Chapter 27
How COVID-19 Exposed an Inadequate Approach to Burnout: Moving Beyond Self-Care

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The COVID-19 pandemic has profoundly impacted the healthcare sector where a range of professionals experience an overwhelming number of acutely ill patients (Shah et al. 2020). Social work in particular represents a profession where COVID-19 has magnified the initiates and impacts of occupational stress. Social workers operate on the macro-level navigating complex systems, advocating for underserved or underrepresented clients while also providing direct clinical interventions. These occupational realities intersect with the profession’s social justice values ensuring that they will be at the vanguard of any pandemic. Moreover, social workers occupy a unique position: serving those infected with COVID-19, as well as the frontline and essential workers combating the pandemic (Vlessides 2020; Wrenn and Rice 1994). In fact, the COVID-19 pandemic exemplifies the concept of a shared trauma, a traumatic event that simultaneously affects clients’ as well as the professional’s person life (Tosone et al. 2012). A shared trauma such as COVID-19 event may hinder a professional’s ability to adequately provide care while their clients become increasingly in need of their care. Furthermore, the number of services that social workers are expected to perform both compassionately and safely during COVID-19 necessitates an acceleration of remedial approaches centered on stress and burnout reduction. Achieving this goal requires a recognition that occupationally induced stress and burnout among social workers are not confined to COVID-19. Rather, the pandemic has exposed and magnified a pervasive preexisting issue across the healthcare sector.

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Critically Understanding the Issue: Causes and Effects of Occupational Stress

Prevalence and Effects

Occupational stress among healthcare workers had already reached endemic levels before the COVID-19 pandemic (Bridgeman et al. 2018; Dyrbye et al. 2017), and its consequences, specifically burnout, are profound economically and humanistically. Numerous studies of burnout confirm its significance as a pressing and detrimental issue for the healthcare sector (Dzau et al. 2018; West et al. 2016). While the prevalence of burnout in the aggregate healthcare sector has not been fully determined, research suggests that it may be as high as 70% (Van Mol et al. 2015) and the rate of burnout specifically among social workers has been estimated to be 60% (Martin and Schinke 1998). Additionally, the degenerative psychosocial effects of burnout are multifold, including decreased empathy (Wagaman et al. 2015), increased clinical mistakes (Cimiotti et al. 2012; Shanafelt et al. 2010), work absenteeism (Gil-Monte 2008), job turnover (Jackson and Schuler 1983), depression (Shirom 2005), and depersonalization (Jaracz et al. 2005). Burnout can be disastrous for the individual employee, client well-being, organizational sustainability, and public trust in healthcare institutions.

Why Social Work Is at Particular Risk

Citing reliable figures for the prevalence of burnout in the healthcare sector is challenging due to industry norms that galvanize healthcare workers to individually reconcile burnout, thereby stigmatizing those admitting to it and seeking support. Social workers in particular face these challenges along with negative perceptions relating to the value of their work (LeCroy and Stinson 2004). When compared with physicians and nurses, the status and social capital of the social work profession is notably less (Murphy and McDonald 2004). Too frequently social work is reduced to its historical roots in charity, suggesting that the services provided by social workers are akin to unpaid caregiving labor. This cultural devaluation places social workers at an increased risk of being overlooked during a traumatic event such as COVID-19 despite the numerous essential services that they provide (LeCroy and Stinson 2004; Peterson 2012). These services include discharge planning, service administration, psychotherapy, and establishing effective interventions across each ecological system (Moore et al. 2017). Generally, in the United States, these ecological systems are highly complex and often under resourced, but under current pandemic conditions, they are in disarray.

Moreover, social workers themselves are confronting a shared stress along with their clients. They, too, must confront and address the dramatic disruptions in their personal daily routines caused by the pandemic along with the pervasive fear of
infecting themselves or a loved one. Therefore, social workers during the COVID-19 pandemic are even more likely to lack the resources necessary to bolster their own physical and psychological safety when providing clients with critical interventions.

The Status Quo: The Case for Self-Care

What Is Self-Care?

The preeminent framework for assuaging all forms of occupational stress, including burnout, is self-care. While there is no operationalized definition of self-care, it can be understood as deliberate personal or professional action to reduce stress (Lee and Miller 2013; Miller et al. 2017). Self-care has become a popular framework for individually initiated strategies or rituals to reduce stress and has incorporated evidence-based practices such as mindfulness techniques (Rudaz et al. 2017). These techniques include meditation, taking breaks during the workday to decompress and reduce exposure to occupational stressors, or taking time off from work entirely (Lee and Miller 2013). For a comprehensive guide on self-care for clinicians during the COVID-19 pandemic, see the chapter “The COVID-19 Self-Care Survival Guide: A Framework for Clinicians to Categorize and Utilize Self-Care Strategies and Practices” in this volume. Despite its popularity, self-care is not a standardized organizational intervention. Workers must subjectively identify their need for self-care and which actions would alleviate their stress. Thus, self-care can only exist as a concept that organizations can encourage among workers. Unlike other stress reduction interventions that operate at a broader organizational level, such as trainings or new management practices, self-care is limited to popular de-stressing procedures chosen by individual workers.

Why Self-Care Became the Predominate Approach

The Benefits of Self-Care

Self-care does provide some noteworthy benefits for improving employee wellness, especially for social workers who have advanced training related to building resiliency and self-sufficiency. This chapter is not meant to contend that there are no benefits to self-care,1 rather that it fails as a primary method for burnout reduction.

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1 For a review of approaches and benefits of self-care, applied specifically for clinicians practicing during the COVID-19 pandemic, see the chapter “The COVID-19 Self-Care Survival Guide: A Framework for Clinicians to Categorize and Utilize Self-Care Strategies and Practices.”
One reason why self-care has become so prevalent and palatable for social workers relates to therapeutic practices utilized with clients. Self-care involves tackling issues with individualized strategies to achieve self-sufficient goals. Social workers are taught that when individuals are able to cope with often uncontrollable proximal and distal stressors, they build resilience (Polizzi et al. 2020). Since these assumptions are valued when applied to clients, it is reasonable to assume that similar practices will promote resilience among practitioners.

Further, self-care is an aspect of social work education (Bressi and Vaden 2017). Nationally, there has been a promotion to incorporate self-care into social work education from CSWE and NASW (Bressi and Vaden 2017), and social work practice courses typically integrate it into their curriculum. Consequently, it is common to find self-care awareness campaigns and practice guides in both educational and professional settings (Bressi and Vaden 2017). Self-care is currently the predominant method for occupational stress prevention and burnout reduction in the social work profession despite the existence of other effective methods (Restauri and Sheridan 2020).

The Critique of Self-Care

Self-Care and Neoliberalism

An alternative explanation for self-care’s popularity is its connection to neoliberal values. First, the rudimentary elements of self-care practices must be identified and enacted autonomously. It is the responsibility of the worker to identify approachable stressful elements of their work. Next, the worker must individually identify a self-care action to remedy their stress. This may paradoxically contribute to burnout among social workers if they invest substantial effort and belief that their self-care practices will eliminate occupationally induced stress. Unlike sociopolitical examples of auto-emancipation, individual workers cannot inoculate themselves with self-care practices to become resistant to occupational stress because the causal structures and dynamics of that stress are unaffected. Even the most thoughtful and practiced self-care strategies cannot neutralize organizationally rooted stressors. This gap between the outcomes and expectations of self-care may explain part of the increasing pervasiveness of burnout.

The theoretical foundations of self-care are based in neoliberal values, such as those espoused by the Chicago School of Economics, which views individuals as solely responsible for their socioeconomic status (Harvey 2007). Self-care’s demand that workers identify the sources and solutions of their stress is akin to neoliberal economic concepts such as “rational self-interest.” Self-care assumes that each individual worker has an equal capability to effectually improve their workplace conditions. Such claims discount the socioeconomic, sociopolitical, and organizational forces that exist in the workplace. In fact, the foundational principles of self-care
support several tenants of American capitalism: a hyper-individualist view of work, ignoring systemic and structural oppression, and a rejection of collective values and actions to improve occupational conditions. Therefore, self-care can be characterized as a laissez faire approach to occupational stress reduction and worker well-being.

The political economy of self-care reveals why it is the most cost-effective method that an organization can endorse because it forces the worker to take on both the identification and cure for their stress. The organization is not required to invest any resources. By embracing self-care, organizations can frame their inaction as a seemingly pragmatic and individualized stress reduction effort. The organization can claim that they are supportive of workers engaging in self-care practices, falsely asserting themselves as partnering with workers in stress reduction and thereby absolving its role in producing the conditions for burnout. In doing so, self-care supports the profit motive more than it serves as a stress reduction strategy to meaningfully address occupational stress and burnout.

How COVID-19 Revealed the Failure of Self-Care

During the COVID-19 pandemic, constant pleas have been made for additional medical personnel, financial support, and equipment. While the number of people being hospitalized and dying from COVID-19 remains staggering, workers across the healthcare sector are deeply distressed by the lack of resources being provided to support their ability to function professionally. Within public hospitals these issues were more prevalent causing a greater risk of exposure and anxiety among healthcare workers (Van Dorn et al. 2020). Clearly, occupational stress during the pandemic continues to be a result of organizational resource deficiencies.

Therefore, the COVID-19 pandemic accentuates the flaws of self-care as the prevalent approach to occupational stress management. Even if a social worker maintained a strong self-care routine, such as taking time off from work when needed, practicing relaxation techniques, and taking full lunch breaks, the pandemic, as an exemplar of a shared trauma, has permeated the social spaces where those practices occur and replaced them with danger and uncertainty. For social workers who are frequently exposed to COVID-19, one of the most stressful situations relates to infecting loved ones, co-workers, or themselves. This type of concurrent professional and personal stress, synonymous with shared traumatic events, can have severe psychosocial and professional implications for the social worker and their clients (Tosone et al. 2011). Thus, a core element of any successful self-care strategy, access to a safe environment removed from the workplace, is compromised. Although social workers frequently have high caseloads and hectic work environments, the COVID-19 pandemic is so socially transformative infiltrating both their professional and personal lives, that many self-care practices are inoperable. Rather, the COVID-19 pandemic has emphasized the importance of organizations investing in structural resources and methods to support their workforce.
How to Progress: Future Directions to Support Our Workers

**Shifting the Focus to Organizational Approaches**

Organizations are large enough to have distinct cultural norms and are more agile than macrosystems. Therefore, organizations should be the primary arena for designing and implementing strategies to reduce burnout and its precipitators. Organizations are both key drivers of occupational stress and burnout and yet are pragmatic environments for creating robust change. There is a precedent for investing such support in organizational action, especially in relation to workforce issues that increase turnover and absenteeism (Morse et al. 2012). If an organization adopts more egalitarian and inclusive decision-making policies or improves management practices to recognize the meaning and value of their employees’ work, structural resistance to precipitators of stress and burnout can be established for all employees. Organizational interventions can provide both preventative actions that build resilience to occupational stressors and the development of burnout, as well as methods to reduce stress in work environments where burnout is already endemic (Awa et al. 2010).

**Refining Our Interventions**

The current array of interventions to prevent and mitigate occupational stress and burnout lacks both specificity and scope. While there is a growing array of interventions, they tend to be implemented on an individualized basis (Awa et al. 2010; Morse et al. 2012), such as self-care, and are mostly tested on a single occupation (Awa et al. 2010). Yet, in nearly every healthcare organization, there is a variety of professions taking part in a client’s care. For example, in emergency rooms treating those with COVID-19, doctors, nurses, social workers, nurse aides, and administrative support staff are constantly collaborating to treat incoming patients. Similarly, in a mental health clinic, treating healthcare workers traumatized from the chaos of the pandemic, a clinical social worker may work with a psychiatrist, peer specialist, and administrative specialist. With the exception of individually administered private practices, healthcare professionals work together.

Therefore, interventions should be tested in a way that we can observe which methods work well for each individual profession within a particular healthcare setting. This means fitting interventions to specific occupational environments such as emergency rooms. Since the intensity and distinctiveness of an occupation are derived largely from the work environment, it is beneficial to observe which interventions are most effective for staff working in a common setting. If future research examines interventions among all of the professionals in a given environment, then we can determine which practices are potentially effective across several professions, while identifying potential patterns of successful intervention types for
specific occupational settings. If mindfulness practices tend to benefit emergency room nurses, but not emergency room social workers or physicians, then instituting a broad mindfulness intervention for the entire emergency room staff would not be effective. However, if we only focus on nurses, we may falsely conclude that mindfulness interventions will mitigate burnout among emergency room staff.

Additionally, existing intervention types are still too broad to accurately address the source of burnout within an organization. Currently, interventions not individually implemented, are considered organizational interventions (Restauri and Sheridan 2020). This is an erroneous assumption. Those categorized as “organizational” interventions may be implemented within distinct areas of an organization, in a specific department, or even in subgroups within departments. For example, a training on burnout awareness in hospital settings may be administered specifically to a social work department or just to the social work supervisors of that department. The effectiveness of such a training would depend on identifying the source of the burnout and applying an intervention to that source. If the supervisors are largely contributing to the burnout of the social work staff, providing a training for them would be most effective. If the training were provided too broadly, then it may be a waste of time and resources, which could increase stress and diminish confidence in the intervention’s effectiveness. If it were too specifically applied, it could fail to address the entirety of causal factors.

Thus, it is beneficial to develop interventions and organizational procedures attuned to the situations causing burnout. Different interventions are needed if a unit of social workers were experiencing burnout due to abusive supervision practices as opposed to a shared traumatic event such as the COVID-19 pandemic. After the September 11th attacks, there was a palpable need among mental health clinicians for increased clinical supervision, peer supervision, and outlets for workers to express and process their emotions and experiences after such a unique and traumatic event (Bauwens and Tosone 2010; Tosone et al. 2012). Future studies should utilize implementation research to characterize an intervention’s area of effect within an organization and to improve their specificity.

**Engaging Stakeholders**

**The Role of the Academy**

Universities where social workers are being trained for an increasingly diverse array of occupations must instill education and advocacy about organizationally rooted burnout reduction measures. Just as social workers are not taught to use uniformed treatments for their clients, they should not be taught that self-care is their only resource for stress and burnout reduction. Rather, it should be one of the several resources to ensure their ability to resist stressors integral to the social work profession, such as an Employee Assistance Program, a supportive organizational culture, and access to trainings that build recognition of and resilience to occupational stress.
and burnout (Lee et al. 2019; Rollins et al. 2016; Vifladt et al. 2016). Educational institutions have an obligation to ensure that students are aware of existing resources and how they can be utilized and taught to advocate for additional resources if needed.

**Professional Advocacy**

Once social workers enter the field, there are governing bodies that could propagate burnout awareness and burnout reduction interventions and enforce their standardization. Where unions exist, such as in major hospitals or large nonprofits, they can promote organizational resources to address burnout as a part of collective bargaining agreements. Because unions can exist across several organizations, their partnership in reducing burnout has the ability to impact industry norms, even influencing nonunionized organizations to introduce similar resources in order to remain competitive. For many health professionals, including social workers, licensing boards could provide a venue for increased awareness of burnout reduction interventions. Since these boards are responsible for continuing education requirements, they could mandate education related to burnout awareness and reduction. These boards also extend beyond individual organizations and can affect a profession’s educational standards.

**Conclusion**

The COVID-19 pandemic has brought extraordinary strain to the healthcare system and represents a global example of shared trauma. Social workers face many of the stressors that other healthcare professionals experience along with some distinctive sources such as social work’s systemic focus and social justice values. Further, the COVID-19 pandemic has underscored the structural insufficiencies of the current healthcare system including self-care, the preeminent method to reduce occupational stress, and its foundation in neoliberal values. Yet, the pandemic also provides insight into how we can develop and promote more progressive and structural methods to improve the well-being of social workers and the entire healthcare workforce. Perhaps a silver lining of this generational disaster will be the impetus to address burnout with the comprehensive, nuanced, and effective interventions that healthcare workers deserve.
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