Journal of Psychiatry
Psychotherapy & Communication

Haverkampf, C. J. (2025). Burnout: Causes, Differential Diagnosis, and Recovery in Work and Life. J Psychiatry Psychotherapy Communication, 2025 Dec 31;14(4):101-107

Burnout: Causes, Differential Diagnosis, and Recovery in Work and Life

Christian Jonathan Haverkampf

Narrative Literature Review

Abstract—Burnout is a work-related syndrome associated with exhaustion, mental distance or cynicism, and reduced professional efficacy; it is not interchangeable with major depression, anxiety, or ordinary tiredness. The phrase 'in work and life' in the title does not extend the ICD-11 construct: burnout remains occupational, while 'life burnout' is informal descriptive language for wider exhaustion and requires a separate formulation. This narrative review examines organizational and individual contributors, including excessive or conflicting demands, low control, inadequate reward, unfairness, value conflict, role ambiguity, poor support, and insufficient recovery. Prospective evidence links burnout with adverse occupational, psychological, and physical outcomes, but overlap with depression and other conditions requires a full differential. Assessment should document exposure, timeline, recovery away from work, sleep, mood, anhedonia, anxiety, trauma, substances, medical symptoms, function, and safety. Recovery is unlikely to last if care targets only the worker while hazardous conditions remain. A clinically coherent response may combine workload or role change, organizational intervention, graded recovery and return-to-work planning, restoration of sleep and relationships, and treatment of identified mental or medical disorders. Communication-focused formulation can clarify unspoken expectations, value conflict, and missing feedback. Burnout should be neither moralized as deficient resilience nor used to avoid assessing severe depression, suicidality, or medical illness.

Index Terms—burnout, occupational stress, exhaustion, depression, work environment, recovery, return to work, organizational intervention

I. INTRODUCTION

Burnout names a recognizable pattern of depleted energy, distancing, and reduced effectiveness, but the word is used so broadly that it can clarify or conceal. It can direct attention to harmful work conditions; it can also become a socially acceptable substitute for depression, trauma, or despair. Accurate use begins by specifying the domain, exposure, time course, and recovery rather than debating whether the person is "really burned out."

A prior JPPC case report located burnout within work, relationships, disconnection, and treatment (Haverkampf, 2013). Later JPPC articles on depression and therapeutic questioning emphasized meaning and communication while retaining diagnostic review (Haverkampf, 2017a, 2017b). This review places that perspective alongside systematic evidence on work design, consequences, intervention, and return to work.

II. SCOPE AND REVIEW METHOD

This narrative literature review used a search cutoff of 30 November 2025. Searches covered burnout definitions, occupational exposures, prospective outcomes, workplace intervention, recovery and return to work, differential diagnosis, depression, and organizational responsibility. Professional guidance—including the WHO employment-sector policy guidance published 24 November 2025—systematic and umbrella reviews, meta-analyses, longitudinal and diagnostic research, and clinically informative original studies were prioritized. Bibliographic details were checked against PubMed, Crossref, or the issuing organization, and relevant JPPC articles were read before citation.

No pooled effect was calculated; group findings are used to support recognition and shared formulation, and guidance remains subject to later revision. Because definitions, measures, and study designs vary, diagnosis, questionnaire scores, behavioral records, and administrative outcomes were not treated as interchangeable, and causal language was limited to what each design could support.

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III. DEFINITION AND BOUNDARIES

Maslach et al. (2001) described burnout research around exhaustion, cynicism or depersonalization, and reduced efficacy. The World Health Organization (2019) placed burnout in ICD-11 as an occupational phenomenon, not a medical condition, resulting from chronic workplace stress that has not been successfully managed. It specifically limits the concept to occupational context.

Everyday speech extends burnout to parenting, activism, study, illness management, and life generally. Those experiences can be severe and deserve care, but 'life burnout' is informal descriptive language, not an extension of the ICD-11 occupational phenomenon. Clinicians can instead describe caregiver exhaustion, chronic overload, or loss of recovery while assessing whether a recognized mental or medical disorder is present.

Burnout is not defined by needing a holiday. Nor is it equivalent to depression, though symptoms and measures overlap. The key is not to protect a pure category but to establish exposure, domain specificity, mood and interest outside work, recovery, course, and comorbidity.

IV. ORGANIZATIONAL CAUSES AND THE SIX MISMATCHES

Burnout is often framed as an individual's depleted resource, but work design is part of the relevant causal context. Maslach and Leiter (2016) summarize mismatches involving workload, control, reward, community, fairness, and values. Excessive demand matters, but so do unpredictable demand, conflicting priorities, moral distress, poor feedback, harassment, and inability to influence how work is done.

A systematic review with meta-analysis linked multiple adverse work-environment factors with burnout symptoms (Aronsson et al., 2017). Associations do not identify one cause in an individual, yet they support organizational responsibility. Telling staff to become more resilient while maintaining unsafe staffing, incivility, or unattainable targets can add blame and conceal exposure.

Values conflict is particularly corrosive when a worker must repeatedly act against professional or personal standards. Low reward includes money but also recognition, security, fairness, and information that work has meaning. Community concerns the quality of connection, repair, and support. Where an organizational constraint blocks a value, formulation should distinguish the worker's authority from responsibilities held by management, governance, regulators, unions, or safeguarding systems. Psychological support may reduce isolation and restore choice, but it cannot substitute for adequate staffing, protection for speaking up, or remediation where these are required.

Six areas of work-life mismatch

Area	Examples	Change questions
Workload	Volume, pace, emotional demand, interruption	What can stop, sequence, staff, or redesign?
Control	No discretion or influence	Which decisions can move closer to the work?
Reward	Low pay, recognition, security, feedback	What fair return and information are missing?
Community	Isolation, conflict, incivility	How are support and repair made reliable?
Fairness	Opaque allocation, bias, inconsistent rules	What process and accountability are needed?
Values	Moral conflict, meaningless metrics	Where does work contradict professional purpose?

V. INDIVIDUAL VULNERABILITY WITHOUT INDIVIDUAL BLAME

People differ in health, caring duties, financial options, perfectionism, threat sensitivity, values, experience, and access to support. These factors affect exposure and recovery without making the person the cause of an unsafe system. A strength such as conscientiousness can become a vulnerability when an organization relies on unpaid overwork and makes limits morally difficult.

Behavior can also maintain strain: checking messages throughout recovery time, avoiding difficult boundary conversations, accepting ambiguous tasks, or using alcohol to transition out of activation. Identifying these patterns creates options but should not substitute for workload analysis. The question is which change belongs to the person, team, organization, or wider system.

Communication-focused formulation asks which expectations are explicit, which are inferred, and whether feedback carries useful information. It also examines self-directed messages such as "rest must be earned." In the therapeutic relationship, these meanings can be named and tested; with partners, colleagues, or managers, costs and limits can be communicated to people able to respond. Silence can otherwise be mistaken for agreement and emergency performance for capacity. Communication helps when it changes understanding, allocation, or consent, not when it merely asks the worker to explain an unsafe system.

VI. CONSEQUENCES AND DIFFERENTIAL DIAGNOSIS

A systematic review of prospective studies associated burnout with occupational, psychological, and physical outcomes, although definitions and confounding vary (Salvagioni et al., 2017). Consequences can include absence, turnover, sleep disturbance, depressive symptoms, and

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impaired functioning. Association does not mean that burnout independently caused every outcome.

Depression may involve pervasive anhedonia, hopelessness, guilt, psychomotor change, and suicide risk beyond work. Anxiety may drive overpreparation and inability to detach. Trauma can arise from workplace violence, moral injury, or repeated exposure. Sleep disorders, anemia, endocrine illness, infection, pain, medication effects, substance use, and neurological conditions can produce exhaustion. Assessment must remain broad.

A partial improvement on leave suggests an exposure relationship but does not prove burnout or settle readiness to return. Severe depression may also improve when work demands are reduced. Lack of recovery may indicate ongoing contact, financial threat, insufficient duration, persistent syndrome, or medical illness. The course is evidence to interpret, not a diagnostic test. Because depressive symptoms overlap with exhaustion, assessment should use a full syndrome and course evaluation; a PHQ-9 score is useful evidence but cannot by itself adjudicate burnout, depression, or their coexistence (Kroenke et al., 2001; Malhi & Mann, 2018). Repeated monitoring can clarify trajectories without turning an administrative data stream into a diagnosis (Pfeiffer et al., 2015).

Differential questions for exhaustion

Possibility	Questions
Burnout	Is the pattern work-linked; are distance and efficacy changes prominent?
Depression	Is loss of interest, hope, and function pervasive outside work?
Anxiety/trauma	Threat, intrusion, avoidance, hyperarousal, moral injury?
Sleep disorder	Opportunity, insomnia, snoring/apnea, shift pattern, daytime sleepiness?
Medical/medication	New bodily signs, pain, dose change, infection, endocrine clues?
Substance	Use to activate, detach, sleep; withdrawal or consequences?
Environment	Harassment, discrimination, unsafe staffing, caregiving, financial coercion?

VII. RECOVERY IS MORE THAN REST

Rest is necessary when capacity is depleted, but returning to the same unchanged exposure can recreate the pattern. Recovery involves physiological restoration, psychological detachment, restored agency, re-entry into valued nonwork roles, and a credible plan for workload and boundaries. It may first reveal how tired the person is; immediate absence of energy should not be moralized.

Kärkkäinen et al. (2017) reviewed factors associated with return to work after burnout and found a heterogeneous evidence base. Awa et al. (2010) reviewed person-directed, organization-directed, and combined burnout interventions; combined programs appeared to have more durable effects, but only six combined programs were included. Recovery plans should therefore be individualized and evaluated rather than treated as universal recipes.

Meaningful activity outside work can restore breadth, but scheduling hobbies as another compulsory optimization target can reproduce the same performance logic. Recovery should include experiences with agency and noninstrumental value. Sleep, nutrition, movement, relationships, and clinical treatment matter, but none can compensate indefinitely for harmful exposure. Return-to-work evidence identifies person, health, and work factors and supports work-focused problem solving, while also showing heterogeneity across systems and outcomes (Dewa et al., 2015; de Vries et al., 2018; Gragnano et al., 2018).

VIII. ORGANIZATIONAL AND CLINICAL INTERVENTION

Organization-directed interventions can include workload reduction, staffing, workflow redesign, schedule control, team communication, role clarity, anti-harassment processes, supervision, and changes to documentation or metrics. DeChant et al. (2019) reviewed organization-directed interventions for physician burnout and found evidence of benefit alongside methodological limits. WHO guidance places organizational intervention, manager and worker training, individual support, accommodations, and return-to-work measures within one system, so personal coping advice should not displace correction of modifiable work conditions (World Health Organization, 2022, 2025). The 2025 guidance is policy guidance for the employment sector, not evidence that any one intervention treats burnout. The specific intervention should follow the diagnosed mismatch.

Individual care may include supportive or evidence-based psychotherapy, treatment of depression or anxiety, sleep intervention, substance support, and medication when a diagnosed condition and person-specific assessment support it. Psychoeducation should validate occupational causation without promising that one therapeutic technique will make an unsafe job safe.

A graded return can test capacity and conditions when appropriate: reduced hours, predictable tasks, protected breaks, lower emotional load, remote or on-site adjustments, supervision, and planned review. It should not become a sequence of arbitrary hurdles. Confidentiality, consent, occupational-health roles, legal obligations, and the distinction between clinical advice and employer decision-making must remain clear. Sleep, eating, and activity may require individual

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clinical attention; the cited studies concern other mental-health populations and do not establish them as burnout treatments or compensate for unsafe work (Freeman et al., 2017; Firth et al., 2019; Schuch et al., 2018).

Recovery plan at four levels

Level	Examples	Outcome to monitor
Body/recovery	Sleep opportunity, health review, paced activity	Energy variability, sleep, basic function
Psychological	Depression/anxiety care, boundaries, values	Mood, threat, choice, self-criticism
Work design	Load, control, role, schedule, supervision	Sustainable performance without emergency effort
System	Staffing, fairness, safety, anti-harassment	Exposure reduction across workers
Return process	Graded duties and review points	Capacity–demand match and relapse signs

IX. PREVENTION AND EARLY SIGNALS

Prevention monitors work conditions before individual collapse. Indicators include chronic overtime, missed breaks, turnover, errors, conflict, moral distress, sickness absence, and staff reports that priorities cannot be met safely. Surveys are useful only if confidentiality is credible and results lead to action. Individual scores should not be used to identify weak workers.

Personal early signs may include sleep change, dread before work, emotional numbing, irritability at home, increasing detachment from clients or colleagues, reduced recovery, mistakes, or abandoning valued activities. A plan links these signs to action: supervision, workload review, leave assessment, clinical consultation, or support. It should not require the person to reach a severe threshold before conditions are addressed.

Leadership communication is preventive when priorities, trade-offs, and limits are explicit. If everything remains urgent, workers must choose privately and absorb the moral consequence. Shared decisions about what will not be done transform burnout prevention from self-care messaging into resource governance.

X. CONTEXT, EQUITY, AND ACCESS

Clinical thresholds are not culturally or socially weightless. Opportunity, exposure, power, language, disability, service design, and prior treatment affect both symptoms and the evidence available to an assessor. Equity does not mean applying less rigorous criteria; it means collecting better contextual evidence and avoiding an interpretation that mistakes structural constraint for individual pathology.

Precarious work. People with fewer employment protections may conceal symptoms and have little control over workload, schedule, or leave. Recommendations should therefore address likely financial and occupational consequences, identify who has authority to change the exposure, and avoid treating a boundary that cannot safely be exercised as a personal failure.

Emotional labor. Care, service, and marginalized workers may carry relational and identity demands that workload counts do not capture. Assessment should ask what emotions must be managed, whose needs receive priority, what recovery is available, and whether unrecognized labor or discrimination contributes to exhaustion and withdrawal.

Fairness. Discrimination, opaque promotion, and unequal task allocation are burnout exposures requiring organizational accountability. The plan should name who can alter conditions, what support is genuinely accessible, and whether poor outcome reflects an unavailable intervention rather than treatment resistance, deficient resilience, or lack of motivation.

XI. ASSESSMENT, DOCUMENTATION, AND FOLLOW-UP

Assessment and follow-up should be designed as one process. The initial formulation identifies what will be observed, over what interval, and by whom; later review asks whether the predicted course occurred and whether the intervention produced a benefit worth its burden. Measures can provide a baseline, but they should be interpreted with chronology, function, exposure, safety, and the person's priorities rather than used as stand-alone diagnostic or fitness decisions.

Begin with work as it is actually done. Describe workload, control, reward, community, fairness, and values over time, including emotional demands, interruption, harassment, ethical strain, and the consequences of error. A concrete episode can show how exposure becomes impairment. Record the source and confidence of material information, then compare evenings, weekends, leave, and genuine detachment. Partial improvement away from work supports an exposure relationship but does not prove burnout or readiness to return; continuing contact, financial threat, another clinical syndrome, or medical illness may explain incomplete recovery.

Evaluate depression, anxiety, trauma, sleep disorder, substance use, medication effects, and relevant medical causes in their own right. Review anhedonia, hopelessness, psychomotor change, suicide risk, threat and avoidance, intrusive symptoms, intoxication or withdrawal, sleep opportunity and quality, and bodily or neurological signs indicated by the history. The medical review should be focused rather than a universal test panel, and an educational review should not prompt abrupt medication change. Function includes errors, absence, conflict, driving, self-care, caring

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duties, and safety-critical tasks; visible attendance may conceal emergency effort or unrecorded support.

Identify who can alter workload, role, schedule, staffing, supervision, safety processes, or a return plan. Clinical services assess illness and function; occupational health may advise on capacity and restrictions; employers and other designated authorities control many workplace decisions. Information sharing should be limited to what is necessary for the defined purpose, with the worker's consent and subject to applicable law. Collateral contact should answer a stated question and should not expose the worker to retaliation, stigma, or additional domestic burden. Where a safety duty limits confidentiality, its reason, scope, and recipient should be explained as clearly as circumstances allow.

Outcomes should span exhaustion, mood, sleep, cognitive reliability, errors, cynicism, recovery between shifts, and participation in relationships and nonwork life. Improvement means more sustainable function at a lower hidden cost, not merely attendance or one better day. With consent, a partner or colleague may clarify change or unseen support, but involvement should not transfer more labor or override the worker's account. The observation window and any continuing contact with work should be recorded.

The review must compare recommended conditions with the work actually performed: hours, task complexity, staffing, breaks, supervision, continuing contact, and safety-critical duties. If an agreed change was not implemented, the worker should not be described as nonresponsive to it. If conditions changed as planned and function still declined, reopen the medical and psychiatric differential and reconsider the pace or level of return. A recurrence plan should link early loss of recovery, sleep erosion, rising cynicism, conflict, or workload drift to named actions by the worker and organization and to thresholds for clinical reassessment.

XII. ILLUSTRATIVE WORK-AND-HEALTH FORMULATIONS

The following contrast illustrates formulation rather than a validated decision rule. Improvement during genuine detachment, followed by deterioration when the same workload, staffing, or role conflict resumes, supports an exposure relationship but does not establish a diagnosis or readiness for return. Pervasive anhedonia, hopelessness, psychomotor change, marked anxiety, trauma symptoms, intoxication or withdrawal, or disproportionate cognitive or physical signs requires a broader formulation. A worker may also have no psychiatric disorder yet face unsafe and unsustainable conditions. In each case, the plan should identify the responsible decision-maker instead of asking a depleted worker to solve a system problem alone.

XIII. DOCUMENTATION, AUTHORITY, AND COMMUNICATION

Documentation should distinguish clinical findings, functional restrictions, workplace observations, and decisions that belong to another authority. It should state who can alter load, schedule, staffing, supervision, or role; who evaluates medical or psychiatric illness; what information may be shared and for what purpose; and when the plan will be reviewed. The person's own description, material constraints, and uncertainty should remain visible. This author-developed sequence is an implementation suggestion rather than a validated instrument or statement of local employment law.

Communication is clinically useful when it makes priorities, costs, limits, and responsibility explicit. Questions include which expectations are stated or inferred, what can be refused, who sets priorities, and whether feedback is usable. The resulting formulation should locate decisions at worker, team, organization, and system levels rather than translating every mismatch into an individual coping target. It should also record whether recommended changes were implemented, what exposure followed, and how symptoms and function changed.

A structured assessment map (author-developed clinical synthesis; not a validated instrument)

Domain	Questions to test
Exposure	Workload, control, reward, community, fairness, values; duration and change?
Domain specificity	What happens during nonwork roles, weekends, and genuine detachment?
Clinical syndromes	Depression, anxiety, trauma, substance use, sleep disorder?
Medical	Pain, infection, endocrine, anemia, medication or neurological signs?
Function	Errors, absence, conflict, care, meals, sleep, driving, self-neglect?
Risk	Suicide, aggression, intoxication, safeguarding, unsafe professional practice?
Change authority	Who can alter load, role, schedule, staffing, safety, or return plan?

XIV. SAFETY, URGENCY, AND BOUNDARIES

Burnout language can conceal severe depression, suicide risk, dangerous fatigue, substance withdrawal, or impaired professional practice. Immediate safety takes priority over deciding whether the final label is burnout. The person should not be left solely responsible for managing system risk while cognitively and physically depleted.

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Urgent and safeguarding considerations (author-developed safety summary; not a substitute for individual assessment)

- Ask directly, when clinically indicated, about hopelessness, suicidal thoughts, self-harm, violence, exploitation, substance use or withdrawal, severe sleep deprivation, inability to meet basic needs or perform safety-critical tasks, and other safeguarding concerns.
- Escalate confusion or delirium, catatonia, collapse or chest pain, new neurological symptoms (especially focal signs), severe medical symptoms or self-neglect, psychosis, mania, acute intoxication or withdrawal, marked behavioral change, or a rapidly deteriorating mental state.
- Address harassment, violence, discrimination, exploitation, and unsafe staffing through appropriate safeguarding and organizational pathways.
- This narrative review cannot determine an individual's diagnosis, fitness for work, medication plan, or level of care; those decisions require an appropriately qualified clinician with access to the person and relevant records.

XV. LIMITATIONS AND RESEARCH NEEDS

Burnout evidence is limited by inconsistent definitions, cross-sectional designs, occupationally narrow samples, self-report outcomes, and overlap with depression. Multicomponent intervention studies rarely show whether benefit arose from changed working conditions or from asking individuals to tolerate them more effectively. Occupational findings may not generalize to unpaid care or insecure work, and the WHO occupational definition does not resolve how nonoccupational exhaustion should be described.

Future studies should link exposure, recovery, relationship strain, organizational response, and sustained return to work while reporting adverse effects and inequalities in the ability to reduce harmful demands. They should distinguish recommended workplace change from what was actually implemented and examine whether improvement reflects restored capacity, reduced exposure, or withdrawal from work. Clinical hypotheses must remain revisable when the course extends beyond the occupational setting.

XVI. CONCLUSION

Burnout is best understood as an occupational pattern embedded in work design, not as a personal failure or a synonym for every form of exhaustion. Assessment must identify the exposure and the course of recovery while actively checking depression, anxiety, trauma, sleep disorder, substance effects, medication, and medical illness. Sustainable recovery combines individual care with credible change to demand, control, reward, community, fairness, or values. The article's central proposition is that return to work is a monitored capacity–condition match, not evidence that symptoms have vanished. Prevention begins when organizations make priorities, trade-offs, and limits explicit before emergency effort becomes the normal operating model.

XVII. CONFLICTS OF INTEREST AND DISCLOSURES

Conflicts of interest—The author developed and writes about Communication-Focused Therapy (CFT). CFT is discussed as a formulation perspective and not as a substitute for established diagnostic assessment, evidence-based treatment, or independent replication. No other conflict of interest was reported.

Funding—No specific funding was reported for this article.

Author contributions—Christian Jonathan Haverkampf is the sole named author and is responsible for the conception, literature review, manuscript preparation, and approval of the final draft.

Patient material—No identifiable patient material is presented. Any brief examples are generic composites created to illustrate clinical reasoning and are not case reports.

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