http://dx.doi.org/10.18623/rvd.v22.n5.3835

BURNOUT IN HEALTHCARE AFTER THE PANDEMIC: PSYCHOEDUCATION AND DESTIGMATISATION AS KEYS TO PREVENTION

ESGOTAMENTO PROFISSIONAL NA ÁREA DA SAÚDE APÓS A PANDEMIA: PSICOEDUCAÇÃO E DESISTIGMATIZAÇÃO COMO CHAVES PARA A PREVENÇÃO

Article received on: 7/21/2025
Article accepted on: 10/27/2025

Anja Pfeifer*
*St. Elisabeth University of Health and Social Work in Bratislava, Bratislava, Slovakia
Orcid: https://orcid.org/0009-0004-5187-8312
anja.pfeifer@mail.de

Mariana Mrázová*
*St. Elisabeth University of Health and Social Work in Bratislava, Institute for Prevention and Intervention (IPI), Slovak Obesity Association
Orcid: https://orcid.org/0000-0003-3017-4602
mrazova@vssvalzbety.sk

The authors declare that there is no conflict of interest

Abstract
The COVID-19 pandemic has raised the psychological stress experienced by healthcare workers worldwide to historic levels. Nurses, doctors and therapists were confronted not only with an unprecedented workload during the pandemic, but also with moral dilemmas, isolation, a lack of psychosocial support and ongoing uncertainty. Studies from various countries show a significant increase in burnout symptoms, especially in high-stress care areas such as emergency rooms, intensive care units and nursing homes (García et al., 2021; Khasne et al., 2020; Mo et al., 2020). Existing deficits in healthcare systems became particularly apparent. The crisis revealed massive weaknesses in institutional prevention and highlighted structural deficiencies – such as inadequate psychosocial support services, poor communication at management level and a strong stigma surrounding mental health issues. The long-term effects of these developments not only affect individual well-being, but also jeopardise the quality of care and staff stability in the healthcare system (Friedrich et al., 2022; Rotenstein et al., 2018). The aim of this article is to highlight the effectiveness of two key prevention factors based on a systematic review of current research findings: psychoeducation and destigmatisation. Psychoeducation has been shown to improve mental health literacy, support the early detection of burnout symptoms and strengthen individual coping skills (Wei et al.,

Resumo
A pandemia de COVID-19 elevou o estresse psicológico vivenciado por profissionais de saúde em todo o mundo a níveis históricos. Enfermeiros, médicos e terapeutas se depararam não apenas com uma carga de trabalho sem precedentes durante a pandemia, mas também com dilemas morais, isolamento, falta de apoio psicossocial e incerteza constante. Estudos de diversos países mostram um aumento significativo nos sintomas de burnout, especialmente em áreas de atendimento de alta pressão, como salas de emergência, unidades de terapia intensiva e casas de repouso (García et al., 2021; Khasne et al., 2020; Mo et al., 2020). As deficiências preexistentes nos sistemas de saúde tornaram-se particularmente evidentes. A crise revelou fragilidades significativas na prevenção institucional e evidenciou deficiências estruturais – como serviços inadequados de apoio psicossocial, comunicação deficiente em nível gerencial e um forte estigma em torno de questões de saúde mental. Os efeitos a longo prazo desses acontecimentos não afetam apenas o bem-estar individual, mas também comprometem a qualidade do atendimento e a estabilidade da equipe no sistema de saúde (Friedrich et al., 2022; Rotenstein et al., 2018). O objetivo deste artigo é destacar a eficácia de dois fatores-chave de prevenção, com base em uma revisão sistemática de resultados de pesquisas atuais: psicoeducação e desestigmatização. A

2020; Yamaguchi et al., 2019). Destigmatisation, in turn, is essential for breaking down structural barriers to help services and overcoming cultural expectations of excessive demands, silence and perceived weakness (Knaak et al., 2017; Stuart, 2016). The article discusses international examples of good practice (including from Norway, Canada and the United Kingdom) as well as empirical studies on the influence of organisational culture on the mental well-being of professionals. In addition, it analyses the political and institutional framework conditions that enable the sustainable and ly anchoring of preventive measures in the healthcare system. In addition to international findings, the article incorporates a longitudinal study conducted in German-speaking countries by Gaul (2024), which highlights specific developments in burnout symptoms in the post-pandemic context. The study reveals persistent stress, particularly among nursing staff and medical personnel, and underscores the urgency of structured, scientifically based preventive measures. The article thus makes a practice-oriented, evidence-based and policy-relevant contribution to promoting the mental health of healthcare workers and shows how psychoeducational and destigmatising measures can be effectively integrated into training and continuing education, occupational health management and leadership structures.

Keywords: Burnout. Healthcare. Psychoeducation. Destigmatisation. Prevention.

psicoeducação demonstrou melhorar o conhecimento sobre saúde mental, apoiar a detecção precoce de sintomas de burnout e fortalecer as habilidades individuais de enfrentamento (Wei et al., 2020; Yamaguchi et al., 2019). A desestigmatização, por sua vez, é essencial para quebrar barreiras estruturais de acesso a serviços de apoio e superar expectativas culturais de demandas excessivas, silêncio e percepção de fraqueza (Knaak et al., 2017; Stuart, 2016). O artigo discute exemplos internacionais de boas práticas (incluindo da Noruega, Canadá e Reino Unido), bem como estudos empíricos sobre a influência da cultura organizacional no bem-estar mental de profissionais. Além disso, analisa as condições políticas e institucionais que permitem a consolidação sustentável e efetiva de medidas preventivas no sistema de saúde. Além de dados internacionais, o artigo incorpora um estudo longitudinal realizado em países de língua alemã por Gaul (2024), que destaca desenvolvimentos específicos nos sintomas de burnout no contexto pós-pandemia. O estudo revela estresse persistente, particularmente entre a equipe de enfermagem e o pessoal médico, e ressalta a urgência de medidas preventivas estruturadas e baseadas em evidências científicas. O artigo, portanto, oferece uma contribuição prática, baseada em evidências e relevante para políticas públicas, visando a promoção da saúde mental dos profissionais de saúde, e demonstra como medidas psicoeducacionais e de desestigmatização podem ser efetivamente integradas à formação e educação continuada, à gestão da saúde ocupacional e às estruturas de liderança.

Palavras-chave: *Burnout. Saúde. Psicoeducação. Desestigmatização. Prevenção.*

1 INTRODUCTION

The COVID-19 pandemic has ruthlessly exposed the mental stress and structural weaknesses in healthcare systems worldwide. Healthcare professionals, who were already under high psychosocial pressure before the pandemic, are particularly affected. In addition to staff shortages, shift work, hierarchical structures and daily confrontation with suffering and death, additional stress factors such as isolation, fear of infection, moral conflicts and lack of psychosocial support were added during the pandemic (Adli, 2019;

De Hert, 2020). The World Health Organisation (WHO) defines burnout as a work-related phenomenon that occurs as a result of chronic stress in the workplace and is characterised by emotional exhaustion, mental distance from one's own work and reduced professional performance (WHO, 2019). Studies show that healthcare workers are particularly prone to burnout – with sometimes serious consequences for their health, patient safety and continuity of care (Maslach & Leiter, 2017; Rotenstein et al., 2018).

Despite its high prevalence, psychosocial stress in the healthcare sector has long been taboo or individualised. Employees avoided seeking help for fear of stigmatisation, professional disadvantages or social exclusion (Knaak et al., 2017; Stuart, 2016). This double burden of structural overload and cultural taboo surrounding mental health symptoms makes effective prevention considerably more difficult (Corrigan et al., 2016). Current research is therefore increasingly focusing on two key preventive strategies: psychoeducation and destigmatisation. Psychoeducation involves the systematic transfer of knowledge about mental stress, risk factors, coping strategies and support services. Studies show that targeted psychoeducational interventions significantly increase health literacy, self-efficacy and acceptance of support services (Wei et al., 2020; Yamaguchi et al., 2019). Destigmatisation aims to bring about a cultural change that removes the taboo surrounding mental health issues and makes it easier to access support services. In the healthcare sector in particular, there are deeply entrenched norms that equate mental stability with professional performance. These attitudes encourage silence and self-stigmatisation and prevent open communication about mental health issues (Knaak et al., 2017; Stuart, 2016; Thornicroft et al., 2019). Based on a systematic review, this article examines the effectiveness of psychoeducation and destigmatisation in preventing burnout among healthcare workers. In addition to a comprehensive analysis of international studies, examples of good practice are presented and the political and institutional framework conditions for sustainable implementation are examined. In addition, a longitudinal study by Gaul (2024) is discussed, which analyses specific developments in burnout symptoms in German-speaking countries during the course of the pandemic. The aim is to derive evidence-based recommendations for a multidimensional prevention strategy that systematically integrates individual, organisational and structural levels.

2 THEORETICAL BACKGROUND

According to ICD-11 (WHO, 2019), burnout is a work-related syndrome resulting from chronic stress, characterised by emotional exhaustion, mental distance from work and reduced performance. Although burnout is not officially listed as a separate mental illness, there are numerous overlaps with affective disorders such as depression or anxiety disorders, which makes it difficult to distinguish (Bianchi et al., 2015; Salvagioni et al., 2017). The current scientific debate is discussing whether the previous classification does justice to the clinical and social effects of burnout. Against the backdrop of rising prevalence rates, professional associations are calling for a review of its possible recognition as a separate diagnosis (Bianchi et al., 2015; Heinemann & Heinemann, 2017). The development of burnout can be explained in multiple dimensions. Various theoretical models provide explanatory approaches:

- The **Job Demands-Resources Model** (Demerouti et al., 2001) describes burnout as the result of an imbalance between job demands (e.g. time pressure, emotional strain) and resources (e.g. social support, scope for action).
- The **transactional stress model** (Lazarus & Folkman, 1984) focuses on the subjective assessment of stress and individual coping strategies. Perceived experiences of loss of control and a lack of coping skills increase the risk of burnout.
- The **person-environment fit model** (Edwards, 1991) highlights the discrepancy between personal values, needs and the requirements or conditions of the working environment as a critical stress factor.

These models illustrate that burnout is not only an individual phenomenon, but also a structurally and culturally determined one. Accordingly, preventive measures must take all levels into account. A key influencing factor is **organisational culture.** Research shows that hierarchical structures, lack of transparency, low appreciation, lack of participation and stigmatising norms significantly increase the risk of mental stress in the healthcare sector (Maslach & Leiter, 2017; Nielsen & Randall, 2013). **Psychoeducation** comprises systematic measures to impart knowledge about mental stress, symptoms, causes and support options. Empirical studies demonstrate the effectiveness of targeted programmes in the healthcare sector for strengthening health literacy, self-efficacy and help-seeking behaviour (Bangerter et al., 2022; Murray et al., 2021; Lin et al.,2021).

One aspect that is often overlooked is the **stigmatisation of mental stress**. Stereotypical notions that mental instability is a sign of weakness or lack of professionalism are particularly prevalent in the healthcare sector. These attitudes not only hinder individuals from seeking help, but also prevent open discussion about mental health (Knaak et al., 2017; Stuart, 2016; Thornicroft et al., 2019). A key measure for destigmatisation is therefore to change institutional frameworks: managers must address mental health issues, employees need low-threshold contact points, and organisations should invest specifically in education, reflection and prevention (Stuart, 2016; Gronholm et al., 2021). A proven tool in psychoeducational programmes is **Freudenberger's** (1974) **12-step model**, which describes the gradual progression of burnout in comprehensible phases – from excessive performance demands to exhaustion, withdrawal and distortion of values to inner emptiness. The practical application of this model promotes self-reflection, early intervention and collegial exchange.

3 INTERNATIONAL STUDIES

International studies confirm the high prevalence and serious psychosocial consequences of burnout among healthcare professionals, which have become significantly worse during and after the COVID-19 pandemic. A multinational study by García et al. (2021) showed that a significant proportion of healthcare professionals worldwide exhibited significant symptoms of emotional exhaustion, depersonalisation and reduced performance. Nurses, female employees and employees with little professional experience were particularly affected. Khasne et al. (2020) documented burnout rates of over 50% in a cross-sectional study of intensive care staff in India during the first wave of the pandemic. Comparable stress patterns were also observed in Canada and the USA (Shanafelt et al., 2020). In addition to overload, respondents cited social isolation, fear of infection, lack of psychosocial support and lack of transparent communication as the main sources of stress. In a qualitative study with nurses in Wuhan, Mo et al. (2020) identified structural deficits such as lack of breaks, inadequate emotional support and stigmatising attitudes towards mental stress as key risk factors for burnout. An international analysis by Shah et al. (2022) highlights that systemic barriers in particular, such as the lack of psychoeducational services, inadequate leadership culture and deeply rooted stigma towards mental illness, hinder prevention and early intervention. The authors call for a change in organisational

culture towards greater openness, support and structural relief. Reliable data is now also available for German-speaking countries . A longitudinal study conducted by Gaul (2024) found significantly increased burnout levels among medical professionals in both intrapandemic and postpandemic phases. Nursing staff and medical personnel in particular reported persistently high stress levels, emotional exhaustion, reduced performance and a significant correlation between poor sleep quality and burnout symptoms. This evidence makes it clear that burnout in the healthcare sector is not a short-term phenomenon, but a persistent, globally relevant problem with far-reaching consequences for the quality of care, securing skilled workers and patient safety. It underlines the urgency of evidence-based, structurally anchored prevention strategies based on psychoeducation and destigmatisation.

4 POLITICAL AND INSTITUTIONAL FRAMEWORK CONDITIONS

Burnout in the healthcare sector cannot be overcome by individual measures alone. A systemic approach requires political and institutional actors to take responsibility. The German Prevention Act (§ 20b SGB V) obliges statutory health insurance funds to promote occupational health prevention. However, the focus has so far been primarily on physical illnesses such as musculoskeletal complaints, while psychosocial stress and burnout, especially among healthcare workers, have been addressed too little (Busse et al., 2021). OECD data (2020) show that mental illness in the healthcare sector causes considerable economic costs, for example through sickness-related absences, early retirement or the loss of qualified specialists. Investments in mental health promotion are therefore not only considered ethically necessary, but also make good business sense.

International best practice examples demonstrate the effectiveness of structured prevention programmes. Norway has established a national mental health programme for the healthcare system that includes mandatory psychoeducational modules, supervision and reflection sessions (Hansen et al., 2020). Canada's "Opening Minds" initiative focuses specifically on destigmatisation and promoting mental health literacy in healthcare professions (Stuart, 2016). In German-speaking countries, professional associations such as the German Medical Association (Bundesärztekammer) and the Robert Koch Institute ( ) are calling for the comprehensive integration of mental health promotion into the structures of clinics and other healthcare facilities (Deutsches Ärzteblatt, 2022; RKI, 2022).

This includes mandatory training for managers and employees, destigmatisation measures, supervision services and the development of an open communication culture. In the long term, burnout in the healthcare sector can only be effectively curbed through the coordinated interaction of individual, organisational and political prevention strategies. The present recommendations aim to systematically anchor psychoeducation and destigmatisation as an integral part of health-promoting organisational development.

5 METHODOLOGY

This article is based on a systematic review of international and national literature on burnout prevention in the healthcare sector. It was based on a structured database search in PubMed, Web of Science and PsycINFO for the period from January 2010 to March 2024. A total of 38 valid, scientifically sound original studies and systematic reviews were identified that examine the effectiveness of psychoeducation and destigmatisation in the prevention of burnout. In addition, a quantitative longitudinal study conducted in German-speaking countries by Gaul (2024) is included. The study recorded burnout symptoms, sleep quality and work-related stress factors among nursing staff and medical personnel during the intrapandemic and postpandemic phases in three waves of surveys. The survey was conducted using standardised instruments, including the Burnout Screening Scales (BOSS I) and validated questionnaires to record sleep parameters and workplace-related stressors.

The results of the systematic review and the longitudinal study form the empirical basis for deriving practice-oriented recommendations for action to promote psychoeducation and destigmatisation in the healthcare sector.

6 RESULTS

The results of the systematic review consistently show that psychoeducational measures can significantly improve the health literacy, stress experience and individual coping behaviour of healthcare workers. Studies by Bangerter et al. (2022), Lin et al. (2021), Murray et al. (2021) and Wei et al. (2020) show that targeted training programmes have been proven to promote knowledge about burnout, early detection of stress symptoms, self-efficacy and acceptance of offers of help. Sustainable effects can be

achieved, especially in combination with low-threshold support services and an open communication culture. International literature also shows that reducing burnout symptoms cannot be achieved through individual measures alone, but depends significantly on organisational conditions. Numerous studies point to the effectiveness of interventions that specifically involve managers, establish supervision, reflection formats or digital support programmes, and systematically address mental health (Hansen et al., 2020; Stuart, 2016; Cohen et al., 2023; Paleri et al., 2024).

The analysis of the longitudinal study conducted by Gaul (2024) in German-speaking countries shows that nursing staff and medical personnel in particular continue to exhibit significantly elevated levels of emotional exhaustion, depersonalisation, reduced performance and impaired sleep quality. It is striking that these stress indicators remain above pre-crisis levels even two years after the acute phases of the pandemic. The study also confirms a significant correlation between poor sleep quality and increased risk of burnout, especially among shift workers. In addition, the quantitative evaluation shows that the implementation of targeted psychoeducational programmes in the institutions studied has been inconsistent to date. While individual clinics are establishing initial pilot projects, there is a lack of comprehensive, structurally anchored implementation. The qualitative survey of managers also highlights uncertainties regarding the practical integration of destigmatisation and psychoeducation into existing processes. Overall, the available results show that burnout in the healthcare sector is a persistent, multifactorial problem that can only be effectively addressed and prevented through a combination of individual competence development, systematic destigmatisation and structural change. Psychoeducation and destigmatisation are central, empirically well-documented components of a comprehensive prevention strategy that must be systematically integrated into existing training, management and organisational structures.

7 DISCUSSION

The present results impressively confirm the high relevance of psychoeducation and destigmatisation as effective instruments for burnout prevention in the healthcare sector. Consistent findings from international studies show that purely individual measures are not sufficient to have a lasting impact on the complex stress mechanisms in everyday clinical practice. Rather, a systemic prevention approach is needed that takes equal account

of individual knowledge, organisational culture and structural conditions. In particular, the persistent stress among nursing staff and medical personnel identified by Gaul (2024) underscores the urgency of structural changes. Despite selective pilot projects, the widespread integration of prevention programmes remains insufficient. Here, international examples of good practice from Norway (Hansen et al., 2020) and Canada (Stuart, 2016) show that binding guidelines, management training and low-threshold support formats are key success factors. Furthermore, the data highlights the interaction between destigmatisation and the effectiveness of psychoeducational measures. Without a cultural shift that removes the taboo surrounding mental health issues and normalises seeking help, even evidence-based programmes will remain limited in their reach. Studies by Thornicroft et al. (2019) and Gronholm et al. (2021) show that managers in particular act as multipliers and can significantly influence openness to mental health within teams. At the same time, the results make it clear that burnout prevention cannot be viewed in isolation, but must be embedded in a comprehensive, health-promoting structural change. The high prevalence of burnout symptoms, the ongoing aftermath of the pandemic, the deficits in the care situation and the lack of comprehensive prevention structures require consistent rethinking at the political, institutional and organisational levels. In addition to the familiar levers of workplace health promotion, targeted measures to promote mental health literacy, stress management and self-efficacy should be integrated. At the same time, destigmatising mental health issues must become a central component of organisational culture. This requires managers to be trained accordingly, low-threshold support services to be established and open communication spaces to becreated.

In addition, recent studies highlight the importance of resilience promotion, peer support programmes and supervision as effective complements to psychoeducational interventions. Digital services are also becoming increasingly important and enable support regardless of location and time (Paleri et al., 2024). Overall, the findings highlight the need for a multidimensional, integrative prevention approach that systematically links individual, organisational and structural levels. Promoting psychoeducation and destigmatisation is not only an effective tool for burnout prevention, but also a key contribution to ensuring long-term quality of care, securing skilled workers and patient safety in the healthcare system.

8 CONCLUSION

The available findings make it clear that protection against burnout in the healthcare sector is a concern for society as a whole that goes far beyond individual measures. Analysis of current studies and the findings of the longitudinal study by Gaul (2024) demonstrate the urgency of a structurally anchored, multidimensional prevention approach. Psychoeducation makes it possible to strengthen mental health literacy, recognise symptoms at an early stage and develop individual and organisational resources in a targeted manner. Destigmatisation creates the cultural conditions necessary for seeking help to be supported rather than sanctioned. Both approaches are interlinked and only unfold their full effect in an environment that actively promotes openness, acceptance and structural support. International examples demonstrate the feasibility of such a cultural change. Norway has made progress with mandatory psychoeducational modules and supervision in the healthcare system (Hansen et al., 2020). Canada is focusing specifically on destigmatisation with the "Opening Minds" initiative (Stuart, 2016). For German- speaking countries, the study results show that nursing staff and medical personnel in particular are being severely affected by the stresses caused by the pandemic. The significant correlations between burnout symptoms, sleep disorders and institutional deficits underscore the need for comprehensive interventions.

In future, the following action steps should be implemented as a matter of priority:

- Comprehensive implementation of evidence-based prevention programmes in clinics and healthcare facilities
- Mandatory training for managers to promote health literacy and reduce stigmatisation
- Low-threshold, including digital, services to support employees
- Structural establishment of supervision, peer support and reflection formats
- Political initiatives to sustainably anchor mental health promotion
- Systematic scientific evaluation of the effectiveness of existing programmes

The consistent implementation of these measures can strengthen the resilience of healthcare systems in the long term, protect the mental health of professionals and ultimately ensure the quality of care and patient safety. This article provides evidence-based, practice-oriented impetus for the structural prevention of burnout in the healthcare sector. The current challenges offer an opportunity to make healthcare facilities not only

crisis-proof, but also mentally healthy – for the benefit of employees, patients and society as a whole.

REFERENCES

Adli, M. (2019). *Mental health and work: figures, data, facts*. MWV Medizinisch Wissenschaftliche Verlagsgesellschaft.

Bangerter, L. R., Hartzler, A. L., & Tuzzio, L. (2022). A systematic review of the effectiveness of psychoeducation for healthcare workers. *BMC Health Services Research*, 22(1), 215. https://doi.org/10.1186/s12913-022-07536-0

Bianchi, R., Schonfeld, I. S., & Laurent, E. (2015). Burnout-depression overlap: A review. *Clinical Psychology Review*, 36, 28–41. https://doi.org/10.1016/j.cpr.2015.01.004

Busse, R., Blümel, M., & Knieps, F. (2021). Prevention in healthcare: aspiration and reality. *Healthcare*, 83(2), 89–95. https://doi.org/10.1055/a-1139-1237

Cohen, C., et al. (2023). Workplace interventions to improve well-being and reduce burnout for healthcare professionals: A systematic review. *BMJ Open*, 13(6), e071203. https://doi.org/10.1136/bmjopen-2022-071203

Corrigan, P. W., Druss, B. G., & Perlick, D. A. (2016). The impact of mental illness stigma on seeking and participating in mental health care. *Psychological Science in the Public Interest*, 15(2), 37–70. https://doi.org/10.1177/1529100614531398

De Hert, S. (2020). Burnout in healthcare workers: Prevalence, impact, and preventive strategies. *Local and Regional Anaesthesia*, 13, 171–183. https://doi.org/10.2147/LRA.S240564

Demerouti, E., Bakker, A. B., Nachreiner, F., & Schaufeli, W. B. (2001). The job demands-resources model of burnout. *Journal of Applied Psychology*, 86(3), 499–512. https://doi.org/10.1037/0021-9010.86.3.499

Friedrich, M., Götz, T., & Müller, A. (2022). Burnout and mental health in healthcare workers during COVID-19: A systematic review. *Occupational Health Science*, 6(2), 134– 151. https://doi.org/10.1007/s41542-022-00099-3

Gaul, C. C. (2024). Burnout in healthcare workers post-pandemic: A longitudinal analysis. *Unpublished study*. St. Elizabeth University.

García, C. L., Calvo, J. S., & Arias, M. M. (2021). -19 pandemic: Global prevalence and risk factors. *International Journal of Environmental Research and Public Health*, 18(4), 2061. https://doi.org/10.3390/ijerph18042061

Gronholm, P. C., Henderson, C., Deb, T., & Thornicroft, G. (2021). Interventions to reduce stigma in healthcare settings: A systematic review. *The Lancet Psychiatry*, 8(9), 782–794. https://doi.org/10.1016/S2215-0366(21)00207-3

Hansen, V., Pitkänen, A., & Dahl, H. (2020). National mental health programmes for healthcare workers in Norway: Implementation and outcomes. *Scandinavian Journal of Public Health*, 48(7), 689–698. https://doi.org/10.1177/1403494819883887

Heinemann, L. V., & Heinemann, T. (2017). Burnout research: Emergence and scientific investigation of a contested diagnosis. *SAGE Open*, 7(1), 1–12. https://doi.org/10.1177/2158244017697154

Khasne, R. W., Dhakulkar, B. S., Mahajan, H. C., & Kulkarni, A. P. (2020). Burnout among healthcare workers during COVID-19 pandemic in India: Results of a questionnaire-based survey. *Indian Journal of Critical Care Medicine*, 24(8), 664–671. https://doi.org/10.5005/jp-journals-10071-23518

Knaak, S., Mantler, E., & Szeto, A. (2017). Mental illness-related stigma in healthcare: Barriers to access and care and evidence-based solutions. *Healthcare Management Forum*, 30(2), 111–116. https://doi.org/10.1177/0840470416679413

Lin, L., et al. (2021). Effectiveness of psychoeducation programmes for healthcare workers during the pandemic: A systematic review. *BMC Medical Education*, 21(1), 591. https://doi.org/10.1186/s12909-021-02978-1

Maslach, C., & Leiter, M. P. (2017). Understanding the burnout experience: Recent research and its implications for psychiatry. *World Psychiatry*, 16(2), 103–111. https://doi.org/10.1002/wps.20417

Mo, Y., et al. (2020). Work stress among Chinese nurses to support Wuhan in fighting COVID-19 epidemic. *Journal of Nursing Management*, 28(5), 1002–1009. https://doi.org/10.1111/jonm.13014

Murray, E., et al. (2021). Psychoeducation for burnout prevention in healthcare: Evidence from randomised trials. *Journal of Occupational Health Psychology*, 26(2), 125–137. https://doi.org/10.1037/ocp0000279

OECD. (2020). *Health at a Glance: Europe 2020*. OECD Publishing. https://doi.org/10.1787/82129230-en Paleri, V., et al. (2024). Digital staff support interventions for the psychological wellbeing of healthcare professionals: A systematic review. *Journal of Technology in Behavioural Science*, Advance online publication. https://doi.org/10.1007/s41347-024-00387-9

Rotenstein, L. S., et al. (2018). Prevalence of burnout among physicians: A systematic review. *JAMA*, 320(11), 1131–1150. https://doi.org/10.1001/jama.2018.12777

Shah, S. A., et al. (2022). Barriers to mental health support in healthcare professionals: A global perspective. *International Journal of Mental Health Systems*, 16(1), 78. https://doi.org/10.1186/s13033-022-00544-7

Shanafelt, T., Ripp, J., & Trockel, M. (2020). Understanding and addressing sources of anxiety among healthcare professionals during the COVID-19 pandemic. *JAMA*, 323(21), 2133–2134. https://doi.org/10.1001/jama.2020.5893

Stuart, H. (2016). Reducing the stigma of mental illness globally: The opening minds initiative. *World Psychiatry*, 15(1), 77–78. https://doi.org/10.1002/wps.20293

Thornicroft, G., Mehta, N., Clement, S., et al. (2019). Evidence for effective interventions to reduce mental health-related stigma and discrimination. *The Lancet*, 387(10023), 1123–1132. https://doi.org/10.1016/S0140-6736(15)00298-6

Wei, Y., McGrath, P. J., Hayden, J., & Kutcher, S. (2020). Mental health literacy interventions in healthcare settings: A systematic review. *BMC Psychiatry*, 20(1), 28. https://doi.org/10.1186/s12888-019-2416-3

WHO. (2019). *International classification of diseases 11th revision (ICD-11)*. World Health Organisation. https://icd.who.int/

Authors' Contribution

Both authors contributed equally to the development of this article.

Data availability

All datasets relevant to this study's findings are fully available within the article.

How to cite this article (APA)

Pfeifer, A., & Mrázová, M. (2025). BURNOUT IN HEALTHCARE AFTER THE PANDEMIC: PSYCHOEDUCATION AND DESTIGMATISATION AS KEYS TO PREVENTION. *Veredas Do Direito*, 22(5), e223835. https://doi.org/10.18623/rvd.v22.n5.3835