The training to become a social worker is arduous, demanding, and complex. My concentration was clinical social work, which during my graduate education was known as casework. I well remember studying my basic curriculum; taking more electives than were required; receiving excellent supervision of my clinical work with individuals, couples, families, and groups; and before it was required, taking many continuing education classes.

Suffice it to say, I learned a great deal— but what it seemed that no one shared with me during these years, or seemed to discuss among themselves as either teachers or therapists, was the sheer exhaustion experienced in clinical work as we do our very best to meet the needs of others day after day, year after year. When one of my deeply trusted supervisors died, and I met his wife for the first time, she told me that sometimes he would return home too exhausted to even speak, and that a frequent statement she heard from a man who obviously treasured his clinical work, teaching, and writing was: “They feel better, but I surely do not.” How well I understood this feeling, I thought. How well so many in our field must understand this feeling. And yet many of us lack the attendant knowledge that can assess and direct this feeling, which is called “burnout” in the literature—or knowledge of the necessary practices to heal and soothe ourselves, which are collectively known as “self-care.” What I have learned over the years is the necessity of addressing this complicated exhaustion before the feeling of depletion leads to dysfunction and beyond. With this in mind, I...
share the precise information that I wish I had known about “burnout” and “self care” in the early years of my work, with references for your further study.

The Problem of Burnout

As a term was first applied by Freudenberger (1975) to describe what happens when a practitioner becomes increasingly inept and unresponsive, according to Freudenberger, this progressive state of inoperability can take many different forms, from simple rigidity, in which the person becomes “closed” to any input, to an increased resignation, irritability, and quickness to anger. As burnout worsens, however, its effects turn more serious. An individual may become paranoid or self-medicate with legal or illegal substances. Eventually, a social worker afflicted with burnout may leave a promising career that he or she has worked very hard to attain or be removed from a position by a forced resignation or firing.

In the intervening 37 years, burnout has been the focus of several studies, each of which has affirmed the phenomenon (van der Vennet, 2002). We may instinctively realize that therapeutic work is “grueling and demanding” with “moderate depression, mild anxiety, emotional exhaustion, and disrupted relationships” as some of its frequent, yet common, effects (Norcross, 2000). We may even have gotten used to some of the factors promoting burnout such as inadequate supervision and mentorship, glamorized expectations...and acute performance anxiety (Skovholt, Grier, & Hanson, 2001). Yet, as social workers, we may still not pay full attention to the reality of burnout until suddenly everything seems overwhelming. At such times, we may lack the knowledge of what is transpiring or the critical faculties to assess our experience objectively that would enable us to take proper measures to restore balance to our lives.

To explore and understand the phenomenon of burnout before it is too late, researchers have found it useful to introduce several components of the term or attendant syndromes, specifically compassion fatigue, vicarious trauma, and secondary traumatic stress. Although there is a great deal of overlap among these terms, each of them poses a particular risk and originates from a different place in the practitioner’s experience or psychology.

Compassion Fatigue

Compassion fatigue is perhaps the most general term of the three and describes “the overall experience of emotional and physical fatigue that social service professionals experience due to chronic use of empathy when treating patients who are suffering in some way” (Newell & MacNeil, 2010). There is evidence that compassion fatigue increases when a social worker sees that a client is not “getting better” (Corcoran, 1987). Yet, a large part of compassion fatigue is built directly into the fabric of the kind of work we do. Although we may strive for a relationship with our clients that is collaborative, our goal is not a relationship that is reciprocal. In many important ways, reciprocity is unethical, even illegal. Although recognizing this fact can lead to an important setting of boundaries, including financial boundaries (charging clients, collecting co-pays), or deciding how missed appointments are handled, compassion fatigue may reflect a deeper “inability to say no,” one of the hazards that “can exacerbate the difficult nature of the work” (Skovholt, Grier, & Hanson, 2001).

In our work, although we are surrounded by people all day long, there is not a balanced give and take. Concentration is on clients, not ourselves. In the truest sense, we are alone—were the givers, and our fulfillment comes from seeing the growth, hope, and new direction in those with whom we are privileged to work. The fulfillment of our professional commitment demands that we ever do our best and give as much as possible in the ethical ways that are the underpinnings of the social work profession. With this awareness, common sense predicts that burnout is a potential threat waiting for us in the wings. However, as we all know, common sense and clear thinking can be eroded when our own unfinished emotional business propels us. Although there are many therapists who describe fulfilling childhoods that are secure and stable, research indicates that the majority who come into our field have known profound pain and loss during their formative years (Elliott & Guy, 1993). Most have experienced one or a combination of five patterns of emotional abuse, which has led to the relentless need to give to others what we wish we had received, coupled by an inability to care for oneself and set limits in order to counteract exhaustion (Smullens, 2010). Social workers, therefore, are especially prone to compassion fatigue, not only because of the nature of our work, but often because our own natures have inspired us to enter this precise field.
Sign Up for Our Free Publications

Email
First Name

Select your interests:
- Social Work E-
- News
- The New Social Worker
- Magazine
- Special Announcements

Submit

Great gift book for social work graduates!

Beginnings, Middles, & Ends:...
By Ogden W. Rogers (Paperback - Jun 9, 2013)

Rated 5 out of 5

Current Issue in Print
SaraKay Smullens’ book, Burnout and Self-Care in Social Work, which grew out of this article, is now available, as of July 2015. The book’s foreword is by Linda May Grobman, publisher/editor of The New Social Worker. Read an interview with SaraKay.

It is essential to remember that when our clients bring these very same issues to us that we have not faced, burnout and the depression that accompanies it can and will set in, leading to emotional exhaustion, depersonalization, and a decreased sense of personal accomplishments. Through the agencies of compassion fatigue and vicarious trauma, burnout systematically decreases our ability to relate to our clients, which strikes at the heart of our self-identification as a healer or positive force in society.