA 2005).

In summary, it seems that there is a belief among politicians and scholars that it will be possible to find effective methods for treating burnout so that it can be reduced or, at least, ameliorated. From this, it is possible to argue that burnout is taken for granted as a legitimate diagnosis, since many policymakers invest a lot of money to obtain better knowledge of the situation. This, however, is not done without strong controversies.

Controversies

Parallel with investments to combat burnout, there exists prolonged discussion among experts and in lay circles as to whether burnout is real. For example, Göran Brulin, of the National Institute for Working Life,[1] has argued that there are no medically objective facts that verify that working life has become more difficult. What has occurred is a change of attitude among Swedes, and the development of a view that sees work as a path to individual satisfaction. The villains in the story, according to Brulin, are those popular science writers and journalists who write that working life claims numerous victims (Fredriksson 2003a). The day after Brulin's statement, a newspaper ran a reply by a 25-year-old woman who insisted that burnout has nothing to do with whether or not one is lazy. On the contrary, she wrote, it is about being too ambitious (Fredriksson 2003b). Similar arguments concerning the reality of burnout exist in the academic arena.

Aleksander Perski, Associate Professor at the Karolinska Institute and one of the leading burnout experts in Sweden, is unequivocal in his belief that the illness exists and should be taken seriously. As the editor of a volume on stress and burnout,

[1] The description of the Institute on its home page (http://www.arbetslivsinstitutet.se/about/default.asp) is as follows: "The National Institute for Working Life is a national center of knowledge for issues concerning working life. The Institute carries out research and development covering the whole field of working life, on commission from The Ministry of Industry, Employment, and Communications. The goals of the National Institute for Working Life are to contribute to: A good working life with well-functioning working conditions—Increased knowledge of and in working life."

Perski writes in the "Introduction" about the changing social milieu in Sweden at the end of the 20th century. He makes his point by noting that, at the end of the 1990s, many Swedes understood *collective experiences* to be part of a machine spinning at its own pace. This machine was driven by a short-term interest in profit, with mass consumption as a reward. Such perspectives were primarily found in schools and the health care arena, for instance, in the public sector and among teachers and employees in the social sector. The issue was one of lack of control, insufficient recognition and remuneration at work, deficient community, the experience of injustice and contradictions among values (a desire to aid one's fellow humans versus a motivation of self-interested profit). It was, according to Perski, about an individualism where the only way community could be achieved was through consumption. The results of this situation were experiences of vulnerability and loneliness (an argument we recognize from Freudenberger). Perski's opinion is that burnout reflects a dramatic change—it is about collective experiences in an increasing inhumane world (Perski 2001, pp. 5–9).

Giving particular attention to the struggle among different perspectives, it is illuminating to take a closer look at Marcello Ferrada-Noli's various attacks on burnout that have been published in *Läkartidningen* (a medical science publication and the official organ of the Swedish Union of Physicians). Speaking as a health science authority, he argues that one should not be given sick leave for problems at home or when under pressure at work. According to Ferrada-Noli, physicians in general should avoid sick-listing people they cannot diagnose. Burnout is thus not a real state of illness but, rather, an academic invention. He makes the point that there has been an increase in the number of burnout diagnoses, especially among working women. Looking back through history, we see that there have always been people who disapprove of work. The only difference today is that people have transformed that displeasure into a medical diagnosis, Ferrada-Noli says (Ferrada-Noli 2004). Perski refutes this position by saying that he and his colleagues have had 700 patients, while Ferrada-Noli has had none. Further on, Perski says that mental illnesses have doubled in the Western world since the 1980s. Many of these are stress related, and therefore, more people suffer from burnout (Jungkvist 2005). Ferrada-Noli has previously called burnout a pseudodiagnosis. He has questioned the scientific character of burnout research, which he says has based its claims on erroneous statistics when discussing burnout among immigrants (Ferrada-Noli 2002a, b; Hallsten 2002). He has, moreover, written that a correlation between suicide and burnout lacks epidemiological evidence. In this way he levels serious charges against well-known Swedish burnout researchers and physicians (Ferrada-Noli 2001a, b).

In the context of the scientific arena, the reality of burnout has become a problem. The issue is whether this disease has been discovered, or somehow invented, as a convenient way of obtaining research grants or intervening in the debate about overwork and other policy issues. The problem of burnout in society is reflected in the academic debate as well. The position of the true believer, illustrated in Alexander Perski's arguments, is that burnout is a real fact since many Swedes, from the 1990s onward, have felt a collective experience of organizational restructuring, high-pressure management and a growing mass consumption culture. The opposition, represented by Ferrada-Noli, argues that burnout is an academic invention based

on erroneous statistics and suffering from a lack of epidemiological evidence. The controversies between the two different parties reaffirm the observation that processes of legitimization do not occur without resistance. As we have seen, legitimization does not mean that everyone is in agreement about a certain answer in a specific situation. The legitimate burnout diagnosis is challenged.

Conclusion: The Legitimization of the Diagnosis

In this article I have described the history of the burnout diagnosis from its early introduction by Freudenberger, via Maslach and Jackson, through its introduction into the ICD-10 and, finally, via this authoritative text into Sweden. From the first founding knowledge of burnout published in 1974, and later by a process of refinement and legitimization by means of the statistical measurement of the phenomenon, we can see how the burnout diagnosis became well established. This was not, however, a linear process, and Freudenberger, Maslach and Jackson were not the only ones attempting to market their product. These scholars have, of course, made efforts to establish their diagnosis by explaining the essence of burnout and differentiating it from other products. Freudenberger can be said to have been a producer when conceptualizing the phenomenon, while Maslach and Jackson refined and legitimized the concept through their authoritative test. Yet these scholars were not acting in a social vacuum. They were promoting their diagnostic definitions and testing techniques during a particular period in a changing society. Burnout, therefore, absorbs and represents certain social trends. It is not just part of a scholarly struggle. The despair felt by many a wayward youth, the therapy-friendly climate of the 1960s and 1970s and a moral correspondence with society at large all contributed to making burnout a legitimate diagnosis of the malaise of modernity among people in the helping professions. Had there been no developed welfare state, or people with extra energy to involve themselves in the intense care of others, there would be no burnout. Burnout is, after all, a product of specific agents—the crusading experts and scholars—but it is also a product of a specific social structure; one is tempted to call it a Zeitgeist. We are speaking about a historical process that made it possible for the burnout diagnosis to be introduced to Sweden in a legitimate manner: finally, through the translation of the ICD-10. As has been seen, the introduction of the diagnosis into a rapidly changing society created complex interactions among the physician's diagnostics, the social insurance response, the policy debate and the academic debate. It has been shown how various Swedish policymakers—physicians, social caseworkers, politicians and burnout researchers—frequently problematized the new uncertain and emotionally insecure experiences articulated via the burnout diagnosis. Problematized as an issue of sickness allowance claims, burnout also became an issue that politicians raised during the elections of 2002. With burnout regarded as a "national disease" (*Folksjukdom*), investments were made in rehabilitation and research to find a solution to the problem. Both politicians and scholars wished to develop rehabilitation to attain a maximum effect, that is, finding the quickest way to get an individual back into Swedish society after having been on sick leave for a long

period of time. This process implies a belief that objective facts and methods can be found, if only a large enough amount of money is invested. Such economic investments, thus, represent the new prioritization with respect to burnout as a social policy issue.

What can we theoretically learn from this specific ethnographic case? I argue that the approach of legitimacy as a fifth principle, in line with Daston′s argument for ontology in motion, principally involves two main processes. The first process involves scientific legitimization of the psychiatric diagnosis, while the second process concerns how a certain state of affairs requires a response from the policymakers. Within the latter process, the search for a response means that the diagnosis, despite the fact that it sometimes gives rise to harsh controversies, becomes a legitimate explanation for the contemporary anxious social situation. Perhaps we can call it a process of relegitimization. The ontology in motion, thus, gives us an opportunity to study how these two processes of legitimization, as described above, take place without any specific consideration for national boundaries or for dichotomies between history and the present, or between constructivism and realism. It is through the concept of legitimacy that we can create a new way of conceiving a specific psychiatric diagnosis in our global world. The diagnosis that seems to be self-evident and natural is here to be observed as an outcome of particular processes. It seems that the concept of legitimacy can create a fresh perspective in the understanding of how a diagnosis, such as burnout, became a psychiatric object of thought in everyday life. By following the processes of legitimization, I hope that anthropologists and sociologists can improve our understanding of various medicalization trends (Furedi, Conrad), become more attentive to the emergence of new medical criterions (Lock) and shed light on the politicized medical principles underlying systems of social control (Szasz) within various cultures and societies.

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