

Systematic Review

Occupational burnout, perceived stress and psychological well-being among healthcare workers: a PRISMA-guided systematic review

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Received: 30 July 2026

Accepted: 26 September 2026

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ABSTRACT

Healthcare workers face elevated occupational demands that place them at risk of burnout, chronic perceived stress, and diminished psychological well-being. Objectives were to systematically identify, screen, and synthesize peer-reviewed literature on the conceptualization, prevalence, antecedents, interrelationships, and mitigation of occupational burnout, perceived stress, and psychological well-being among healthcare workers, following PRISMA 2020 reporting principles. A structured, multi-query search was conducted across academic and biomedical search-engine-indexed sources (covering PubMed/PMC, Scopus-indexed journals, JAMA, BMC, MDPI, Frontiers, and ScienceDirect), supplemented by backward citation searching. Records were screened against pre-specified eligibility criteria (PICOS) by a single reviewer; a PRISMA-style flow diagram documents identification, screening, eligibility, and inclusion. Of 96 records identified, 43 met eligibility criteria and were included: 8 foundational theoretical/instrument sources, 15 systematic reviews or meta-analyses, and 20 primary empirical studies spanning nurses, physicians, and allied health professionals across more than a dozen countries, including India. Reported burnout prevalence ranged from approximately 11% to over 80% depending on profession, instrument, and pandemic period. Emotional exhaustion was the burnout dimension most consistently associated with anxiety, depression, and reduced psychological well-being, while personal accomplishment and organizational resources functioned as protective factors. The evidence base confirms substantial, heterogeneous psychological risk among healthcare workers and points to combined individual- and organizational-level intervention as the most defensible path forward. Limitations of the review's search and screening approach are discussed.

Keywords: Occupational burnout, Perceived stress, Psychological well-being, Healthcare workers

INTRODUCTION

Healthcare work is among the most psychologically demanding occupations, characterized by high patient loads, emotionally charged encounters, irregular shift schedules, and continuous exposure to suffering and mortality. These occupational demands have long been associated with elevated rates of occupational burnout, chronic perceived stress, and compromised psychological

well-being among nurses, physicians, and allied health professionals.¹

In 2019, the World Health Organization formally recognized burnout as an occupational phenomenon in the eleventh revision of the International Classification of Diseases, describing it as a syndrome resulting from chronic workplace stress that has not been successfully managed.² Burnout, perceived stress, and psychological well-being are conceptually distinct yet empirically

interconnected constructs. Burnout is typically operationalized as a three-dimensional syndrome comprising emotional exhaustion, depersonalization, and reduced personal accomplishment.³

Perceived stress refers to the degree to which individuals appraise situations as unpredictable, uncontrollable, and overwhelming.⁴ Psychological well-being, drawing on Ryff's multidimensional model, encompasses autonomy, environmental mastery, personal growth, positive relations with others, purpose in life, and self-acceptance.⁵ Despite an expanding evidence base, the literature remains fragmented across professions, countries, instruments, and theoretical frameworks, producing considerable heterogeneity in reported prevalence and inconsistent conclusions about risk and protective factors.⁶

This review applies a formal, PRISMA-guided search and screening protocol to address five questions: (a) how are burnout, perceived stress, and psychological well-being conceptualized and measured; (b) what is their documented prevalence among healthcare workers; (c) what antecedents and risk factors are most consistently reported; (d) how are the three constructs interrelated; and (e) what interventions have demonstrated effectiveness.

METHODS

This review followed the reporting structure recommended by the PRISMA 2020 statement to the extent feasible within a single-reviewer, tool-mediated search process; deviations from a full institutional systematic review protocol are stated explicitly in the limitations section.⁷

Information sources and search strategy

Searches were conducted using an AI-assisted academic search tool that indexes and retrieves content from PubMed/PMC, Scopus-indexed journals, JAMA, BMC, MDPI, Frontiers, ScienceDirect, Springer, and Wiley, among other publishers. This is a pragmatic, single-tool search process rather than a direct Boolean export from institutional database platforms (e.g., Ovid MEDLINE, CINAHL, PsycINFO); this constraint is discussed under limitations. Eleven structured search queries were run, combining terms for burnout, perceived stress, psychological well-being, and healthcare worker subgroups (Table 2). Searches were supplemented by backward citation searching: the reference list of one comprehensive, closely aligned primary study was hand-screened, yielding 15 additional named studies that were independently located and verified.⁸

Table 1: Eligibility criteria (PICOS).

Elements	Criteria
Population	Practicing healthcare workers (physicians, nurses, and allied/frontline clinical staff) in clinical or hospital settings. Studies of students, general community samples, or non-healthcare occupational groups were excluded.
Interest/exposure	Occupational burnout and/or perceived stress, measured with a named validated instrument (e.g., Maslach Burnout Inventory, Perceived Stress Scale, Copenhagen Burnout Inventory, Oldenburg Burnout Inventory) or clearly operationalized construct.
Comparator	Not required (associative/descriptive designs eligible); where present, comparisons across professions, settings, or time periods were noted.
Outcome	Psychological well-being or a closely related mental-health outcome (e.g., anxiety, depression, quality of life, resilience) reported in relation to burnout or perceived stress.
Study design	Peer-reviewed cross-sectional, cohort, or intervention studies, and systematic reviews/meta-analyses/scoping reviews; foundational theoretical or instrument-development papers were included regardless of design.
Timeframe	2018-2026, to capture pre- and post-COVID-19 evidence; seminal theoretical works included regardless of date.
Language	English
Source quality	Peer-reviewed journal articles only; institutional blogs, test-publisher marketing pages, and clinical-trial registry entries without reported results were excluded.

Table 2: Search strings, focus areas, and number of records returned across the eleven structured queries.

Search string	Focus	Records returned
occupational burnout perceived stress psychological well-being healthcare workers systematic review	General topic scope	8
Maslach burnout inventory theory conceptualization emotional exhaustion depersonalization	Burnout theory/measurement	6
Cohen perceived stress scale Ryff psychological well-being model nurses healthcare	Stress/well-being theory and measurement	8
Job demands-resources model burnout healthcare workers prevalence nurses' physicians global	Theoretical framework and prevalence	8
interventions reduce burnout stress improve well-being healthcare workers meta-analysis mindfulness organizational	Interventions	8
PRISMA 2020 statement systematic review reporting guideline Page McKenzie	Methodology	8
"burnout" AND "perceived stress" AND "psychological well-being"	Primary-study	8

Continued.

Search string	Focus	Records returned
healthcare workers cross-sectional	identification	
nurses burnout perceived stress psychological wellbeing predictors 2023 2024 quantitative study	Nursing-specific primary studies	8
physician burnout perceived stress well-being meta-analysis prevalence 2022 2023	Physician-specific evidence	10
India healthcare workers burnout perceived stress psychological well-being hospital study	South Asian/Indian context	8
(verification searches for author/citation metadata)	Citation verification	1

*“Records returned” reflects the number of distinct result entries examined from each query; totals include duplicates across queries, which were subsequently removed during screening (see Figure 1).

Study selection and data extraction

Titles and abstracts of all retrieved and citation-chained records were screened by a single reviewer against the PICOS criteria above. Records excluded for population mismatch (e.g., students, general community samples, social workers), non-peer-reviewed/ promotional source type, clinical-trial registry entries without reported outcomes, superseded preprints, and insufficient topical alignment. Remaining records were assessed in full for eligibility, with further exclusions for insufficient extractable data on burnout, stress/ well-being outcomes, or duplicate reporting of the same cohort in a companion publication already included. For each included primary study, the following data were extracted where reported: authors and year, country, sample and setting, design, instruments used, and key findings relevant to burnout, perceived stress, or psychological well-being.

Quality considerations

Given the single-reviewer, non-registered nature of this review, a formal dual-reviewer risk-of-bias tool (e.g., the Newcastle-Ottawa Scale or JBI Critical Appraisal Checklists) was not applied with independent scoring. As

a lighter-weight quality safeguard, included primary studies were required to report a named validated instrument, a defined sample and setting, and a peer-reviewed publication venue; studies relying solely on unvalidated/ ad hoc measures excluded. This represents a methodological limitation relative to a full institutional systematic review and is discussed further below.

Study selection results

The search process identified 96 candidate records (81 via direct search queries and 15 via backward citation searching). After removing duplicate records (n=24, chiefly mirror hosts of the same article across PMC, publisher sites, and repository copies, and repeat appearances across queries), 72 unique records were screened at the title/abstract level. Nineteen records were excluded at this stage for population mismatch, non-peer-reviewed source type, trial-registry status without results, or a superseded preprint. The remaining 53 records were assessed in full; 10 were further excluded for insufficient extractable data or duplicate cohort reporting, yielding a final set of 43 included sources. Figure 1 presents the PRISMA-style flow diagram.

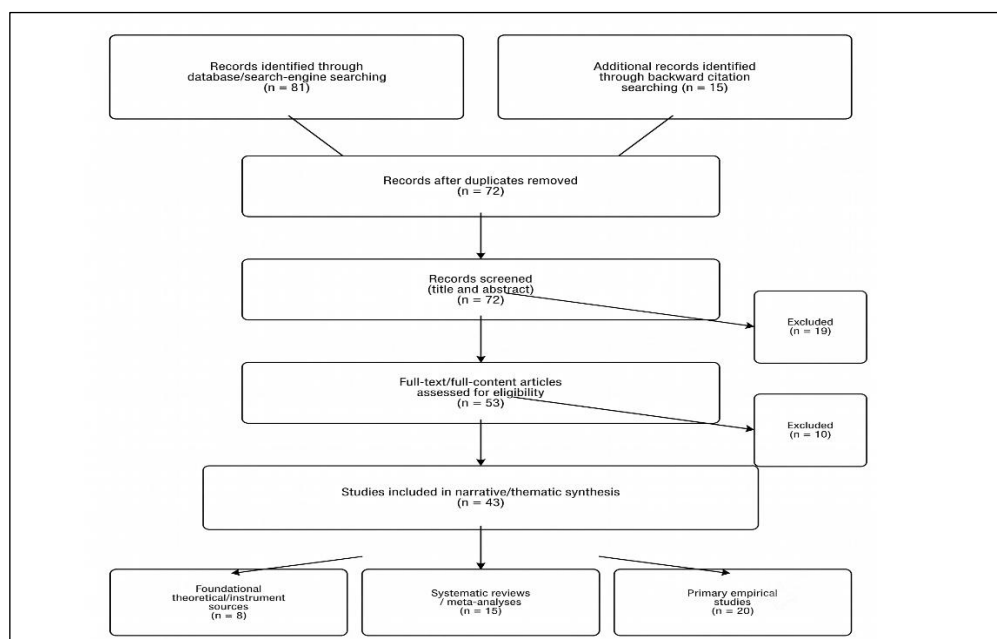


Figure 1: PRISMA-style flow diagram of record identification, screening, and inclusion.

RESULTS

Overview of included studies

Of the 43 included sources, 8 were foundational theoretical or instrument papers underpinning the burnout, stress, and well-being constructs; 15 were systematic reviews or meta-analyses synthesizing

prevalence, risk factors, or intervention effectiveness; and 20 were primary empirical (mostly cross-sectional) studies. Included primary studies spanned the Czech Republic, Singapore, the United Kingdom, Poland, Finland, Sweden, China, Peru, Lithuania, Saudi Arabia, the United States, and India, with sample sizes ranging from 76 to 3,537 participants. Table 3 summarizes the primary empirical studies most central to the synthesis.

Table 3: Characteristics and key findings of the primary empirical studies most central to the synthesis.

Studies	Country	N	Design	Key instruments	Key finding
Dobešová Cakirpaloglu et al⁸	Czech Republic	1,064	Cross-sectional	MBI, PSS, SUPSO-7	46% high emotional exhaustion; EE explained 63% of variance in depression
Denning et al¹⁴	UK, Poland, Singapore	3,537	Multinational cross-sectional	OLBI, HADS, SAQ	67% screened positive for burnout; patient-facing roles at highest risk
ICU Singapore study 2025	Singapore	76	Single-center cross-sectional	MBI-HSS, CPSS, PHQ-4	56.6% overall burnout rate; 84% reduced personal accomplishment
Kashmir disaster-impacted study 2024	India	514	Cross-sectional descriptive	PSS, burnout and resilience scales	Elevated perceived stress and burnout amid compounded disaster/pandemic stressors
Menon et al¹⁵	India (10 states)	967	Cross-sectional (telephonic)	Burnout and psychological distress measures	Over 50% reported high psychological distress during COVID-19
Indian ICU tertiary-hospital study 2019	India (South)	204	Cross-sectional	PSS, MBI-HSS, job satisfaction scale	80% high burnout; markedly higher among nurses than doctors
North India medical college study 2019	India (North)	152	Cross-sectional	PSS-10, Copenhagen Burnout Inventory	High perceived stress and burnout, greatest among nurses
Zhang et al²⁰	China	480	Cross-sectional, latent profile analysis	Psychological capital, PSS, burnout scale	Low psychological capital linked to higher burnout and stress, especially introverted junior nurses
Palvimo et al¹⁹	Finland	2,115	Cross-sectional survey	Burnout Assessment Tool	Job resources most strongly reduced burnout; destructive leadership increased it
Wei et al¹⁸	China	455 (474 sampled)	Cross-sectional, path analysis	JD-R model measures	Workload and anxiety/depression positively predicted burnout; support was protective
Baños Chaparro et al²³	Peru	450	Cross-sectional, structural equation modeling	Burnout, PSS, quality-of-life measures	Perceived stress negatively predicted quality of life among nursing staff

Conceptual and theoretical foundations

The dominant conceptualization of burnout derives from Maslach and Jackson's multidimensional theory, operationalized through the Maslach Burnout Inventory and later reframed by Maslach and Leiter as a chronic

mismatch between an individual and six dimensions of the work environment: workload, control, reward, community, fairness, and values.^{1,3,9} Perceived stress is measured through Cohen et al Perceived Stress Scale, rooted in transactional stress theory, while psychological well-being draws on Ryff's 6-dimension eudaimonic

model.^{4,5} Two integrative frameworks recur throughout the included literature: the Job Demands-Resources (JD-R) model, which holds that excessive job demands drive burnout while adequate resources buffer this effect, and Hobfoll's.^{10,11} Conservation of resources theory, which frames chronic stress as a depletion of personal, social, and material resources that cascades into burnout and diminished well-being.

Prevalence of burnout and stress among healthcare workers

Reported burnout prevalence varied substantially across the included studies, from approximately 11% of nurses globally in a pre-pandemic meta-analysis of 113 studies to 54.6% among physicians during the COVID-19 pandemic across 45 observational studies, and as high as 80% among ICU staff in an Indian tertiary hospital, where burnout was markedly more prevalent among nurses (69%) than doctors (6%).^{12,13} A multinational study of 3,537 healthcare workers across the United Kingdom, Poland, and Singapore found that 67% screened positive for burnout, with doctors and nurses in patient-facing roles at significantly elevated risk.¹⁴ Indian evidence was broadly consistent with this global pattern: a 10-state cross-sectional study of 967 healthcare workers found that over half reported high psychological distress during the COVID-19 pandemic, while facility-level studies from northern and southern India similarly documented high perceived stress and burnout, concentrated among nursing staff.¹⁵ A systematic review of physicians across 45 countries found prevalence estimates ranging from below 10% to nearly 80%, a spread attributable largely to inconsistent burnout definitions and cut-points rather than true underlying differences.⁶

The COVID-19 pandemic substantially intensified these risks across the included evidence base. A systematic review and meta-analysis of healthcare workers during COVID-19 documented markedly elevated burnout compared with pre-pandemic baselines, consistent with a Latin American scoping review reporting burnout prevalence between 13.2% and 70.3% across included studies (2019-2023).¹⁶ Notably, longitudinal U.S. physician data suggest a decline from a 2021 pandemic peak (62.8%) to 45.2% by 2023, indicating that elevated pandemic-era rates were not a permanent shift.

Antecedents and risk factors

Across the included literature, risk factors cluster into individual, interpersonal, and organizational categories, consistent with the JD-R model's distinction between job demands and resources. High workload, excessive administrative burden, and insufficient staffing were the most frequently cited organizational demands.¹⁷ A path-analytic study of Chinese frontline medical staff found workload and anxiety/depression symptoms positively predicted burnout, while self-compassion and

organizational support were protective.¹⁸ A large Finnish survey of 2,115 nurses found that job resources produced the greatest reduction in burnout, while destructive leadership and job demands increased it.¹⁹ Among junior nurses in China, low psychological capital, particularly among introverted individuals, was associated with greater vulnerability to burnout and stress.²⁰ Emotional labor and interpersonal demands also emerged as salient risk factors: emotional exhaustion was significantly associated with anxiety and depressive symptoms among South Korean nurses.²¹

Interrelationships among burnout, perceived stress, and psychological well-being

A consistent body of evidence links burnout and perceived stress to poorer psychological well-being. A systematic review and meta-analysis of 101 studies confirmed a significant association between emotional exhaustion and both anxiety and depression.²² In a large Czech sample, emotional exhaustion explained 63% of the variance in depressive symptoms, while personal accomplishment consistently functioned as a protective factor, positively predicting well-being.⁸ Among Peruvian nursing personnel, perceived stress negatively predicted quality of life in a structural equation model.²³ Among Chinese physicians, burnout was negatively associated with subjective well-being, an effect moderated by perceived social support.²⁴ These findings support the Conservation of Resources framework: chronic occupational stress and burnout appear to deplete the psychological resources that sustain well-being, while social and organizational resources buffer this depletion.¹¹

Interventions and mitigation strategies

Individual-level psychological interventions, particularly mindfulness-based programs, were the most extensively studied. A systematic review and meta-analysis among primary healthcare professionals found significant reductions in emotional exhaustion and depersonalization alongside increases in personal accomplishment, a pattern echoed in a meta-analysis focused specifically on nurses.^{25,26} A meta-analysis of 22 randomized controlled trials among physicians found a significant reduction in burnout following prevention programs, predominantly mindfulness-based stress reduction, though only two of the 22 trials targeted structural rather than individual-level change. This imbalance recurs throughout the intervention literature: organizational strategies such as workload management, adequate staffing, and supportive leadership are consistently identified as necessary complements to individual coping-skills training, yet remain comparatively under-evaluated in controlled trial designs.^{18,27}

DISCUSSION

The included literature converges on several conclusions. First, burnout, perceived stress, and psychological well-

being are theoretically distinct but empirically intertwined, connected through the resource-depletion mechanisms described by the JD-R model and Conservation of Resources theory.^{10,11} Second, emotional exhaustion is consistently the burnout dimension most strongly associated with anxiety, depression, and declining well-being, while personal accomplishment and organizational resources function as protective factors.^{19,22} Third, prevalence estimates vary widely across professions, countries, and instruments, reflecting genuine contextual differences as well as persistent inconsistency in operationalizing burnout.⁶ Fourth, evidence from India specifically mirrors the global pattern, with facility-level studies reporting burnout and perceived stress concentrated among nursing staff and intensified during the COVID-19 pandemic, consistent with the facility-level literature gap that motivates continued research in this area.¹⁵ Fifth, the COVID-19 pandemic served as an acute amplifier of these risks, with some evidence of partial normalization in subsequent years.

This review's search and screening approach carries specific limitations beyond those typical of narrative systematic reviews. First, searches were conducted through a single AI-assisted search tool rather than direct Boolean export from institutional databases (e.g., Ovid MEDLINE, CINAHL, PsycINFO, Scopus); consequently, the review may not have exhaustively captured all eligible literature, and true total-record counts for each search string are not verifiable against a database export log. Second, screening and eligibility assessment were performed by a single reviewer without independent dual screening or inter-rater reliability statistics, which is a departure from best-practice systematic review conduct and increases the risk of selection bias. Third, no formal, tool-scored risk-of-bias or quality appraisal (e.g., Newcastle-Ottawa Scale, JBI Checklists) was applied to included primary studies. Fourth, the review was not prospectively registered (e.g., with PROSPERO). Fifth, most included primary studies remain cross-sectional, precluding causal inference about the direction of relationships among stress, burnout, and well-being. These limitations mean the review is best characterized as a rigorous, PRISMA-informed narrative/thematic systematic review rather than a fully compliant systematic review or meta-analysis suitable for direct clinical guideline use; readers seeking the latter should consult the primary systematic reviews and meta-analyses cited herein e. g., directly.^{6,12,22}

CONCLUSION

This PRISMA-guided systematic review synthesized 43 sources on occupational burnout, perceived stress, and psychological well-being among healthcare workers, drawing on foundational theory and recent empirical evidence spanning nurses, physicians, and allied health professionals across more than a dozen countries, including facility-level evidence from India. The evidence

confirms that healthcare work carries substantial and unevenly distributed psychological risk, with emotional exhaustion as the central mechanism linking occupational stress to declining well-being, and organizational conditions as the most actionable intervention target. Future work would benefit from formally registered, dual-reviewer systematic reviews with full database access, longitudinal designs, standardized measurement, and rigorous evaluation of organizational-level interventions delivered alongside individual psychological support.

Funding: No funding sources

Conflict of interest: None declared

Ethical approval: Not required

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Cite this article as: Arshad MH, Majumdar S, Narang A. Occupational burnout, perceived stress and psychological well-being among healthcare workers: a PRISMA-guided systematic review. *Int J Community Med Public Health* 2026;13:6073-9.