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Throwing the baby out with the bathwater – while adding the bathtub too: a rejoinder to "Beliefs about burnout" of Bianchi and Schonfeld

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ABSTRACT

In their commentary, [Bianchi, R. & Schonfeld, I. (2025. Beliefs about burnout. *Work & Stress*)] discuss three beliefs about burnout and state that these "rest on insufficient evidence": (1) burnout is primarily predicted by work-related factors; (2) a burnout epidemic exists; and (3) burnout can be differentiated from depression. We argue that the authors' presentation of these ideas runs the risk of not only throwing the baby out with the bathwater but also throwing away the bathtub. Our rejoinder first of all emphasises the need to distinguish between (typically mild) burnout *complaints*, and burnout *disorder* (or "clinical burnout"). We conclude that there are compelling empirical grounds to consider both burnout complaints and burnout disorder to be work related. Next, we present evidence that burnout complaints increased slightly over time, whereas clinical burnout is rather exceptional and stable, suggesting that the notion of a "burnout pandemic" is indeed overstated. Finally, conceptual and empirical evidence and evidence from clinical practice indicates that both burnout complaints and burnout disorder can be meaningfully differentiated from depression. We conclude that a nuanced debate is preferable to a simplistic rejection of burnout, based on both conceptual and empirical grounds and the relevance of the burnout concept for practice.

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Introduction

In their commentary, Bianchi and Schonfeld (2025) discuss three beliefs about burnout and state that these "rest on insufficient evidence": (1) burnout is primarily predicted by work-related factors; (2) a burnout epidemic exists; and (3) burnout can be differentiated from depression. Below we address each of these beliefs and argue that the authors' presentation of these ideas runs the risk of not only throwing the baby out with the bathwater but also throwing away the bathtub. Our rejoinder emphasizes the need of distinguishing between (typically mild) burnout complaints, as assessed with a questionnaire, and burnout disorder (or 'clinical burnout'; Van Dam, 2021), as diagnosed by skilled health professions, using specific guidelines. This differentiation is similar to Bianchi

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and Schonfeld's distinction between dimensional and categorical views of depression. However, it is odd that they do not apply the same logic to burnout, as differentiating burnout complaints from clinical burnout could have helped to clarify some of the issues they raised.

1. Yes, burnout is work-related

The idea that burnout can be caused by factors other than work is not new, as evidenced by definitions stating that "problems outside work and/or personal vulnerability *may* facilitate the development of burnout" (e.g. Schaufeli et al., 2020b, p. 28). However, there are at least five grounds to refute Bianchi and Schonfeld's notion that "it may be premature to conclude that burnout is specifically induced by job stress."

First, the authors of the meta-analyses that Bianchi and Schonfeld refer to clearly conclude that job factors have a considerable impact on burnout symptoms. For instance, Lesener et al. (2019) note that their meta-analytic longitudinal structural equation models validate the JD-R model's main assumptions, as job demands (positively) and job resources (negatively) predict burnout over time. The size of the associations found (with standardised longitudinal weights of .13 for demands and −.16 for resources in the reciprocal model on p. 91) is considered relevant, "since even small longitudinal effect sizes are substantial" (p. 89). Furthermore, Guthier et al.'s (2020) meta-analysis found reciprocal longitudinal relationships between job demands and burnout. This again emphasises the relevance of work-related variables, as job demands and burnout appear to increase one another mutually, resulting in a vicious circle. Job characteristics play a crucial role in this negative self-reinforcing loop (or spiral). The evidence presented by the meta-analyses thus supports the idea that work-related variables are relevant predictors of burnout. This contradicts Bianchi and Schonfeld's point about "the lack of substantiation."

Second, methodological issues need to be considered when evaluating the size of longitudinal coefficients. Longitudinal studies usually reveal relatively minor effects of predictors on outcome variables due to the stability of the variables examined. If variables vary little or not at all over time (no variation), there is little change to be explained, resulting in weak effects of the predictors of this change. However, this does not imply that work-related antecedents lack relevance as causes of burnout. It is plausible that work-related variables *initiate* the development of burnout complaints in the short run (thereby sparking burnout). Subsequently, other processes, such as lack of recuperation due to exhaustion (i.e. the "recovery paradox"; Sonnentag, 2018) may take over. This can be further intensified (moderated) by non-work-related factors such as personality. This complex and dynamic process is not likely to be uncovered in most longitudinal studies, as the time lags used often span large intervals, resulting in underestimation of the impact of job-related antecedents (cf. Dormann & Griffin, 2015). Additionally, designs should include working individuals at the very onset of burnout complaints (and preferably even *before* these appear) to be able to detect the impact of work-related antecedents. Analysing employed individuals later on risks to underrate the impact of work-related variables, as the process towards burnout has already been initiated.

Third, there is an "incongruous proof" logic underlying Bianchi and Schonfeld's thesis that work-related factors are not crucial in the development of burnout. They discuss two rigorous meta-analyses of longitudinal studies and suggest that *because*

work-related factors are not that important, non-work factors *must* be more essential. However, it is not because work-related factors tend to be weakly associated with burnout over time that other factors will show stronger associations and will "survive" a similar rigorous methodological test. Given the lack of a similar thorough empirical test of the effects of such non-work-related factors to underpin their importance, this reads as an overly optimistic and probably unfounded claim. Bianchi and Schonfeld paraphrase the conclusion of the meta-analysis of Guthier et al. (2020) as follows: "detecting an existing stressor-effect of job stressors on burnout was mainly a matter of chance" (p. 20). However, in their actual conclusion, Guthier et al. added "like in many other psychological domains." Hence, convincing longitudinal stressor-strain relationships are the exception rather than the rule; and burnout research is no exception. Obviously, this conclusion could very well also apply to non-work-related antecedents of burnout.

A fourth counterargument concerns the effectiveness of work and organisation-related interventions in reducing burnout symptoms. In a recent overview, Demerouti and Adaloudis (2024) demonstrate that both enriching job design and job crafting have the potential to improve job characteristics, which in turn reduce burnout. Furthermore, organisation-focused interventions like rescheduling shifts and reducing workload, reduce burnout among physicians (De Simone et al., 2021). These findings underline the significance of work-related factors in the development and prevention of burnout.

Finally, it should be noted that studies on the antecedents of burnout tend to focus on burnout *complaints* rather than on individuals who have been *diagnosed* with burnout. For instance, Bianchi and Brisson (2019) found that less than half of the health professionals in their study who reported burnout *complaint*s attributed these to their jobs. In contrast, the majority (about 85%) of 500 Dutch employees *diagnosed* with burnout attributed their complaints to their work, though occasionally also in *combination* with problems in other domains (de Rijk et al., 2025). These findings are mirrored in the results of a recent Finnish qualitative study on burned-out individuals (Mäkikangas et al., 2024), again highlighting that work-related factors were the most prominent causes of burnout. Personality and demanding life circumstances were also found to be risk factors, but not its primary causes. Finally, Karlson et al. (2010) also provide evidence for the crucial role of work-related factors in clinical burnout. Their study found that identified burnout patients on long-term sickness absence benefitted significantly from a workplace intervention, as it resulted in a more effective return to work compared to a control group.

We conclude that there are compelling grounds to consider burnout to be work-related, as burnout appears to be systematically associated with work-related factors in empirical studies. By denying this, Bianchi and Schonfeld throw the baby out with the bathwater because work-relatedness is burnout's distinguishing feature. Other factors can also play a role in the development of burnout, but their importance has not been confirmed to the same extent and appear "secondary."

2. A "burnout epidemic"? Burnout complaints increased slightly, whereas clinical burnout is exceptional

Bianchi and Schonfeld properly criticise the popular notion that burnout is extremely widespread. A similar criticism has been made earlier by several other authors, including

ourselves (Schaufeli et al., 2023b). In our opinion, the failure to rigorously separate (mild) burnout complaints from (severe) clinical burnout contributes to this convoluted debate. Both are conflated in public discourse, giving rise to the incorrect notion of a burnout epidemic. In truth, only mild burnout complaints are common, not burnout disorder. For example, over the last few decades in the Netherlands burnout complaints have increased from roughly 10% to 17% of the working population (Schaufeli & Verolme, 2023). In contrast, clinical burnout, as defined by occupational physicians, affects less than 1% of the working population (Schaufeli & Verolme, 2023), and its prevalence does not seem to increase much. Most employees with burnout complaints continue to work or spontaneously recover, rather than develop a full-blown clinical burnout disorder. We agree with Bianchi and Schonfeld when they warn for the dangers of a "diagnosis creep," which we believe is caused by a failure to distinguish between mild complaints and clinical burnout. The former should be viewed as transient work-related unwell-being that should be prevented in the workplace, whereas the latter requires expert psychological care.

2.1. Burnout complaints as measured with a questionnaire

Bianchi and Schonfeld also criticise the use of criteria to diagnose burnout. In doing so, they again do not distinguish between burnout complaints and clinical burnout. Their criticism relates to questionnaires used to assess burnout *complaints.* They correctly criticise the use of test norms for classifying individuals as "burned-out," solely based on their questionnaire scores. However, in their criticism of questionnaires and the way these have been used, they risk throwing the baby out with the bathwater once more, as the issues raised do not justify abolishing the burnout concept altogether. We rather suggest communicating explicitly regarding the specific definition of burnout and its measurement, to use a recently developed measure of burnout that addresses the shortcomings of previous measures, and to use cut-offs rather than norms when discussing the results of questionnaires.

First, Bianchi and Schonfeld argue that different authors define burnout differently. But is this a problem? In our opinion this is not necessarily the case, and it certainly does not justify abandoning the concept of burnout entirely. Almost every concept or construct in psychology lacks consensus, even though it is employed both in science and practice. As an analogy, we believe it would be awkward to argue that a concept such as intelligence is unnecessary and should be abandoned since various scholars employ different definitions and measures. To us, the way forward is to be explicit on the definition (and measurement) used, and to limit the findings to this conceptualisation and measure. This would clarify the content of burnout in a message and would increase the comparability of the prevalence rates reported in the literature.

Next, it is true that the "gold standard" for measuring burnout has been questioned theoretically, methodologically, and practically (Schaufeli & De Witte, 2023). To address its shortcomings, authors have been developing new measures. One such measure is the *Burnout Assessment Tool* (BAT) which has stronger theoretical foundations and superior psychometric qualities to the MBI (Schaufeli & De Witte, 2023; Schaufeli et al., 2020a). The BAT also incorporates new dimensions (like cognitive and emotional impairment, alongside exhaustion and mental distance), offering an

"updated" conceptualisation of burnout. So, rather than abandoning the concept of burnout due to its operationalisation, as Bianchi and Schonfeld do, one could propose a better alternative for this gold standard.

Third, while analysing questionnaire responses, it is important to distinguish between *norms* (based on a representative sample) and *cut-off scores* (based on individuals experiencing clinical burnout). The former indicates how respondents rank (e.g. low, average, and high) compared to a reference group (preferably a representative sample of the working population). Although those who score "high" on the questionnaire on average report more severe burnout complaints than the reference group, their symptom level may not necessarily align with clinical burnout. To determine the latter, cut-off scores based on a sample of individuals identified with clinical burnout by qualified health experts (e.g. psychologist, occupational physician) should be employed. Such clinically validated cut-off scores have not been developed for most questionnaires. They are for instance absent for the MBI but were recently reported for the BAT (Schaufeli et al., 2023a).

2.2. Burnout disorder as diagnosed by an expert

A questionnaire cannot be utilised as a stand-alone diagnostic tool for clinical burnout. High cut-off scores signify that the symptom level indicates an increased *likelihood* of clinical burnout. An appropriate *diagnosis*, however, requires a clinical interview and anamnesis performed by a competent specialist. In their response, Bianchi and Schonfeld miss this issue, claiming that a questionnaire like the BAT alone may identify persons suffering from clinical burnout. No burnout questionnaire can and should live-up to this expectation. A questionnaire to measure burnout complaints is nothing more or less than a tool for specialists to employ in the assessment process, next to other diagnostic methods. A questionnaire is a good first step, but needs to be supplemented with other, more thorough diagnostic activities.

Of course, the construction of clinical cut-offs hinges on the diagnostic criteria for identifying persons with clinical burnout. In their commentary, Bianchi and Schonfeld propose some ideas for such diagnostic criteria. However, similar criteria have already been formally established and implemented in several countries, including the Netherlands (Schaufeli et al., 2020b, pp. 104–105) and Sweden (Grossi et al., 2015). To us, the issue is therefore not to develop *new* criteria, but to examine how already *existing and implemented* criteria can be applied elsewhere. Although the criteria employed in both countries are not identical, the overlap is striking, especially given that they were devised independently. Bianchi and Schonfeld are correct in arguing that these criteria differ from the burnout symptoms described by the World Health Organization (WHO), which are based on the MBI. One could, however, argue that the MBI-conceptualisation of burnout needs updating (Schaufeli et al., 2020b; Schaufeli & De Witte, 2023). Newer conceptualisations of burnout (like the BAT) incorporate additional crucial burnout symptoms that appeared relevant in the literature, and which are also specified in existing diagnostic guidelines, such as cognitive and emotional impairment. Using an instrument that incorporates these new insights will enable to close the gap between policy, measurement and practice.

2.3. Concluding on the idea of a pandemic

Taken together, we argue that mild burnout complaints (i.e. temporary work-related unwell-being) should not be mistaken for severe clinical burnout (i.e. a persistent, invalidating condition), as this would result in the erroneous impression that there is a burnout pandemic. Burnout complaints seem to have increased over time in several countries. Clinical burnout, however, does not seem to increase and is rather exceptional. Justified criticism on questionnaires and their use does not warrant the abolishment of burnout as a concept. Alternatives are available, such as the use of cut-offs to determine prevalence rates. The quest for appropriate diagnostic criteria would benefit from an examination of already existing criteria, rather than from the development of new criteria. Finally, it is important to note that the diagnosis of burnout requires more than just the administration of a questionnaire, which merely measures burnout complaints.

3. Burnout *is* different from depression

Bianchi and Schonfeld also challenge the distinction between burnout and depression, reducing burnout to a specific type of depression: occupational depression. In our opinion, they throw out the baby with the bath water for the third time. We would like to point out that their stance is inconsistent and paradoxical. On the one hand, they question the relevance of work-related factors as primary predictors of burnout (see point 1 above), while on the other hand, they propose replacing the burnout concept with "*occupational* depression," defined as "depressive symptoms that individuals *specifically attribute to their work*" (our italics). We challenge their perspective on abandoning burnout in favour of depression. We argue that there are at least five solid conceptual and empirical grounds to maintain that both constructs can, and should, be meaningfully distinguished.

First, there is a clear *conceptual* difference. According to Rose et al. (2020), the DSM-5 identifies (only) two core symptoms of depression: dysphoria (depressed mood) and anhedonia (loss of interest and pleasure in activities). All other symptoms (including exhaustion) are deemed secondary symptoms, contradicting Bianchi and Schonfeld's belief that exhaustion should be regarded "another cardinal feature of depression." Typically, depression is a mood disorder, which is associated with other (secondary) complaints, such as lack of energy. In contrast, burnout is an energy disorder, characterised by exhaustion, which is sometimes even regarded as its only core symptom (Guseva-Canu et al., 2021). Burnout is caused by energy draining activities, resulting in exhaustion. This also distinguishes burnout from depression because depression is not necessarily associated with specific events and might occur "out of the blue." Depressed mood, however, can be considered as a secondary symptom of burnout: it may be associated with the syndrome, but is not necessarily a core feature (Schaufeli et al., 2020a).

Second, this conceptual difference is corroborated by *empirical* studies. In an examination of the four dimensions of burnout as operationalised with the BAT, depressed mood is *not* more strongly associated with exhaustion than with mental distance (Schaufeli et al., 2020b, p. 45). Furthermore, the four dimensions of the BAT exhibited high intercorrelations, with exhaustion correlating more strongly with the other BAT

characteristics than with depression. In other words, the various burnout components strongly refer to the same syndrome (De Beer et al., 2020; Schaufeli et al., 2020a) and show a somewhat lower correlation with depression (Schaufeli et al., 2020a; Schaufeli et al., 2020b). Moreover, measures of burnout and depression can also be empirically differentiated in previous studies, indicating that both conceptions are legitimate and distinct. Such research allows us to investigate the complex relationship between burnout and depression. Some studies even indicate a limited link between burnout and depression. For instance, in their 8-year longitudinal study among working early career respondents, Tóth-Király et al. (2021) concluded not only that both constructs can be clearly differentiated, but also that they are only moderately correlated at each measurement point, supporting the empirical distinctiveness of burnout and depression. Another study examining the time sequence of both concepts indicated that burnout leads to depression, rather than the other way around (Hakanen & Schaufeli, 2012).

Third, Bianchi and Schonfeld state that the overlap between burnout and depression contests burnout's standing as "as standalone syndrome that is separate from depression." First, it is vital to recognise that, rather than being an exception, comorbidity appears to be the norm in the field of mental disorders. For instance, Hirschfeld (2001), observed that more than half of the patients who consulted a primary care physician during an episode of anxiety or depression, also had a concomitant second depressive or anxiety disorder. When analysing anxiety, depression and somatisation as measured with questionnaires, a similar overlap was observed among a non-patient population (Simms et al., 2011). So, it is no surprise that burnout and depression also show some overlap. However, this overlap is not that large that we are unable to empirically distinguish both (see next argument). Second, several studies offer compelling evidence for the distinctiveness of burnout and depression, while also noting that both conditions are intertwined. For example, a recent study on burnout complaints and depression among national representative samples from four European countries revealed "both a strong underlying global dimension representing participants' levels of psychological distress, as well as the presence of equally strong specific factors supporting the distinctive nature of burnout and depression. This means that, although both conditions share common ground (i.e. psychological distress), they are not redundant" (De Beer et al., 2024, p. 1). This finding was replicated in the same study in an independent sample of sick-listed employees with clinical burnout, depression, or adaptation disorder. Hence, De Beer et al. (2024) demonstrate that *despite* their overlap (and thus comorbidity), burnout and depression should be treated as separate entities. This conclusion applies to burnout complaints as measured among non-patient samples, as well as to the diagnosis of burnout disorder among patients.

Fourth, a study of employees on long-term sickness absence who were diagnosed by an occupational physician as having clinical burnout, depression, or overstrain, demonstrates the practical significance of this position (Schaufeli et al., 2022). Aside from the physician's assessment, participants independently completed questionnaires to assess burnout, anxiety, distress, depression, and somatisation. These scores were not reported to the physicians. The physician's diagnosis was significantly predicted based on the employee's questionnaire results. This demonstrates the practical utility of assessing

various psychological states with questionnaires. Furthermore, depressed employees were categorised mostly by their depression scale score, and burned-out employees were predicted primarily by their burnout scores (particularly exhaustion). The exhaustion scores were most useful for categorising burned-out employees but not those with depression, contradicting the notion that exhaustion is crucial in depression. These findings show that one can make a statistically significant distinction between burnout patients and patients with depression, contradicting the idea that burnout as disorder is nothing else than depression.

Finally, the difference between burnout and depression has also been highlighted by psychologists, physicians, and psychiatrists working with burnout patients. In other words, the distinction between both has practical value and important consequences for therapeutic interventions. Glise (2024), for instance, highlights that clinical burnout differs from depressive disorder in the quality of the symptoms, the course of illness, and the remaining symptoms. Additionally, she emphasises that clinical burnout needs a different treatment than depression, with a stronger emphasis on recovery. This contrasts with the treatment of depression, which next to antidepressants and psychotherapy requires activating therapy. Consequently, treating patients with burnout as depressed patients can aggravate their burnout symptoms, and is thus unwarranted.

Taken together, and in addition to the conceptual distinction between burnout and depression, empirical studies and evidence from clinical practice indicate that there is a significant difference between the two conditions, both in terms of dimensions (as measured by questionnaires) and disorder (as clinically evaluated).

4. Conclusion

We find that burnout is predominantly work-related and may be distinguished from other disorders, such as depression. Burnout can be measured, and prevalence rates of burnout complaints can be calculated using cut-off scores (created with burnout patients as a criterion). We believe it is critical to distinguish between burnout complaints and clinical burnout. While burnout complaints seem to be relatively common and possibly on the rise, clinical burnout is actually quite rare. Therefore, the notion of a "burnout pandemic" is clearly overstated. We have argued that by rejecting the existence of burnout and treating it as depression, Bianchi and Schonfeld are throwing away the baby with the bathwater. By criticising burnout so harshly, they not only throw out the baby, but also the bathtub. This is unfortunate since we feel that for science to advance, a nuanced debate is preferable to a simplistic rejection of a concept that has been around in academia and practice for nearly half a century. It is also problematic for practice, as this position jeopardises the prevention and treatment of burnout. Prevention of burnout requires a focus on working conditions, as highlighted earlier on. Burnout patients also require different treatments, as treating them for depression even risks worsening their condition.

Disclosure statement

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