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The tired hero and her (il)legitimation: Reworking Parsons to analyse experiences of burnout within the Dutch employment system and lifeworld

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ABSTRACT

Burnout is an illness label, and in some healthcare systems a diagnostic category, which has received growing attention and usage. Despite its ubiquity and widespread media coverage, the medical sociological literature on the condition remains small and the wider sociological literature tends to treat the rise of burnout as a straightforward reflection of changing working environments. Very few studies have critically reflected on the nature of burnout, its diagnosis and lived experiences of the condition. This neglect is surprising given the relative legitimacy of burnout as an illness category in several national healthcare contexts, not least in the Netherlands. Drawing on in-depth qualitative interviews with a range of burnout sufferers (n = 18) and diagnosing professionals (n = 12) in the Netherlands, we explore participants' narrated understandings of the condition in light of a reworked Parsonian framework. Narratives suggested sufferers of burnout generally received legitimation, often being understood as hardworking, diligent and altruistic. Experiences of (partial) acceptance through a medical label, and the relative lack of stigma were important to sense-making and coping. This recognition of burnout was particularly striking, given several features burnout shares with conditions commonly associated with ontological doubt, moral suspicion and stigma. Yet recognition of commitment and strength sat in tension with psychological assistance, which sought to correct tendencies for working too hard for too long. Drawing on insights from Habermas's extensive reformulation of Parsons's work, we understand the legitimation and tensions around burnout care in light of meanings, metaphors and manipulation which, in turn, we locate in relation to the functioning of wider socio-cultural lifeworlds and political-economic systems, including the sediments of earlier political-economic and cultural structures.

1. Introduction and context

Since the 1970s burnout has been used – with growing frequency – to refer to a work-related medical-psychological problem (Maslach, 1976; Farber, 1983). In recent decades considerable research has led to more than thirty definitions, yet the most common conceptualisation resulted from empirical research done by Maslach and her colleagues in California (Schaufeli et al., 2009: 204; McCormack and Cotter, 2013) who developed the Maslach Burn-out Inventory (MBI) to assess experiences of burnout. Consonant with this scale, burnout has commonly been understood as 'a psychological syndrome of exhaustion, cynicism and inefficacy in the workplace' (Maslach and Leiter, 2000: 358; Schaufeli, 2009).

Despite neat definitions and assessment scales, not to mention forty years of psychiatric research, the clinical diagnosis of burnout remains problematic, with significant variations across countries in (non)diagnosis (Lastovkova et al., 2018). One key obstacle to wider consensus is the significant overlap of the stress-related medical features of burnout with those of depression (Bianchi et al., 2020). Other reasons for diagnostic uncertainty include the lack of positive neurobiological markers for burnout syndrome (van Luijtelaar et al., 2010) and of specific biomedical mechanisms to explain the development of the condition (McCormack and Cotter, 2013). Moreover, at the time of data collection (2014), the international classification systems DSM-5 and ICD-10 did not provide for the diagnosis of burnout. While the ICD-10 mentions burnout as a 'state of vital exhaustion' (Z73.0), this was not regarded as a diagnosis *per se* as no diagnostic criteria were provided (Flach 2013; van Luijtelaar et al., 2010: 208). Consequently, related diagnoses have been commonly invoked as a proxy basis for diagnosing burnout. In the Netherlands, the ICD-10 definition of Neurasthenia (F43.8) was

commonly used by doctors (Kleijweg et al., 2013: 436) though these neurasthenic symptoms should additionally have been work-related (Schaufeli et al., 2009: 213). Many authors and clinicians have been using 'work-related neurasthenia' as a working formulation of burnout in psychiatric terms (Kleijweg et al., 2013) but this has been just one of many pragmatic tendencies towards (non)diagnosis across Europe (c.f. Lastovkova et al., 2018; Maija and Katri, 2019).

In light of the medical sociological literature, we would expect these diagnostic ambiguities and inconsistencies around 'burnout' to be problematic for sufferers' experiences of meaning and legitimacy. All conditions are imbued with various social and cultural meanings which are bound up with social attitudes towards the condition or label (Scambler, 2009) and its commonly conceived 'genuineness' (Parsons, 1975). Historically-rooted cultural connotations involving 'madness' render some psychologically-oriented labels as profoundly stigmatizing (Corrigan and Watson, 2002), with various negative associations continuing to linger as 'sediments' of earlier cultural systems (Shilling, 2002:624). Such moral (il)legitimacy of different conditions are also connected to understandings of whether individuals are seen as responsible for their conditions or not (Parsons, 1975). As a psychological condition attributed to individual performance in the workplace, the moral legitimacy of burnout might therefore be presumed as being open to question.

These features of moral legitimacy can be distinguished from – though, as we will see, are not unconnected to – aspects of ontological legitimacy regarding understandings of the 'existence' of a condition. Symptoms that are not detectable as biomedical 'signs' but solely verifiable based on the patient's description may thus fail to gain legitimacy (Broom and Woodward, 1996:375; Dumit, 2006), as the validity of sufferers' symptoms are often questioned. This has commonly been the case with chronic fatigue syndrome and fibromyalgia (Asbring and Närvänen, 2003: 712). Cases that defy neat ontological categorisation tend to lack wider recognition and moral legitimacy, fostering stigma (Dumit, 2006:583).

One further defining feature of illness legitimation pertains to duration. From a Parsonian perspective, important tensions emerge within the moral dispensation of the 'sick role' in longer-term conditions – between the fiduciary commitments of the doctor to recognise and treat a condition and the reciprocated fiducial duty of patients to be motivated to return to their 'normal' roles (Parsons, 1975:267; Crossley, 1998). The failure on both sides – regarding effective treatment and full restitution – may lead to uncertainty about the capability of medical professionals and of the patients' genuine motivation 'in working toward the common goals of the system as a whole' (Parsons, 1975:267).

At the time of data collection, burnout sufferers in the Netherlands took 189 days sick-leave per year, on average, and sick-leave could legally last up to two years (Flach, 2013). Yet despite this longer duration, and the aforementioned uncertainties around visibility, biomarkers and diagnosis, burnout would appear to be an established medicalised condition in the Netherlands. With more than 1.3 million employees reporting burnout related symptoms (15.9 per cent of the workforce, CBS, 2017), burnout makes up the majority of occupational-health problems in the Netherlands (Schaufeli, 2007: 534). Despite ambiguities around diagnosis, burnout is included in medical handbooks and health professionals are trained in assessing and treating burnout. Subsequently, the label burnout facilitates referral through the insurance-based healthcare system and has provided individuals with access to financial compensation arrangements, reintegration programmes, psychotherapeutic treatment and rehabilitation for many years (Schaufeli et al., 2009: 211). Similar recognition and legitimacy is apparent within employment law, where sufferers are exempted from work responsibilities and granted sick-leave which may last up to two years. During these two years, employers are obliged to continue to pay wages (in some sectors at 100% usual salary - Aumayr-Pintar et al., 2018), in accordance with the Dutch Continued Payment of Salary Act [Wet Verlenging Loondoorbetalingsverplichting bij ziekte] (Flach,

2013: 51–52). In exceptional cases, employees have been deemed eligible for financial compensation – a 46-year old insurance company consultant was granted €237,000 b y the Dutch state to compensate for his disability caused by burnout (Schaufeli, 2007: 534).

This recognition and legitimation of burnout, in the Dutch context at least, despite its core features – psychological, lack of biomarkers and a neat diagnostic category, long-term, behaviour-exacerbated and incapacitating – marks it out as a salient case for sociological investigation. Yet very few researchers have examined the burnout phenomenon from a critical medical sociological standpoint and even fewer studies have focused on exploring the social meanings of burnout. The label burnout is generally used unquestioningly to refer to particular symptomologies resulting from pressurised experiences of paid labour in late-modernity. For instance, in his writings on the rapid changes in societal and labour market structures, Eriksen (2001:126) mentions burnout as one of its consequences - a by-product of the rapidly changing society - without further reflexivity towards the label. Previous research largely fails to denote how understandings of burnout are embedded in social and cultural systems and meaning contexts and how these are vital to the ostensible legitimacy of the label, with Maija and Katri's (2019) study of the moral ordering of sick-leave after a burnout being one important exception. Broader sociological research on work-stress (e.g. Wainwright and Calnan, 2002) does not refer to burnout specifically and, while adopting a critical historical perspective, has tended not to interrogate processes of illness legitimation.

In the study below, we set out to explore experiences of illness (il) legitimation through analysing interview accounts of individuals diagnosed with burnout alongside those of a small number of doctors, within the broader Dutch context (briefly sketched above) where the apparent legitimacy of burnout is commonly regarded and legally institutionalised. We chose to interview Occupational Medicine Specialists and General Practitioners as these two groups are responsible for diagnosing burnout, respectively, among those in and outside formal employment. Far from denying the lived experiences of our participants, we were especially interested in how sufferers and doctors made sense of physiological and psychological symptoms in light of illness labels and the impact of this sense-making work – and related meanings, metaphors and (il)legitimation – on the ongoing lived experiences of sufferers. In this sense our orientation is somewhat broader than Maija and Katri's (2019) study of burnout-related sick-leave. This broader approach was also shaped by important Parsonian insights on sickness (il)legitimation.

1.1. Theoretical framework – extending the rehabilitation of Parsons

As noted, the relative legitimacy of burnout, at least within the Netherlands, raises various theoretical questions which are germane to classic debates within medical sociology, not least in terms of the legitimation of illness through interaction with, and diagnosis by, medical professionals. Parsons's (1951) classic conceptualisation of an ideal-type 'sick role' would appear to be especially apt given the work-related, psycho-somatic and motivational features of common burnout diagnoses. These fit neatly within Parsonian themes of illness and healthcare as pertaining to the deterioration, control and restitution of physiological, mental and social functioning, in relation to the wider social system (Parsons, 1975; Crossley, 1998).

Long-standing conventions in medical sociological writing would render these brief mentions of Parsons sufficient, before we would move on to address more current and less criticised perspectives (see Williams, 2005:123–124). This well-trodden path, of acknowledging while largely stepping around Parsons's work, has gradually been obstructed however by a series of reappraisals (Lupton, 1997; Crossley, 1998; Shilling, 2002; Williams, 2005; Willis, 2015). These works have commonly set out to: correct the mistakes of regular critiques of Parsons (especially in terms of problematically narrow, overly literal, or mistaken interpretations of the sick role); pull out neglected yet important facets of his work (not least important psychodynamic insights on interactions, emotions and

culture); and discuss the ongoing or even renewed salience of these facets for contemporary sociologies of medicine, health and illness (see Lohm et al., 2020). What these studies tend not to do, with the partial exception of Shilling (2002), is to develop a more systematic reworking of Parsonian medical sociological theory.

Given our interest in meaning-centred socio-cultural processes – and contrary to the reported neglect of this within accounts which crudely reduce Parsons's analysis to mere structural-functionalism – Parsons's relevance has been affirmed within Shilling's (2002) reappraisal of the sick role in light of its Weberian influences (see also Gerhardt, 1989). The broader social system, within which the sick role must always be understood (Williams, 2004:125), is very much a historically constituted one – defined by a peculiar form of (Western) rationalisation and therefore imbued with particular cultural values, role-norms and meaning resonances as the 'sediment' of earlier protestant-Christian cosmologies (Shilling 2002: 623).

Lupton (1998) meanwhile traces a different set of themes and influences in her study, emphasising the psychodynamic features of Parsons's work. Far from portraying a passive patient object (as some critics suggest), Parsons's (1975) attentiveness to the more or less conscious motivational ambivalences of patients offers a very rich assessment of the explicit and taken-for-granted tensions which lie at the heart of subjective illness experiences (Lupton 1997). While there are important methodological limitations to the study of psychodynamic processes, particularly within empirical sociological research (see Pilgrim's 1998 critique), Lupton nevertheless develops a host of Parsonian themes which raise many important considerations regarding the influence of 'discourse and metaphor' in constituting 'the ways that "health" and "disease" or "illness" are psychically invested with meaning' (Lupton, 1997: 573–574). These lines of inquiry are pertinent in fleshing out the sedimentation effects of 'cultural instrumentalism' denoted by Shilling (2002:622). Such Calvanist 'left-overs' (Habermas, 1987:328) are apparent within the often highly implicit, yet symbolically violent, binaries or 'splitting' which contrast positive connotations of health with the devaluing of certain patient groups as 'uncontrolled' and 'undeserving' (Lupton, 1997: 573). Several such associations are visible within taken-for-granted processes by which professionals and patients alike 'keep up the belief that self-control, "being strong", the concealment of anger and anxiety and the promotion of hope are vital to the latter's chances of getting better' (Lupton, 1997:574). Evidence of similar tendencies are apparent in Maija and Katri's (2019) study of burnout, though not explained historically.

These richer, less simplistic, readings of Parsons's work on medicine, health and illness make clear that various weaknesses ascribed to either stream of Parsons's dual approach – functional-systems or interactive-psychodynamics – are able to be largely resolved by the other. The reductionist-objectivist problems widely attributed to structural-functionalist systems-based approaches are offset by the rich experiential and interactive depths of Parsons's psychodynamic orientations. Meanwhile the methodological difficulties of applying psychodynamics within sociology, such as locating sub-conscious processes largely within the individual (see Habermas, 1987 and Pilgrim, 1998 for important critiques), may be countered by exploring related concerns of meaning, metaphor and manipulation within the various layers of Parsons's systems mechanisms – including the more or less paternalist interactions of doctors and patients (Parsons, 1975), the ritual-magical properties of these exchanges (Fox, 2000:410), and broader patterns of socio-cultural norms (Shilling 2002) and their shaping of a 'health role' (Frank, 1991; Williams, 2005). Metaphors and their taken-for-granted shaping of thinking and communication are especially pertinent to analysing health and illness norms (Kirmayer, 1992; Lupton, 1998). Replacing the unknowable subconsciousness with a more robust conceptualisation of everyday taken-for-granted lifeworlds, partially sedimented from current and past socio-cultural norms and system imperatives, provides us with a clearer basis for empirical inquiry (Parsons, 1975; Habermas, 1987).

Such an extension of Parsons, leaning on Habermas's (1987: pp.199–331) extensive critical appraisal and reworking of Parsonian theory in terms of an instrumental system and socio-cultural lifeworld, can be especially pertinent to analysing experiences of burnout. Central to cultural meanings of burnout are metaphorical notions, involving manifold compressed meanings which may be transferred from one object to the next in ways which provide rich cultural bases for meaning-making, communication and critique. These lifeworld processes simultaneously generate a potent combination of cognitive, emotional and somatic associations (Kirmayer, 1992: 324,332) in ways which may enact economic interests and power (Habermas, 1987).

Lifeworld-system considerations also guide us in considering patients' illness experiences, not least the reworking of the self through illness narratives (Giddens, 1991; Ezzy, 2000), where the moral experience of illness can be seen as inseparable from scientific verifiability (Broom and Woodward, 1996). Parsons explores how systems of moral legitimation tend to 'converge' with the interests of powerful institutions (Parsons 1937:404; Habermas, 1987:208). Indeed the ability of individuals to rebuild a legitimate self amid illness is shaped by available material resources and the influence of authority (system), alongside the psycho-cultural understandings and social legitimation (of their lifeworlds).

It is in these senses that Parsons provides a far richer basis for contemporary medical sociological inquiry than is typically recognised, especially when it comes to interrelated processes of diagnosis and illness experience (Fox, 2000; Williams, 2005; Willis, 2015). The dual streams of his work remind us that ontological uncertainties within medical organisations are inseparable from the symbolic, metaphorical and moral meaning-making processes of clinical encounters (see also Jutel, 2009:278). The social production of diagnoses emerges out of value-based interactions between actors located amid particular configurations of power and with different goals. These must, in turn, be understood within a wider socio-cultural framework, whereby the negotiated access to legitimation via the sick role may lead to socio-cultural understandings prevailing over, or coordinating, clinical judgements (Wainwright et al., 2006: 87). These understandings are rooted in metaphorical associations and their implicit values and deep resonances, which we can understand as cultural sediments of systems of political-economy – past and present (Shilling, 2002:623; Habermas, 1987:186).

2. Methods

Our research aims (noted earlier) informed our qualitative analysis of the in-depth narratives collected from a small sample of burnout sufferers (n = 18) and physicians (n = 12; 7 occupational health specialists and 5 GPs), recruited through social media (sufferers) and cold-contact emails (physicians). In order to generate rich, detailed yet varied insights into burnout, purposive and structured variation sampling was followed using specific parameters (see table one for more detailed participant information) to span: men (n = 8) and women (n = 10); from across two contrasting age brackets (20–30 and 45–60); living in rural and urban areas (these locations are identified in the literature as influencing levels of stress and burnout symptoms – see Abel and Sewell, 2010); and active across wide-ranging job sectors (see Table 1). Within interpretative traditions of medical sociology, 30 interviews lasting 1–3 h (mean length of interviews with sufferers = 1 h 46 min) is considered a large volume of data. The completed interviews were deemed sufficient based on data saturation principles, with no new themes emerging in the latter interviews. By adopting theory-informed, purposive sampling, as emphasised within 'mainstream' qualitative research (Tavory and Timmermans 2014), we cannot make claims regarding representativeness or external validity.

At the time of the interviews all but three sufferers perceived themselves to be fully recovered. While a burnout diagnosis provided by a medical professional was initially part of the inclusion criteria, we

Table 1

Basic participant information.

Pseudonyms	Age bracket	Sex	Job sector	Residency
Rianne	20–25	F	Wholesale	Small Rural
Emma	20–25	F	Student	Large Urban
Sophie	20–25	F	Student	Rural Setting
Jelmer	20–25	M	Student	Urban Setting
Julia	26–30	F	Student	Small Rural
Ramon	26–30	M	Transport	Urban Setting
Vera	26–30	F	Communication	Large Urban
Mike	26–30	M	Industry	Urban Setting
Robert	46–50	M	Agriculture	Small Rural
Karen	46–50	F	Education	Urban Setting
Ruben	46–50	M	Retail	Rural Setting
Richard	46–50	M	Industry	Rural Setting
Hanneke	50–55	F	Public service	Small Rural
Ria	50–55	F	Health care	Urban Setting
Margriet	50–55	F	Education	Large Urban
Martin	56–60	M	Public service	Large Urban
Corry	56–60	F	Hospitality	Small Rural
Gerben	56–60	M	Finance	Rural Setting

prioritised individuals' accounts of experiencing burnout, thus we did not exclude one participant who identified as having experienced burnout without an official diagnosis. Interviews were carried out by JB in a location of the participant's choosing – usually their home (sufferer) or workplace (physician). JB had experienced a diagnosis of burnout herself several years before the study. Her personal experience facilitated deeper understanding and probing, and sensitivity to various topics during interviews. These prior experiences of burnout were only mentioned when participants inquired, and this appeared to encourage trust and openness during interviews. These and other power dynamics and wider ethical considerations around access and informed consent were approved within the institutional structures of [anonymised] the Medical Anthropology and Sociology graduate programme at the University of Amsterdam.

Narrative interviews allowed an in-depth exploration of micro-level processes of meaning-making and experiences of burnout as shaped by interactions with others and broader socio-cultural lifeworlds (Wu et al., 2004). Our analysis was informed by an interpretative approach, using detailed consideration of the transcribed narratives (noting laughter, weeping, whispers and silences) to grasp actors' understandings and meaning-making processes around their experiences in terms of illness labels and metaphors (Kirmayer, 1992; Wu et al., 2004). These broad orientations guided the initial open coding, alongside techniques of defamiliarization and searching for surprising findings, following abductive techniques (Tavory and Timmermans, 2014). During axial coding phases, the 'sick role' theme was identified as important for further research, thus becoming a 'selective' analytical focus in its own right and the focus of this article. More specifically the broader structures of interview narratives – often coded as relating to earlier role functions, the illness experience, and returning to 'normality' – alongside surprising levels of legitimacy and the role of emotions, metaphors, professional guidance, and sufferer obligation, were interpreted as indicating the salience of Parsonian insights.

3. Findings

3.1. The tired hero

In this section we explore various ways in which participants described their understandings of burnout and gave meaning to the label. Findings presented in this section reflect characteristic themes across the participants, informed by their emphasis and frequency within and across the elicited narratives.

In popular media in the Netherlands burnout has been commonly described as a 'sickness caused by working too hard', often associated with 'workaholics' (van Bergen, 2011). Without exception, all

sufferer-participants described their understandings of burnout as related to excessive job-related activities and that those affected by it were typically the most hardworking:

> Ria, 50–55: Well, people who were overworked. What I had in mind, were people who are continuously at work. I thought of people who worked hard till 9 [or]10 at night.

'Work' was highly salient to participants' understandings ('work' was mentioned 39 times per interview on average) and, more specifically, common considerations of burnout as resulting from unusually hard work over an extended time period. In emphasising the extent of overwork, some went further to contrast burnout (the English term is commonly used in Dutch) with a less serious condition referred to using the Dutch term 'overspanning' (literally 'over-strain'):

> Martin, 56–60: Well I think burnout is more severe. I mean, I work in tourism and that means that leading up to the holidays I have to do many extra hours and I can handle that. But afterwards, I do feel a bit more agitated and do need some extra rest. Well that's what you could call overstrain [overspanning]. That's not a bad thing, because it will resolve itself with some rest and in the course of normal life. But a burnout, well that took me 2–3 years [to recover from].

Martin differentiated here between normal hard work and then problematically high levels of work. Whereas Martin contrasted medical descriptions, others used more metaphorical narratives:

> Hanneke, 50–55: You have to look at it like a battery which is completely exhausted and needs to recharge.

Such narratives, though varying in style and content, tended to imply or explicate burnout being inflicted by outside forces, with this having important implications for blame and accountability amid illness narratives. As Martin continued:

> My thoughts were, 'well this is really not my fault and I don't have to feel ashamed or anything'. Yes I am sick, there is nothing wrong with that right?

As with Martin's narrative here, other diagnosed-participants tended not to emphasise guilt or shame. Framing the cause of burnout as work-related, narratives typically considered burnout more in somatic terms and placed the cause of the illness on the work-situation and therefore outside the self (Leone et al., 2011). These accounts appeared to render participants relatively blameless for their illness, as victims of an externally caused 'overload'. Electrical metaphors, of overload or a battery that had run empty, were common and potent, implying an understandable or normal physical outcome resulting from the wider circuitry.

Alongside metaphors, the relative absence of blame and stigma in narratives (c.f. Asbring and Närvänen, 2003; Maija and Katri, 2019) was furthermore evident when scrutinizing participants' language. Verbs used to describe the process of becoming ill were revealing of the (assumed) underlying causation and the sufferer's role in bringing on the condition (Fleischman, 1999). Participants generally referred to burnout as something they 'got' or 'had'. 'Getting' or having 'a burnout' – unlike in English, the grammar of 'burnout' in Dutch typically considers it as an individual object – cast participants in a more passive, blameless role vis-à-vis the pathology. Moreover, they described the process leading to a burnout as something that 'struck' them, further distancing the self from pathology in speech patterns (Cassell, 1976; Fleischmann, 1999).

Alongside these ways of referring to the condition, several diagnosed-participants' accounts of burnout emphasised strengths related to the individuals affected by burnout (including themselves), not least of high endurance as they managed to endure years of work stress before finally 'falling down'. It was difficult for us to pinpoint the origin of these understandings, however the data collected through interviews with

doctors suggested that sufferers' meaning-making may well have been drawn from, or at least legitimised by, their interactions with medical professionals. Doctor-participants strongly asserted the strength and commitment of burnout sufferers:

> Occupational Health Specialist (OHS)3: [Burnout typically affects people] with a long endurance, who don't reach their limits easily, because someone who notices at an early stage - I can't do this - will hit the brakes.

The same doctor went on later to add:

> Burnout sounds like 'I went down fighting'. Well done! Bravo, for working that hard! It implies that people really worked too hard and some say that if you have a burnout, it's actually quite cool [..] If someone, who really busts a gut, falls down, people have a certain degree of respect for that.

> OHS2: A burnout is rather an overload for many years, you know.

In short, common accounts of a long pre-history associated with burnout led to certain presumptions about those affected with the pathology - strong, engaged people with endurance. These professional accounts also echoed wider popular writings in the Dutch public sphere on burnout: 'Lazy people do not get a burnout: only people full of fire can burn out, others would have given up long before' (Bronsberg and Vestlund, 2006:18).

Whether drawn from popular portrayals in books and magazines, and/or via interactions with occupational health doctors, GPs and other professionals – participants typically described themselves in similar terms, as strong, engaged and having the ability to take everything on; therefore the 'ideal candidate for burnout'. For instance, Richard joked that he would 'graduate with honours' for getting burnout, denoting his own strengths:

> Richard, 46–50: I could do thousands of things at the same time and I was mentally so strong, really, I could do everything.

Similarly, Gerben (56–60) asserted: It was highly unlikely I would get a burnout because I was so strong, that wouldn't happen to me …

Our neo-Parsonian framework leads us to further consider these assertions in the context of historical structures of Dutch socio-cultural systems and the cultural sediments and metaphorical resonances these have left behind. Central here would be the salience of a Protestant-Calvinist work-ethic, characterized by deeply felt obligations to work hard and a degree of suspicion regarding leisure (Bogt, 2005: 421; Elshout and Velthuis, 2013). In a society where working hard has been perceived as a laudable virtue, individuals affected by a condition associated with 'working too hard' may arguably attain a higher moral status, sympathy and legitimacy.

Narratives of strong and dedicated individuals, resonating with certain highly valued virtues in Dutch society, were apparent in various interview accounts, including those of the occupational health doctors:

> OHS4: The tired hero, always worked so hard, did their utmost best for others, with heart and soul, and now they're burned out.

> OHS3: Loyal, involved, perfectionist, who doesn't reach their limits easily.

The following section will illustrate how this moralised narrative of a 'tired hero', alongside understandings of external work-related causes and (partial) blamelessness, shaped the illness experience of participants.

3.2. Legitimating the hero

Several past sufferers described experiences of widespread support from their contemporaries, in stark contrast to what one would expect given the earlier description of burnout and the uncertainty over its ontology, classification and diagnosis (c.f. Asbring and Närvänen, 2003; Dumit, 2006) and studies of burnout elsewhere in northern Europe (e.g. Maija and Katri, 2019). Ruben explained how his line-manager responded when he retreated from work in response to burnout:

> Ruben, 46–50: I stayed at home for several weeks, then my employer visited me and told me - this gave me some peace - like eh, 'don't do anything, you don't have to do anything, only think about Ruben now'. That was a huge relief.

Such support, from within the workplace and across wider social environments, was common among participants interviewed in this study, both those employed and those in other contexts (students, for example). Similar to Ruben, Sophie described how receiving a diagnosis allowed her to retreat from her normal social roles, granting access to the 'sick role', as Sophie suggested:

> Sophie, 20–25: [after the diagnosis …] Then I could finally give in and really take my rest. I couldn't give in before, I still kept fighting it - but I could really take rest now, legitimate rest, and people [around me] allowed me to take rest.

Receiving a burnout diagnosis was perceived by Sophie as legitimizing her absence from 'normal' social roles and assisting her need for recuperation. Such responses were common among participants, suggesting that burnout was generally perceived as a legitimate reason for stepping back from everyday duties (Parsons, 1951). Following Parsons, individuals must have legitimate reasons for not fulfilling their normal social roles which, among other features, should be beyond their control, as seen in the preceding section:

> Robert, 46–50: Yes, [I received] maximum support […] and that was also a confirmation. That it's caused by your work and- because at a certain point you start looking at yourself but eh- In the end it was very clear that it was related to my work, and it made me feel better when they told me that it was actually unavoidable, seeing how we work [in agriculture].

These 'legitimate' exemptions, affirmed by others, were common and often left patients with a huge sense of relief, as Gerben related to his visit at the doctor:

> Gerben, 56–60: [I felt …] very emotional. I cried there [at the GP]. It was very emotional. I remember when I left and he told me: you can stay at home, you don't have to work. That was an immense relief, that […]that felt so, I felt so relieved, that for a while I didn't have to do anything.

Alongside relief at being (temporarily) exempted from typical roles, participants also referred to relief in terms of being able to explain their situation to others in more acceptable, legitimate terms. Rianne explained how it helped her coping in daily life:

> Rianne, 20–25: I told everyone and I think that really helped me, that they knew. That I could say: I have a burnout. And everyone was so understanding. I think if I hadn't, I would have had a lot of fights. Because they can take it badly when you say like: I'm tired. But now it was ok.

Receiving a burnout diagnosis could function as a powerful social device for participants, legitimizing their experiences to contemporaries and in negotiating their taking a step back from multiple social contexts.

In line with the wider literature on diagnosis and illness narratives (Broom and Woodward, 1996: 373; Ezzy 2000; Madden and Sim, 2006), several participants furthermore described how receiving a diagnosis helped them to organise and thus make sense of their experiences. Julia explained how it opened up possible solutions for participants and paths toward coping:

Julia, 26–30: When I finally knew what it was, I felt like I could move on or at least work on it, because it had a name and I could take a step back and grow from that.

As in Julia's experience, diagnosis often gave meaning to participants' experiences and relieved them from stress or ambiguity of the unknown, and in some cases ruling out other less legitimate possibilities:

Sophie, 20–25: I was always wondering, what's wrong with me? And if you have an explanation, you know where you're at. So for me it was a relief that I wasn't so weird after all, that there was an explanation for what's going on.

Participants described the diagnosis as providing them an explanation for unidentified symptoms and allowing them to regain control over their situation (c.f. Madden and Sim, 2006). As apparent in Sophie's account above, the label was experienced as normalizing, partly through helping rule out more stigmatised conditions. Karen similarly expressed her concerns, regarding the possibility of a 'psychiatric disorder', which were alleviated through her burnout diagnosis:

Karen, 46–50: The difference for me was that I stopped doubting myself, I stopped thinking that I might have some psychiatric disorder or something. I remember thinking: ok, I still have a healthy mind. I still can tell what's normal from what's not.

Within Karen's illness narrative, her trust in her 'self' was repaired by the diagnostic encounter with the occupational doctor, allowing her to re-establish a coherent identity (Giddens, 1991; Ezzy 2000). Apparent in this excerpt, as with Ria below, is the understanding of burnout as existing externally to the sufferer's own mind.

Ria, 50–55: [..] it turned out I'm a very normal woman. Things just all got a little bit too much and I need to learn how to set boundaries.

For Karen and Ria, the more mundane 'psychological' condition of burnout was able to be distanced from 'abnormal' 'psychiatric' problems. Burnout was able to be associated with a normal mind and personhood, and a relative absence of stigma. This common understanding emerged in interviews despite narratives regarding the apparent effects of burnout on mental wellbeing and everyday cognitive tasks.

We understand the apparent tensions here, both in the individual narratives and in the broader societal understandings of burnout, as contradictions which become more glaring when considered alongside studies of the experiences of (largely female) sufferers of myalgic encephalomyelitis or fibromyalgia (Broom and Woodward, 1996; Wainwright et al., 2006). That these tensions in cultural meaning-frameworks remained largely 'veiled' (Brown and Gale, 2018) in the case of burnout, and that sufferers described relatively high levels of legitimacy and relatively little scepticism, relate to particular interactions between wider social meaning structures (lifeworlds) and other social systems (see Discussion).

We explore further tensions in the final data sub-section where, despite the common understandings and interactions which can be seen as largely affirming sufferers' identities, our participants also referred to an apparent need to rework their 'selves'.

3.3. Even heroes must rework themselves in the face of the disruption of burnout

In this final data section we explore how participants in this study reconstructed their concept of 'self' in the aftermath of their burnout. As suggested earlier, participants often associated their concept of 'self' with characteristics such as being strong, dedicated, hardworking and altruistic. These characteristics were described as central to identity and everyday interactions with others. Alongside a post-diagnosis affirmation of such selves, we have also seen evidence above that pre-diagnosis experiences had undermined taken-for-granted assumptions about the self.

Interview narratives reflected tensions between these two understandings - experiences of affirmation and undermining of the self – and illustrated how participants came to re-evaluate their conception of self and everyday conduct after the experience of burnout. Narratives often referred, more or less directly, to a 'learning process' where the burnout experience was characterized in terms of reflexivity and of re-evaluating their former self and conduct in everyday life:

Gerben, 56–60: You could say burnout is something positive, because you become very aware of what you been doing, how you have lived, huh? [..] Because of that burnout I started to look at my behaviour much more consciously.

While here Gerben describes reflecting on his 'behaviours', it was more common for participants to refer to their personhood or identity:

Karen, 46–50: I feel a much stronger person, I just learned a lot from it and because of that I feel a richer human being.

The most common themes within these accounts of the reflexive burnout experience were learning, change and becoming stronger as a result of burnout:

Vera, 26–30: It [burnout] is something that makes you learn a lot about yourself and eventually makes you stronger. Because you learn so much about yourself.

Overall, (former) sufferers described the self in terms approximating a 'reflexive project', something to be altered, moulded and reflected upon (Giddens, 1991: 32). This 'response shift' – a recalibration of standards, values and goals (Sprangers and Schwartz, 1999) – is not an uncommon finding among studies of illness narratives (e.g. Ezzy, 2000). There were though some cultural and burnout specific emphases to the shape and direction of this reworking of the self.

The foci of this reflexivity denoted two key tendencies. First, (former) sufferers often described how their strength and capabilities had been called into question, as they had envisioned themselves as *strong*, which they could not reconcile with the experience of burnout. For instance, agricultural worker Robert described how his prior taken-for-granted perception of strength had become challenged:

Robert, 46–50: No, you think you can take on everything. There's no limit. But then there *is* a limit. Yes, that's a harsh message.

Second, many diagnosed-participants narrated how they later came to reframe their loyalty, dedication and altruism as causing them to work excessively and sacrifice themselves for others; associating these pro-social tendencies with a risk of burnout. Amid self-reflexivity, therefore, older participants in particular described gaining a heightened awareness of their altruistic behaviour or commitment to the group as counterproductive and potentially dangerous. Corry thus came to re-evaluate these traits:

Corry, 56–60: It worked against me, while I only wanted to do good. And now I think: I wish I hadn't. I won't try to fix things anymore because that didn't save me.

Richard similarly referred to the 'pitfalls' of being obliging:

Richard, 46–50: Never telling people no, that's one of my biggest pitfalls. Everyone's always asking me for help, [with] the stupidest things. But in the end, you've only been working for others, eh, yes that's one pitfall – you only work for others. But I don't do that anymore now.

In several instances it became apparent that this reflexivity and re-evaluation of identity, character and everyday practices were importantly shaped by the various professionals (psychiatrists, psychologists,

social workers and therapists) with whom, alongside the occupation health doctors, (former) sufferers were working as their treatment and rehabilitation developed.

> Karen, 46–50: She [therapist] has made the difference in my life, just by teaching me that letting people walk all over you is a choice, and you can say: stop! And she literally told me: 'when are you going to slam with your fist on the table and demand what you want and you think'.

This guidance from professionals to take care of oneself before taking care of others, was central to many narratives, though in other accounts the re-orientation of one's working practices was narrated more as the result of self-discovery:

> Ria, 50–55: First you, and then others. Don't worry about others anymore. It won't help you, and it won't reward you either. I know from this experience that it hasn't helped me; where is everyone now? You have to say: this stops now. I don't want this anymore. Start to work on yourself, very consciously. I told myself: 'Ria, you have to change, after this. You have to'. I need to toughen up. It's hard, but I have to, otherwise it will go wrong again.

Considered alongside the core themes presented in the first two data sections above, these latter requirements to 'change' and 'toughen' reveal important ambivalent processes and tensions around the (il) legitimacy of self and burnout. Common understandings of the hard work of the 'tired hero' could, as seen in many instances in our data, create a social legitimation of participants' suffering, and assisted their claim to the sick role (as seen in prior sections). Yet this 'hero' nevertheless required modification amid the sick role process (Parsons 1951) – with socio-cultural roles and expectations fostering pressure to find a 'solution', which was typically understood in an individualised, psychologised sense of excerpting control within one's organisational environment. Parsons's sick role model, alongside an attentiveness to common burnout metaphors such as the battery, help us work through this ostensible contradiction of weakness (Robert's 'harsh message' of having been dominated by his environment) and strength (endurance). Both characteristics were tied to morally-appropriate social obligations, with the loyal agency of the enduring worker sufficient to allow for, and to excuse, the empty 'battery' – in light of the demanding 'circuitry'.

Our reworked Parsonian approach thus leads us to consider lifeworld processes, of meaning-making in relation to norms and metaphors, with an eye to the way these processes may also involve manipulation in line with underlying goals of political-economic systems (Habermas 1987:208). In the preceding section we saw how Sophie felt legitimated through the biomedical understanding of her condition (she was not 'weird') yet – in Parsonian terms – this biomedical understanding cannot be separated from her social obligations to seek help and to want to get better (Williams, 2005: 124):

> Sophie, 20–25: I felt this pressure to find a solution and not just stay home, but really make sure to find a solution, so I could really participate in society again and … It was of course not accepted that I was sick that often.

The expectancy to do 'less', as expressed by many (former) sufferers, especially younger ones, can be understood from a medical perspective in terms of averting future illness and, moreover, from a wider socio-functionalist perspective in ensuring their continuous functioning in the social and labour-market systems. In this, we suggest that the sick-role functioned to modify participants into more sustainable, 'resilient' employees, thereby channeling and altering their altruistic conduct – via particular interpretations of the experience of burnout – in patterns which ensured a certain kind of role-continuity in economic and social contexts, despite the changing dynamics and pressures of these same contexts.

4. Discussion

The Netherlands remains an interesting and pertinent national setting in which to study burnout. While self-reported European Working Condition Survey data indicated that the Netherlands had the lowest level of overwork in Europe (see Schaufeli, 2018:6), Lastovkova and colleagues (2018:162) found that the numbers of those diagnosed 'with acknowledged burnout syndrome' and sick leave entitlement in 2015 were much higher in the Netherlands (and Denmark) than the other European countries for which data were available (e.g. Sweden). These phenomena – elevated recognition and diagnosis of burnout – help us understand the more positive narratives and relative legitimation described in our study compared with other qualitative sociological studies into burnout narratives in Sweden (Eriksson et al., 2008) or Finland (Maija and Katri, 2019). In contrast, Maija and Katri (2019) note that in countries such as Finland where burnout is not a disease category entitling workers to sick leave, other psychiatric conditions may be used by doctors instead (e.g. depression), yet these carry with them more stigma and deny the hard-work-related metaphors and cultural meaning frameworks apparent in our data.

Schaufeli and colleagues (2009: 214) refer to a 'paradox' whereby 'the popularity of burnout in North America lies in the very fact that "burnout" is a non-medical, socially accepted label that carries a minimum stigma in terms of a psychiatric diagnosis', while 'the reverse seems to be true in Europe: burnout is very popular because it is an official medical diagnosis that opens the gates of the welfare state with its compensation claims and treatment programs'. In the Netherlands, however, we see evidence of both a medicalisation of burnout, enabling generous welfare state income protection and treatment, *and* greater levels of social acceptance and common usage of the term. Indeed medical diagnoses in our data were important for social legitimation of the condition and the self (Parsons 1951).

The relatively low levels of stigma reported among our participants may have partially resulted from the sample and timing of the interviews (most participants were recovered, see Corrigan and Watson, 2002), or conditions whereby participants were defensive and reluctant to acknowledge stigma (though a small number became aware that they were being interviewed by a researcher who herself had experienced the condition). Our data were thus inevitably shaped by interview dynamics, norms to give order and coherence to experiences post-hoc, and existing meaning-making 'vocabularies' (Mills, 1940). Yet these limitations do not mean that our data do not provide important insights into the meaning-making processes of our participants and the wider cultural and power dynamics which structured their lifeworlds. With these qualifications in mind, and while we cannot generalise from our small, purposive sample, our findings are nevertheless striking in comparison to qualitative studies in other national contexts (e.g. Maija and Katri, 2019) or of conditions with similar characteristics, such as CFS or ME (Broom and Woodward, 1996; Madden and Sim, 2006; Dumit, 2006).

We have further interpreted this exceptionalism in terms of Parsons's sick role and its combining of medical treatment and social acceptance (Parsons, 1951; c.f. Schaufelli et al., 2009). Invitingly, and as discussed earlier, Parsons points us towards various connections and tensions within his dual framework, yet he also fails to coherently knit these two together (Habermas, 1987; Williams, 2005). Habermas's seminal (Habermas, 1987) work seeks to salvage and rehabilitate Parsonian theory but has not been used for this purpose by medical sociologists. We can understand Habermas's core concepts of system and lifeworld as capturing much of what Parsons conceptualises as an instrumental-scientific system (Habermas's system) and the socio-cultural system with its subconscious processes (Habermas's taken-for-granted lifeworld). A system-lifeworld approach thus provides an effective and intricate framework in which we can locate many important Parsonian insights while furthermore a) replacing Parsons empirically problematic sub-conscious themes (Pilgrim, 1998) with the taken-for-granted depths of lifeworld, b) enabling a far more elaborate

conceptualisation of the relationship between system and lifeworld and their development over time (thus overcoming the static weaknesses of functionalism).

Metaphors are one important way in which illnesses can be understood and connected to wider patterns of meaning and values in ways which tap into deeper social assumptions, values and interests (Kirmayer, 1992; Lupton, 1997). The interactions and tensions between the instrumental and the symbolic, between the system-oriented functioning of doctor-patient interactions (for example) and their metaphorical and meaning-related features, are defining of Parsonian models of illness and healthcare (Williams, 2005:127) and indeed these tensions are striking in our data.

When we consider the role of the symbolic and metaphorical within doctor-patient encounters, in terms of culturally ascribed meanings within illness experiences, therefore, we are never far from the processes which bring relative order and (sometimes strained) consensus within this interaction and within broader society (Parsons, 1937). By denoting processes of ambivalence and manipulation within the more psychodynamic features of doctor-patient interactions (Parsons, 1975; Lupton, 1997), Parsons furthermore points us towards the strategic functioning of power within the symbolic clinical interactions and sedimented stocks of (illness) knowledge and values which shape the different systemic layers through which societal order is maintained: 'Thus, [Parsons's] answer to the question of how social order is possible is that institutions not only embody values, but *integrate* values with interests" (Habermas, 1987:208, original emphasis).

We see such attempts to connect the instrumental with the symbolic in various elements of Parsons's writing around the sick role, not least in his relating functional 'incapacity' to socially-symbolic 'deviance' (Gerhardt, 1989; Williams, 2005:130) – as we see in Parsons's (1975: 259) notions of the 'genuine'. Here the values of patients, doctors and the wider systems in which they operate are bound up with the respective functions of motivation, diagnosis/healing and production, with the interests at stake here ultimately serving the wider system and its political-economic functioning. It is this locating of doctor-patient interactions and illness experiences amid wider structures of culture *and* power that crucially help us understand:

the ambivalences and tensions that emerge in our data;

the relative legitimacy of burnout sufferers in our study in contrast to sufferers diagnosed with other conditions with similar features;

the features of meaning, metaphor and manipulation which characterise these two analytical considerations.

Crucially, the lifeworld processes of shared (doctor-patient) meaning-making and (re)socialisation of the self are warped by both the current system and the sediment of earlier political-economic and symbolic regimes.

As with the original, our reworked Parsonian approach struggles to conceptualise the meso-institutional processes – such as the relative power of occupational health specialists in the Netherlands, for example – and dynamic interaction between social problems, science and policy-making (see Friberg 2009). These would aid us further in explaining inter-country variations. Nevertheless we hope that the framework developed here provides an extension to the wider project aimed at salvaging and repairing the many rich insights developed by one of medical sociology's founders.

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