

How to Diagnose Clinical Burnout Using Dutch and Swedish Approaches?

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"A 38-year-old teacher, mother of two, is taken by her husband to the emergency room. She panicked because she could not figure out how to log into her work computer and feared that something was seriously wrong with her brain. The medical examination shows no signs of physical illness, yet she reports having visited doctors twice in the past year for sleep disturbances, headaches, and stomach problems. The following day she feels utterly exhausted, unable to get out of bed, and incapable of reading or watching television because she struggles to comprehend written and spoken text. Her stress has been building for years: two colleagues are on long-term sick leave, which has increased her workload, while at home she also faces the demands of caring for her elderly father with dementia." This case illustrates the severe end of a spectrum of work-related stress symptoms, ranging from fatigue and irritability to a disabling condition often referred to as clinical burnout—or, in Sweden, stress-related exhaustion disorder (SED).¹ We adopt a synthesis of existing definitions presented in a seminal and widely cited monograph^{2-p.36}: "Burnout is a persistent, negative, work-related state of mind in 'normal' individuals that is primarily characterized by exhaustion, which is accompanied by distress, decreased motivation, and the development of dysfunctional attitudes at work." Burnout can be seen as a specific psychological stress reaction that develops from prolonged exposure to job-related stressors. It reflects a process of imbalance between external demands and what that person can manage with their available resources. So, stress is seen both as a response and a process that leads to that response. Whereas

many people experience transient burnout symptoms that resolve with rest or recovery, others develop a chronic, debilitating disorder that impairs both social and occupational functioning, which we named clinical burnout (to distinguish from burnout symptoms). Despite its widespread impact, there is still no universally accepted set of diagnostic criteria for clinical burnout.

In this Forum article, we not only address the question of whether diagnostic criteria for clinical burnout are needed but also propose specific criteria that can be applied internationally. Drawing on experiences from Sweden and the Netherlands—two countries that have recognized and managed clinical burnout for more than 2 decades—we propose a pragmatic diagnostic framework that distinguishes between mild, subclinical complaints and severe, disabling conditions.

WHY DIAGNOSTIC CRITERIA ARE NEEDED

Stress-related mental health problems have risen sharply in European welfare states. In Sweden, stress-related psychiatric illness quadrupled between 2010 and 2020,³ whereas one in five Dutch employees now report burnout complaints.⁴ At the European level, work-related stress costs are estimated at over €600 billion annually due to absenteeism, presenteeism, turnover, and health care expenditure.⁵

In Sweden and the Netherlands, diagnostic criteria guide access to treatment, rehabilitation, and social security benefits. Without clear standards, workers risk inconsistent diagnoses and unequal access to care. For researchers, standardized criteria allow cross-country comparisons and reliable evaluation of interventions. Current international classification systems fall short. The *International Classification of Diseases, 11th Revision* lists burnout merely as an "occupational phenomenon," not a medical condition, whereas the *Diagnostic and Statistical Manual of Mental Disorders, 5th Edition* omits it entirely. A harmonized diagnostic approach is therefore needed to bridge practice and research.

BALANCING RISKS OF MEDICALIZATION

Critics warn that medicalizing burnout could divert attention from workplace causes such as workload, poor management, or lack of recovery time.⁶ From this perspective, burnout is best addressed through organizational change. In European welfare states, however, diagnostic labeling has advantages: it validates patients' suffering, structures occupational health services, and provides access to compensation. The solution lies in distinguishing between subclinical stages—where prevention is key—and severe clinical burnout, which requires medical attention. Sweden and the Netherlands both make this distinction in different ways, offering valuable lessons.

SWEDISH AND DUTCH APPROACHES

In the late 1990s, increasing numbers of Swedes presented with exhaustion, cognitive problems, and stress-related somatic complaints. In response, diagnostic criteria for SED were developed in 2003 and adopted nationally in 2005 (*International Classification of Diseases, 10th Revision* code F43.8A).⁷ The criteria emphasize prolonged stress exposure, exhaustion, and cognitive dysfunction, with exclusion of other psychiatric or somatic disorders.

Independently, the Dutch Association of Occupational Physicians introduced guidelines in 2000, later updated in 2011 and 2019.⁸ These guidelines define a spectrum from stress complaints (mild), via overstrain (loss of control, functional impairment) to burnout (severe, chronic overstrain with exhaustion as core feature). Unlike Sweden's single diagnosis, the Dutch system emphasizes successive stages, with prevention and return-to-work guidance as central goals. Empirical

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Funding Sources for All Authors: None declared.

Conflicts of Interest for All Authors: None declared.

No support relevant to the publication was provided.

Specific Author Contributions: Conceptualization: all authors. First and next drafts: W.B.S. Written comments on all drafts: A.d.R., J.H., and M.Å.

Data Availability: Not applicable.

EQUATOR Network Checklist: Not applicable.

AI was exclusively used for English language editing (as all authors are nonnative speakers).

Ethical Considerations and Disclosures: Not applicable (as the paper is a nonempirical FORUM contribution).

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DOI: 10.1097/JOM.0000000000003644

TABLE 1. Comparison of the Swedish and Dutch Approaches to Clinical Burnout

Stress-Related Exhaustion Disorder (Sweden)	Work-Related Stress (Netherlands)
<p><i>Early risk stage</i> Various symptoms, eg, 1. Feeling mentally and/or physically tired 2. Sleep problems 3. Anxious worrying 4. Feeling down/sad 5. Irritability, feeling “on the edge” 6. Somatic complaints (eg, headache, palpitations, gastrointestinal problems, muscular pain) 7. Concentration problems, forgetfulness</p> <p><i>Late risk stage</i> Symptoms as above but more severe and persistent, plus: 1. Concentration problems and forgetfulness more prominent 2. Recurrent short sick-leave periods due to dysfunction</p> <p><i>Acute stage</i> 1. Severe stress and lack of restorative time (at least 6 months) 2. Severe exhaustion with lack of mental energy (1 month) 3. Significant cognitive dysfunction (ie, concentration problems, problems with information processing and executive functioning, and memory problems; 1 month) 4. Marked increase of sensitivity to external stressors (1 month) 5. At least three of four associated symptoms: a. Sleep disturbance b. Physical weakness, fatigue c. High sensitivity to stimuli such as noise and light d. Somatic complaints 6. Unable to work for some time because of severe symptoms during the acute stage</p>	<p><i>Stress complaints</i> Three or more of the following symptoms: 1. Fatigue 2. Disturbed, restless sleep 3. Irritability 4. Inability tolerating crowds, noise 5. Emotional instability 6. Worrying 7. Feeling agitated 8. Concentration problems, forgetfulness</p> <p><i>Overstrain</i> Symptoms as above plus: 1. Loss of control/powerlessness 2. Significant limitations in professional and/or social functioning</p> <p><i>Clinical burnout</i> Symptoms as in overstrain plus: 1. Exhaustion in the foreground 2. Symptoms for at least 6 months</p>
<p><i>Exclusion</i> Other psychiatric and somatic diagnoses must be ruled out, particularly primary affective disorder.</p>	<p><i>Exclusion</i> Symptoms are not due to substance abuse, medication, treatment, mood disorder, or any other mental disorder.</p>

studies confirm that complaints, sickness absence, and burnout scores escalate along this spectrum.⁹

TOWARD UNIVERSAL DIAGNOSTIC CRITERIA

To assess the overlap and to develop novel diagnostic criteria for clinical burnout based on both national approaches (see Table 1), we organized a series of eight 1-hour online meetings aimed at reaching consensus. All four authors participated in the first and both final sessions, with five bilateral sessions in between. Minutes were circulated after each meeting. In addition, external experts were consulted. In the Netherlands, this was a senior occupational physician who has been involved since 2000 in developing successive national guidelines on the topic. In Sweden, the criteria were reviewed by a working group of 13 leading experts sponsored by the Swedish Psychiatric Association. Most of the changes proposed by these external experts were incorporated into our final proposal.

Despite differences, both systems converge on key points: burnout develops gradually from mild to severe complaints, exhaustion and cognitive impairment are central in the acute stage, and functional impairment and exclusion of other disorders are required for diagnosis. Building on this overlap, we propose internationally applicable diagnostic criteria that distinguish three phases—early risk, advanced risk, and clinical burnout—followed by a recuperation stage (Table 2).

DISCUSSION AND OUTLOOK

Our proposal addresses two urgent needs: preventing unnecessary medicalization by recognizing subclinical stages

and providing coherent diagnostic standards for severe clinical burnout. At-risk workers should be supported through preventive measures such as workload reduction, recovery opportunities, and stress management. Clinical burnout, in contrast, requires a formal diagnostic process (including differential diagnosis), treatment, and social insurance support. Evidence from Sweden highlights the value of combining rehabilitation with employer involvement to reduce sickness absence.¹⁰

Broader practice guidelines, like those in the Netherlands, should embed diagnostic criteria within prevention, sickness absence management, and return-to-work guidance by specialized professionals. Moreover, multidisciplinary collaboration is essential. Finally, clear criteria also advance research. Prevalence studies currently report widely varying rates, but applying standardized stages will improve comparability and intervention evaluation.

CONCLUSION

Clinical burnout is a clinical reality, not a vague metaphor or a mere workplace complaint. There are subclinical stages of clinical burnout that merit recognition and preventive action but not a formal medical diagnosis. The experiences of Sweden and the Netherlands show that diagnostic criteria can structure health care, research, and policy.

We propose international diagnostic criteria (Table 2) that distinguish early risk, advanced risk, clinical burnout, and recuperation. This staged approach helps prevent overmedicalization while ensuring support for those most affected.

TABLE 2. Proposed Diagnostic Criteria for Stages Toward Clinical Burnout**Early risk stage**

Presence of at least three stress-related symptoms for a minimum of 3 months. The symptoms represent a change from previous functioning:

1. **Fatigue:** Often mentally and/or physically exhausted, even after rest.
2. **Sleep disturbances:** Difficulty falling or staying asleep, or experiencing restless, nonrestorative sleep.
3. **Anxious worrying:** Often troubled by uncontrollable thoughts of concern or fear.
4. **Irritability:** Increased sensitivity to minor frustrations, feeling “on the edge,” or struggling to tolerate crowds or noise.
5. **Emotional instability:** Strong emotional reactions such as anger outbursts, crying fits, or feeling easily overwhelmed.
6. **Cognitive lapses:** Occasional memory issues, making mistakes more frequently, or forgetfulness.
7. **Mental distancing:** A growing sense of detachment from work or other social roles, sometimes accompanied by cynicism or aversion.
8. **Somatic complaints:** Physical symptoms like headaches, heart palpitations, gastrointestinal discomfort, or muscular pain.

Advanced risk stage

Includes several or all symptoms from the early risk stage, with increased severity and persistence, plus:

1. **Frequent cognitive impairments:** Increasing forgetfulness, and noticeable difficulties in maintaining attention and focused thinking.
2. **Loss of control:** A strong sense of helplessness and powerlessness in managing daily life or work.
3. **Functional impairments:** Significant limitations in professional, social, or household activities due to stress-related symptoms.

Clinical burnout stage

Presence of all the following criteria:

1. **Stress-related symptoms** from the early risk stage have persisted for at least 6 months.
2. **Severe exhaustion:** Extreme mental and physical fatigue that dominates daily life.
3. **Cognitive dysfunction:** Significant and sustained problems with attention regulation, memory, and executive functioning.
4. **Feeling emotionally overwhelmed and/or heightened stress sensitivity:** Sustained and increased reactivity to external stressors. Affective display is frequently difficult to regulate, and cognitive functions may further deteriorate in stressful situations.
5. **Severe functional impairments:** Severe limitations in professional, social, or household activities due to stress-related symptoms.

Differential diagnosis:

Symptoms are not better explained by a mood disorder or another mental disorder or mental condition.

Exclusion: Symptoms of the previous stages are not attributable to the following:

- Substance use or medication
- Another medical condition
- Medical treatment

Recovery stage

This starts when the individual is able to actively engage in discussions about resolving problems and exploring new opportunities. Progress is marked by an ability to initiate and participate in solutions and envision future possibilities.

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