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Mini Review

Perrotta-Marciano Burnout Risk Interview 1 (BORI-1): The new clinical interview to investigate burnout risk in public and private workplaces

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Abstract

Starting from the general concept of "burnout", thus describing the lack of energy, fatigue, and unproductivity at work that a person develops in the workplace, the present paper defines the specific characteristics of the syndrome and related contexts and then proposes a new psychometric instrument (Perrotta-Marciano Burnout Risk Interview 1, BORI-1), in the interview version, capable of assessing and graduating the risk of the same, to intervene promptly in borderline situations that could degenerate into injurious and self-injurious acts. The interview aims to analyze the risk of burnout in individuals who work in both the private and public sectors and who for reasons of service may be put under pressure, even if they have passed the medical and psychiatric examination. It is therefore proposed as a tool for investigation, prevention, and clinical evaluation of burnout syndrome in its clinical signs, thus bridging the critical issues noted in the current psychometric instruments dedicated to the subject under consideration.

Introduction

The term "burnout" literally means 'exhaustion', thus describing the lack of energy, fatigue, and unproductivity at work that a person develops in the workplace. It first took on the connotations of clinical syndrome when psychologist Herbert Freudenberger defined it as a condition of psychophysical depletion that would wear a person down due to chronic exposure to interpersonal stresses in the workplace, with the manifestation of physical, emotional, and behavioural symptoms [1].

Freudenberger, drawing on the studies of Maslach and Cherniss that focused on defining the characteristics of burnout among social and healthcare workers, laid the groundwork for a series of insights in other areas as well, such as the military, social welfare, and work in general [2,3].

The World Health Organization, in the International Classification of Diseases-11 (ICD-11), defines burnout as "*a state of vital exhaustion due to work-related stress*"; however, not all authors agree on this definition, such as Borgogni and Council, who differentiate the burnout syndrome from work-related stress. According to these authors, burnout has more emotional aspects than physical ones, since this syndrome is grafted onto a work situation that has become chronic over time; moreover, the impairment of interpersonal relationships is seen as a symptom and not a cause. In this sense, other authors also stress the importance of differential diagnoses for burnout. Burnout, in the ICD-11, has the code "QD85" and is characterized by four symptoms: feeling mentally and/or physically drained; progressive mental distancing from the workplace; cynicism related to one's workplace and colleagues; and reduced professional effectiveness [4-6].

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It was to be the American psychiatrist Maslach, the world's leading expert in the field of burnout, and in agreement with other researchers who introduced the 3 main dimensions of this syndrome: a) Emotional Exhaustion (EE), in which the extent to which the subject perceives the demands as excessive compared to the psychophysical resources available is investigated (the subject's difficulty in recovering energy is also captured in this dimension); b) Depersonalization and cynicism (DP), in which it is investigated how well the subject exhibits these characteristics (this dimension favours if elevated emotional detachment, thus avoiding demands and/or disappointment); c) Ineffectiveness and unsatisfactory work accomplishment (PA), in which it is investigated how much the person may experience feelings of inadequacy that undermine self-esteem. It was also investigated how, certain aspects of personality may predispose the subject to develop burnout: specifically, it was seen that subjects prone to depression are more likely to experience the dimension of Emotional Exhaustion (EE) while the dimension of Depersonalization and Cynicism (DP) is related exclusively to the characteristics of the work environment [7,8].

To test, therefore, for the presence of burnout, as a syndrome, four different aspects must be analyzed: 1) the characteristics of the work environment and job; 2) the subjective perception of stress; 3) the level of job satisfaction; and 4) the consequences in the burnout sufferer. The presence or absence of this syndrome, therefore, can only be verified through batteries of tests [9].

Concerning the work environment, six objective characteristics were identified that relate to the work itself: workload, decision autonomy, rewards, sense of belonging, fairness, and values [10]. Concerning the work environment and the climate experienced within it, some very toxic aspects were identified such as an inadequate workplace, unresolved conflicts between colleagues, the absence of mutual support, the presence of destructive social behaviours, and work-life balance i.e., the balance between work commitment and available free time [11].

The analysis of these aspects is assessed through the use of specific standardized psychometric instruments. For example, to analyze organizational aspects and stress perception, Griffiths' Work Organization Assessment Questionnaire (WOAQ) test and the Occupational Stress Indicator are used. For the analysis of moderate factors and the effects of burnout, the most popular tool is the Maslach Burnout Inventory (MBI) which is based precisely on the EE, DP, and PA dimensions. This questionnaire consists of 22 items divided into 3 main dimensions: EE (9 items), DP (5 items), and PA (8 items). Another functional instrument is the 14-item Shirom-Melamed-Burnout-Measurament (SMBM), which measures levels of physical fatigue (FF, 6 items), cognitive fatigue (SC, 5 items), and emotional exhaustion (EE, 3 items) [12-16]. During the pandemic, these psychometric instruments proved to be very useful, although they showed some structural and functional shortcomings, such as the defect in the relationship between the effectiveness of the data obtained and the actual psychopathological condition of the subject with regard to psychophysical health risk and the actual risk of burnout related to suicidal tendencies [17,18].

New proposal: Perrotta-Marciano Burnout Risk Interview – 1 (BORI-1)

To address these deficiencies [17,18], a questionnaire (Perrotta-Marciano Burnout Risk Interview - 1, BORI-1) has been developed and is being administered for validation, that intends to address the critical issues identified. The test (Table 1) is structured into 6 sections, for a total of 50 items, described as follows and taking the most widely used psychometric tests as a reference model, paying more attention to the issue of risk [19-21].

a) Section A consists of 15 items and is dedicated to personal information relating to the chronological age from 18 to 75 years (A1), the years of working service corresponding to the actual years (A2), the sexual gender (A3), the sexual orientation (A4), personal location (A5) and family location (A6), to evaluate geographical distances, the type of professional service provided (A7), the location where the service is performed (A8), the period carried out on missions or transfers, both in national territory (A9) and internationally (A10), overall time duration for carrying out missions or transfers in Italy (A11) and abroad (A12), personal status (A13), family status (A14) and possible presence of children (A15).

b) Section B consists of 7 items (B1-B7) and is dedicated to personal information relating to the neurotic symptoms suffered, in terms of anxiety, avoidance, phobia, obsessions, somatizations, and behavioural dependency patterns, in line with the Perrotta Integrative Clinical Interviews (PICI) model, cluster A [22-25].

c) Section C consists of 7 items (C1-C7) and is dedicated to personal information relating to the dramatic symptoms suffered, regarding depression, manicity, theatricality, instability, and attachment, in line with the PICI model, cluster B [22-25].

d) Section D consists of 7 items (D1-D7) and is dedicated to personal information relating to psychotic symptoms, regarding delirium, paranoia, dissociations, and hallucinations, in line with the PICI model, cluster C [22-25].

e) Section E consists of 11 items [E1-E11] and is dedicated to work information relating to one's own or others' conduct, in the specific workplace, with indications of the different daily dynamics.

f) Section F consists of 3 items [F1-F3] and is dedicated to personal information relating to one's experiences with suicidal tendencies.

The scoring involves the partial calculation of sub-sections B-C-D-E-F indicating specifics in the areas of neurotic symptoms (B), dramatic symptoms (C), psychotic symptoms

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(D), negative consequences in the work environment (E) and suicidal tendency (F), and an overall calculation measuring the risk of burnout in current time and space. Responses to Section a are instrumental in framing the personal context of the respondent and therefore have no scoring to be done. Scoring thresholds are calibrated based on the study protocol being applied, in a representative population sample; studies are ongoing, and are detailed here:

a) Section B is made up of 7 items, structured according to a Likert type with six scoring categories from 0 to 5 (L0-5) response scale with specific responses, and can give a minimum total score of 0 and a maximum total score of 35, established according to a graduated risk, so if the score is between 0 and 7, the frequency of neurotic symptoms is considered low, from 8 to 21 is considered medium (suspicious threshold) and therefore worthy of clinical investigation, while from 22 to 35 is considered high (clinical threshold) and therefore worthy of intervention, even in the presence of the subject's contrary opinion.

b) Section C is made up of 7 items, structured according to a response scale L0-5 with specific response, and can give a minimum total score of 0 and a maximum total score of 35, established according to a graduated risk, so if the score is between 0 and 7, the frequency of dramatic symptoms is considered low, from 8 to 21 is considered medium (suspicious threshold) and therefore worthy of clinical investigation, while from 22 to 35 is considered high (clinical threshold) and therefore worthy of intervention, even in the presence of the subject's contrary opinion.

c) Section D is made up of 7 items, structured according to a response scale L0-5 with specific response, and can give a minimum total score of 0 and a maximum total score of 35, established according to a graduated risk, so if the score is between 0 and 7, the frequency of psychotic symptoms is considered low, from 8 to 21 is considered medium (suspicious threshold) and therefore worthy of clinical investigation, while from 22 to 35 is considered high (clinical threshold) and therefore worthy of intervention, even in the presence of the subject's contrary opinion.

d) Section E is made up of 11 items, structured according to an L0-3 response scale with the specific response, and can give a minimum total score of 0 and a maximum total score of 33, established according to a graduated risk, but increased in as for the overall numerical summation of this sub-section (E), a "+ 1" must always be added for each answer given with a value of 2 and "+2" for each answer given with a value of 3, and if, finally, there are at least 6 /11 of answers with a value of 2 or 3, a further "+5" total must be added. The final total thus goes from 33 to 60. Therefore: if the score is between 0 and 6 the frequency of the discomfort is considered low, from 7 to 33 it is considered medium (suspicious threshold) and therefore worthy of clinical investigation, while from 34 to 60 is considered high (clinical threshold) and therefore worthy of intervention, even in the presence of the subject's contrary opinion.

e) Section F is made up of 3 items, structured according to an L0-5 response scale with specific responses, and can give a minimum total score of 0 and a maximum total score of 15, established according to a graduated risk, but increased as the overall numerical summation of this sub-section (F) must always be doubled, and only then must a "+ 5" be added for each answer given with a value of 2 or 3, "+10" for each answer given with a value of 4 and " +15" for each answer given with a value of 5. The final total thus goes from 15 to 75, precisely due to its clinical importance. Therefore: if the score is between 0 and 6 the frequency of suicidal risk is considered low, from 7 to 33 it is considered medium (suspicious threshold) and therefore worthy of clinical investigation, while from 34 to 75 it is considered high (clinical threshold) and therefore worthy of immediate intervention, even in the presence of the subject's contrary opinion.

The overall total score of all 35/50 items can be a minimum of 0 and a maximum of 240, distributed as follows: from 0 to 36 burnout risk is considered absent and insignificant, from 37 to 72 is considered low (and limited), from 73 to 123 is considered medium (and significant), from 124-174 is considered high (and marked), and from 175 to 240 is considered high (and critical); clinical intervention is suggested as early as a score of 124/240 or higher, even against the opinion of the subject under investigation.

Conclusion

The proposed "Perrotta-Marciano Burnout Risk Interview - 1 (BORI-1)" addresses the need to investigate burnout risk, paying particular attention to symptomatic manifestation and suicidal tendencies. To validate this psychometric instrument, a study is being conducted with a representative population sample that will demonstrate its ability to be valid, efficient, and effective concerning its goals and objectives.

(**Table 1:** *BORI-1 test*)

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