

CHAPTER 1

Burnout: Backdrop, Definition, and the Four Attendant Syndromes

It is essential that burnout warning signs are clearly marked and communicated before lives are destroyed! Wherever burnout originates—personally, professionally, relationally, physically, or societally (or a combination)—it impacts interactively, bringing grave danger. When overwhelmed, overloaded, and overburdened by external pressures, when anxiety and exhaustion seem everywhere, the destruction of self-confidence, self-respect, and an inability to connect with others are in the wings.

(Journal entry, December 23, 2019)

I was startled when I read the following words from one of our questionnaire respondents: “I feel like there should be a healthy fear of entering the social work field” (respondent 60). To me, these words underscore the necessity of preparing for what we will find in our chosen field. I would not choose the word “fear,” but I am convinced that all social workers, from the time we are students, must have a healthy awareness of what it means to choose our profession, how it will affect us, and how to prepare for these realities. This means that a full knowledge of burnout, including its impact and consequences, is essential. A focus on the developmental issues that strengthen and protect us, and thus allow us to withstand external pressures, is also essential.

With this necessity in mind, later in this chapter, following a general framing, I will address the four attendant syndromes: compassion fatigue, vicarious (secondary trauma), countertransference, and moral distress. After

Careful examination of extensive literature, where understandably one finds differences (and overlap) in definitions and explanations, I have selected these syndromes to provide differentiation, clarity, and warnings of impending burnout overload. In this way, the four syndromes can be easily identified by social work practitioners, those in related professions, and others seeking an overall understanding of the dangers of burnout. Once these syndromes are recognized, we can begin the journey toward compassion satisfaction (chapter 3) and use the self-care attitudes, behaviors, and strategies (chapters 4, 5, and 6) that will break their hold, and in doing so, prevent and alleviate burnout.

How We Got Here

In his groundbreaking book, *Future Shock*, published in 1970, Alvin Toffler predicted the impact of a breathlessly fast-paced society that awaited us all. Toffler coined the phrase “information overload” and foresaw the impact of the coming technological revolution on human relationships, predicting that without preparation it would result in increased crime, rising drug use, and threats to the nuclear family and the communities that sustain us. Further, he warned that the illiterate of the future would not be those who could not read or write, but those who could not adjust economically and emotionally to vast and constant change. It was during this same decade that Sidney Garfield, MD, co-founder of the health maintenance organization Kaiser Permanente, coined the phrase “the worried well” in a *Scientific American* article describing people who are healthy but are worried about becoming ill, and as a result visit doctors and request unnecessary medication.

As was noted in the Introduction, psychologist Herbert Freudenberger coined the term “burnout” in 1974. In 1976, psychologist Christina Maslach published a seminal paper discussing the causes and manifestations of burnout (Maslach, 1976). An exploration conducted over the course of several years of the complexities of burnout resulted in her 1981 publication (Maslach & Jackson), in which *burnout* was succinctly defined by three chief components: (1) emotional exhaustion (inability to feel compassion for clients), (2) depersonalization (detachment from the emotional needs of their client), and (3) lack of a feeling of personal accomplishment.

Common symptoms of burnout offered by Norcross (2000), due to our “grueling and demanding” therapeutic work are “moderate depression, mild anxiety, emotional exhaustion and disrupted relationships” (p. 710), which can be brought on by “inadequate supervision and mentorship, glamorized expectations . . . and acute performance anxiety” (Skovholt, Grier, & Hanson, 2001, p. 170). Regardless of setting, mental health practitioners can become emotionally and intellectually inflexible and, as burnout progresses, experience long bouts of irritability and hopelessness, leading to feelings of ineffectiveness and worthlessness. More serious cases can lead to paranoia, self-medication with legal or illegal substances, or even the end of a promising career.

To complicate matters, the nonreciprocal nature of the practitioner–client relationship may lead practitioners to neglect their own needs until suddenly all aspects of their lives seem overwhelming (Skovholt et al., 2001). In short, if we do not recognize the early stages of burnout or treat its development with due respect for its potential severity, the consequences may be catastrophic.

As will become clear, although initial research concentrated on work-related burnout, further studies have revealed that burnout is a complex phenomenon that can manifest personally, professionally, relationally, societally, and physically (or in combination), and that a manifestation of burnout in one arena may interact and intensify in the other arenas. We may experience conflict at home, emotional abuse at work, or heightened periods of extreme societal pressure. In addition to these considerations, all of us will have issues from our past that may echo in our work with clients.

Burnout was first identified in the mental health professions on the basis of the complex relationship between caregiver and client (Oser, Biebel, Pullen, & Harp, 2013). Assuredly, burnout can and does occur in professions other than social work, and regardless of profession, can also be caused by overload in personal relationships. Several months ago, a good friend who had planned an evening at the theater with my family months before did not arrive as scheduled. When we finally got in touch with her, we learned that our plans had completely slipped her mind due to what she described as “exhaustion and depletion” after spending the day with her father, who had been deeply unhappy at his care facility and begged her to take him home to live with her and her family.

In the almost 50 years since Freudenberger (1974) coined the term, qualitative and quantitative research on burnout have expanded dramatically. We know that the impact of social work turnover is highly unsettling, not only for those who leave our profession, but for all concerned. This decision affects staff sense of well-being, quality of services, client faith in our organizations, and organizations’ financial stability (Kim & Stoner, 2008). Yet, as we examine this research more closely in the coming sections, we will find that further clarification is needed. Many of Freudenberger’s questions remain unanswered or are answered only provisionally, including: What are the best ways to recognize the presence of burnout? Can it be avoided? If so, how? What are the most effective ways to create and maintain staff fulfillment? Are certain types of people more prone to suffer burnout than others? Are we willing to realize the potential dangers of burnout to our clients, our loved ones, and ourselves?

Burnout versus Depression

Depression caused by loss, rejection, betrayal, connivance can be experienced as a fierce body punch. One may feel blindsided and bewildered, as if slats in the floor of an emotional home have disappeared. With burnout the body speaks to us differently: “My

shoulders, my arms, my being can no longer carry what is asked and expected. My brain feels fried."

(Journal entry, June 2021)

It is important at this juncture to make a distinction between burnout and depression. Much has been written about the differences between the two, and the debate as to whether the two can be separated has intensified since the publication of this book's first edition. In the related field of psychiatry, Bianchi, Schonfeld, and Laurent (2017) state: "First, there is now robust evidence that burnout is a depressive condition" (p. 1397). Others do not agree. In response to this article, Epstein and Privitera (2017) write: "Recognition of major depression is important. We do not agree, however, that there is robust evidence that burnout is merely depression" (p. 1398). This discussion continues: "Whether there is an association between burnout and MDD [major depressive disorder] is currently an unresolved, active debate with compelling arguments on both sides" (Oquendo, Bernstein, & Mayer, 2019, p. 1111).

My examination of the literature, coupled with over 30 years of clinical experience, leads me to side with those who see burnout as a condition separate from depression, one requiring different understanding and remediation. Although there can be overlap between the two, which should not be overlooked, depression initiates as an internal, debilitating force, while burnout is heavily influenced by external factors. My experience further indicates that many who believe they are depressed may instead be experiencing burnout. As you will read in the next chapter, the World Health Organization (WHO) agrees with this differentiation, describing burnout not as a psychiatric illness, but rather as a syndrome defined as a combination of emotional exhaustion, depersonalization, and reduced personal accomplishment caused by chronic occupational stress (WHO, 2019).

In the field of social work, manifestations of depression occur with regularity—often as an understandable internal reaction to traumatic life events. We and our clients may experience such events as a forceful blow to our emotional equilibrium, and our shock may be accompanied by physical symptoms, such as shortness of breath or an inability to control tears. This loss of emotional equilibrium can be triggered by events such as the death of a loved one, or the diagnosis of a dangerous illness in ourselves or a loved one. It may also be seen if we are abandoned by someone we love, if a trusted friend betrays us, if we experience connivance in a professional relationship, or if we lose our livelihood. Each of these life events elicits fear and anxiety, compounded by anger, shock, and sadness.

Depression may also result from unrecognized, yet deeply engrained anger, as well as frustration with one's life direction. As a treatment for depression, talk therapy with a therapist one trusts and experiences connection (augmented with medication, if needed) can lead to new coping patterns, insights, awareness, and direction, as well as renewed strength and calm. However,

when one does not begin to regain equilibrium through new strategies, the reason for depression cannot be determined and worked through, what is described by clients as “a black descending cloud” or “relentless hopelessness” is experienced, or a diagnosis of bipolar disorder or psychosis is confirmed, the definition of depression changes from emotional turmoil anchored in real-life events to a psychiatric illness.

Stress, anxiety, overwhelming helplessness, anger (both internalized and expressed), and physical symptoms can be associated with both burnout and depression as we attempt to adapt to burdensome experiences. And yes, as said, burnout and depression can coexist. One example is my client, whose husband died of COVID-19 at age 37, leaving her responsible for the emotional and financial well-being of three young children. Another client, age 42, whose parents had completely dominated her life, told me at our first appointment, “I have no idea where my parents end and I begin. I have no idea *who I am*.” Initially overwhelmed and overburdened by constant parental demands (none of an urgent nature) and intrusions into her life, my client has learned to say, “No!”

A poignant example of the combination of burnout and depression involves caring for a cherished friend, partner, or parent who suffers from a serious, progressive disease or the natural evolution of aging. Again and again, in these instances, coupled with exhaustion, I see and hear mourning in body and voice, as the person they knew and loved slips away. Another example of the combination involves caring for a child who is severely ill and will not recover. In these tragic instances, parents entering therapy tell me that their dreams have been destroyed, only to be replaced by anguish and the death of hope and optimism.

In my experience, the self-care strategies in this book, if wisely adopted and firmly integrated into one’s life, are effective in easing the sorrow and suffering involved in both burnout and depression for the general population. However, due to the specific nature and demands of our work, focus and discussion will revolve around the concept of burnout encountered by social workers and mental health professionals, with special emphasis on preparedness and proactive approaches. This said, *I hope to speak in a way that allows other readers to be able to adopt information and insights into their individual lives, circumstances, and professions.*

The challenge is to identify burnout symptoms early, before they become destructive. Although burnout has become more frequently discussed in the literature, in college classrooms, and in professional settings, its sources and interactions and their potential damage are rarely confronted to the degree that is truly warranted. Those who do not take proper measures to protect themselves remain dangerously unprepared, not only for the rigors of social work and related professions, but also for the rigors of life.

The Four Attendant Syndromes

Because burnout has proven to be such a dangerous and complex phenomenon, researchers have found it useful to explore causation through their faces,

markers, or signals—the various related aspects that could be thought of as attendant syndromes: *compassion fatigue* (Figley, 1995); *countertransference* (Pearlman & Saakvitne, 1995); *vicarious traumatization* (Pearlman & Mac Ian, 1995), commonly known as *vicarious trauma* (as well as the closely related *secondary trauma*) (Figley, 1995; Stamm, 1995); and *moral distress and injury* (Jameton, 1984; Litz et al., 2009; Reamer, 2014).

As you read, keep in mind that faces of burnout overlap; rigid separations in real-life experiences are nonexistent. Despite this overlap, however, each of the four attendant syndromes presents a valuable lens through which to view the development and experience of burnout. For the remaining part of this chapter, I will concentrate on each attendant syndrome and offer illustrative case studies. I will conclude, as I will in future chapters, with opportunities for reflection. *The descriptions you read may feel overwhelming, but I assure you, chapter 3 and the concluding half of our book devoted to self-care—both promises and gifts to your Self—will direct you in addressing and preventing each attendant syndrome.*

Compassion Fatigue

Compassion fatigue is the broadest of the four attendant syndromes through which to view burnout in our professional lives. Further, compassion fatigue is always also a factor in the other three syndromes. This attendant syndrome highlights the emotional and physical fatigue that social workers and those in related professions may experience due to “the chronic use of empathy when treating patients who are suffering in some way” (Newell & MacNeil, 2010, p. 61). Helping or wanting to help a traumatized or suffering person can result in compassion fatigue (Figley, 1995), especially when we do not receive relief from the burden and the responsibility that such efforts place on us (Fox, 2003). There is evidence that compassion fatigue increases when a social worker sees that a client’s situation is not improving (Corcoran, 1987). On a societal level, compassion fatigue and the other arenas of burnout are negatively affected by unaddressed societal problems and relentless suffering. This awareness is heightened by constant exposure to violence and discord as a backdrop to our lives, where no safe havens seem to exist, all played out endlessly on social media (Smullens, 2020a, 2020b).

You may notice in this chapter that compassion and empathy are used somewhat interchangeably. In chapter 3, when transforming compassion fatigue into “compassion satisfaction” is discussed, differences between them will be addressed, as will the importance of their union for both our most effective work and our protection from compassion fatigue. It will become clear that the road to compassion satisfaction is accomplished by an appreciation of the value of empathy over the related concepts of sympathy or pity. As Dane (2002) explains, a lack of empathy poses a profound danger that can

result in client retraumatization. One of our respondents noted a preference for the term “rust out” to illustrate physical and emotional fatigue, likening this state to

an old car that wasn't maintained; they're thin in the metal . . . they give their all in service to others and . . . become worn out, through a combination of long-term service and exposure. . . . They . . . provide good helpful service, but they're tired and need help with self-care.
(*respondent 34*)

My colleague Michelle, a social worker in family court, exhibited this rusted-out quality of burnout. Michelle and I met when I was in court as an expert witness for several days. Over coffee one afternoon, she confided that at the end of her workday, regardless of how she tried, she could not escape the pained voices and visions confronting her daily: “The screaming adults and tears of those hurting and frightened, especially the children, are the most unbearable.” Though her sister, whom Michelle lived with, on occasion wanted to go out during the week, and always on the weekends, Michelle felt too exhausted for the companionship she had enjoyed in previous years, both with her sister or anyone else. Michelle described the constant upheavals in her clients' lives as “a totally exhausting emotional assault on my senses that feels almost physical.” To calm herself, Michelle turned to several glasses of wine and mindless TV each night. In fact, once she was finally home, her cat was the only living being she could bear contact with. When Michelle was finally able to sleep, she was awakened with regularity by nightmares relating to “the horrors I witness hour by hour, day in and day out.”

This constant turmoil is not what Michelle was seeking or expecting when she chose social work as her profession. She wanted to help bring what she describes as “light and hope” into her clients' lives. Instead, as time passed and she could not leave the impact of her experiences at work, she increasingly found herself keeping her clients at arm's length, unwilling or unable to engage fully with her new assignees. Her sense of depletion heightened, turning into a callousness, verging on bitterness, that shocked her.

Many types of work can become a grind, but social workers experience a specific form of hopelessness brought on by compassion fatigue. We are the givers, and our fulfillment comes from seeing the growth, hope, and new directions in those we are privileged to work with. Our professional commitment demands that we do our best and give as much as possible within the ethical guidelines of our profession, often with totally inadequate resources, both for our clients and ourselves. Far too often, even when we leave our professional settings, we take the visions and voices of our clients home with us. Without distinction between our work and our personal lives, we are unable to find the necessary relaxation, enjoyment, and balance to sustain and

energize us. As those around us enjoy life, we can easily retreat into ourselves or lash out, not knowing why. As in Coleridge's "Ancient Mariner," yes, there is "water, water everywhere"; yet, devoid of energy, we cannot find a single "drop to drink" (Coleridge, 1965).

In this state, clear thinking is easily and predictably eroded. To once again quote from our respondents:

"I should have chosen a different profession."

"Why am I still here?"

"What is my purpose?"

"Why bother?"

"What difference are we really making?"

"What is the point if no one cares?"

"I am not contributing in a meaningful way."

"I don't even want to go to work."

"I cannot make it through this day."

Countertransference

Not only does a social worker's daily milieu provide the occasion for experiencing burnout, but many social workers are themselves inherently more vulnerable to its impact because of the second attendant syndrome of burnout: countertransference. *Countertransference* was originally defined by Freud (1958) as the result of the patient's influence on the practitioner's (positive or negative) unconscious feelings about significant persons during the patient's formative years or in the present.

Countertransference occurs naturally and only becomes a problem when boundaries are lost, when we do not recognize that we are relating to our client as representing someone from our past (or present). This concept was later expanded by Winnicott (1949) and Kernberg (1965) to include the broader experience of a therapist's conscious and appropriate reaction to a client. In other words, some of our clients are a true privilege to spend time with, whereas others are anything but. To avoid burnout, it is important to face how we feel about each client, and helpful to recognize what a client touches in us about our past and present. In this process, one does not have to be pure in thought or deed; a sense of humor can be helpful. In other words, it is perfectly acceptable to wish we could throw a glass (or pitcher!) of water, but of course not a great idea to do so. On a societal level, countertransference involves a broader experience, either a positive one, due to functional and compassionate leadership, or a negative one, when we are impacted by ruthless people in powerful positions (Smullens, 2020a).

Childhood experiences can make us exceedingly vulnerable to boundary loss. Although there are many in the helping professions who describe secure and stable childhoods, research indicates that the majority who come into our field have known profound pain and loss during their formative years (Elliott & Guy, 1993). Elliott and Guy (1993) found, for example, that women working in mental health professions were more frequently traumatized as children by physical abuse, alcoholism, emotional and sexual abuse, and familial conflict than were women working in other fields. In addition, therapists appeared to have come from more chaotic families of origin, with significantly fewer experiences of familial cohesion, moral emphasis, and achievement orientation. In a study comparing psychotherapists and physicists, psychotherapists were significantly more likely to perceive themselves as assuming a future caretaking role than were physicists (Fussell & Bonney, 1990). The same study showed that psychotherapists experienced significantly more parent-child role inversion (*parentification*) than did the physicists. It is understandable that a codependent parenting role can easily spill over into boundary violations with clients: The engrained behavior pattern, enhanced by a strong desire to give others what we ourselves have longed for, can easily lead to a lack of distinction between our lives and the lives of our clients, a lapse that leads to emotional overload and an open invitation to burnout.

Because “unfinished emotional business” (Sarf, 1995) can and does affect all aspects of personal and professional lives, we (and all professionals) can protect ourselves by reflecting on our formative experiences and truths about our present realities. Do we have issues with members of our family of origin that are unresolved and place a drain on present relationships, keeping us from seeing clearly? Do we long to establish closeness with a family member who has continuously made it clear that this is not a mutual desire? Without realizing it, are we hoping that friends and acquaintances will take the place of loved ones who, for various reasons, are no longer in our lives? Are there present issues regarding a romantic partner or sexual orientation? Are we struggling to find the intimacy we crave, yet which eludes us? The list, in myriad forms, goes on and on.

It is imperative to be continually aware that we strive for relationships with our clients that are based on mutual respect, relationships that, while collaborative, retain essential boundaries. Achieving this balance and differentiation requires not only concern for our clients, but also an appropriate degree of distance or detachment, by which the client is always seen as an individual separate from us, and our objectivity is protected for the good of the therapeutic relationship.

Our goal with a client is never reciprocal. Violating the boundaries of a therapeutic alliance does far more than jeopardize the client-social worker relationship. Mistaking a successful therapeutic bond with a client for something more than a professional relationship can lead to both destruction of an

ongoing therapeutic relationship and grave injury to the client. Further, slipping beyond appropriate recognition of our role can lead to unethical actions, such as entering into a close personal friendship or sexual relationship with a client. Examples of more subtle professional boundary challenges include how we respond to missed appointments, how we maintain appropriate financial relationships, and how we conduct ourselves when we unexpectedly meet a client in our day-to-day lives outside of our offices.

Countertransference issues may also reflect an inability to say no, which increases the likelihood of succumbing to inappropriate professional relationships and is one of the hazards of the profession that can complicate already-difficult work (Skovholt et al., 2001). A mental health professional may be burned out and lonely, yet be totally unaware of this debilitating, vulnerable state. Without realizing it, one may choose a profession as a way to escape a painful inner turmoil. In other words, by entering into one of the helping professions, one may be asking for one's own personal help.

If this is true of you, do not let it frighten you. Many who select social work and other mental health professions enter the field in this position. Further, it is a healthy and effective coping strategy that children who face trauma in their homes (almost always with no words to describe or understand their pain and panic) learn to protect themselves. In other words, dealing with one's own fears by helping others is a highly effective defense mechanism. If this describes you, facing it will be a positive and helpful first step.

Of course, many people in completely different fields unknowingly select a profession in an attempt to escape inner turmoil. However, their professional training does not necessitate that they become aware of it. Mental health professions necessitate continual thought regarding what clients touch in us: To confuse a client's world with our own opens the door to burnout. The paradox, of course, is that we may have chosen social work because we sincerely want to help others, while at the same time avoid past pain or current difficulties in our own lives. Yet without reflection and self-awareness, we may harm both our clients and ourselves.

When difficulties presented by our clients touch on our own unresolved conflicts, a combination of skilled supervision and increased introspection can help to ensure the continuity of the safe, nurturing environment that our clients require (Dane, 2002). Dombo and Gray (2013) pointed out that understanding countertransference can help us make "a clear distinction between 'taking in' what the client is experiencing, and 'taking on' the client's experience" (p. 92). This is the difference between leaving our work at the office and taking it home—and inappropriately acting it out—to the detriment of ourselves and our loved ones.

I remind clients and students repeatedly that our unconscious holds a wild, irrational, potentially destructive force that can only be tamed through reflection and self-awareness. Self-awareness enables us to protect necessary boundaries and to see and hear our clients in the fullest, deepest ways.

Through this process of self-reflection, we will not fear hearing our clients' truths, and our clients—free from the intrusion of our internal struggles in their healing—will be open, without fear that they will hurt or anger us, perhaps leading to their rejection.

With this in mind, it is essential to remember that we are far more susceptible to burnout when our clients bring issues to us that parallel those we have denied in our own lives. The courage to face truths about our lives and journey is necessary to ensure the healing process. At the same time, it protects us from the ravages of burnout and provides the surest road toward personal and professional fulfillment.

Vicarious and Secondary Trauma

The third attendant syndrome of burnout is vicarious trauma (and its closely related cousin, secondary trauma), which results from a social worker's direct exposure to victims of trauma. Hearing the traumatic stories of others can affect our own worldview and sense of security (Humphrey, 2013). Stated somewhat differently: Without having directly witnessed or been involved in a traumatic event, practitioners can begin to mirror effects of trauma victims (Tabor, 2011) through a cumulative negative transformation that impacts all aspects of our lives (Dragon, 2019). Such reactions may be built directly into the very fabric of social work. According to Fox (2003), "Ironically, our empathic ability makes us particularly susceptible to emotional contagion, experiencing the feelings of the sufferer."

Vicarious trauma refers to the emotions that result from knowing about a traumatizing event experienced by a client and the stress resulting from helping or wanting to help this person (Bell, Kulkarni, & Dalton, 2003). I have regularly seen colleagues and students become overwrought with feelings of guilt and failure when their clients have made decisions that place them in harm's way. A closely associated concept, *secondary trauma* (Figley, 1995), also referred to as *secondary traumatization* or *secondary traumatic stress*, involves a client's firsthand narrative of a traumatic event that results in the clinician experiencing parallel stress and symptoms. Relatedly, the term *traumatic countertransference* has been used to describe a social worker's feelings for a trauma survivor and the traumatic events being discussed (Dane, 2002). An intense reaction can impede our ability to attend appropriately to a client's experience and issues (Fox, 2003). Also, such a reaction can replicate the effects of posttraumatic stress disorder (PTSD): persistent reexperiencing of symptoms from the past; avoiding places, events, or objects that are reminders of an experience; or being easily startled and feeling tense or on edge (American Psychiatric Association, 2013).

It is essential to keep in mind that the trauma experienced by our clients, however labeled, can result in practitioner burnout for numerous reasons, including "the effects which graphic and painful material (for example, death,

violence, injury, 9/11) presented to us by different individuals produce in our own cognitive schemas or belief, expectations, and assumptions about ourselves and others” (Fox, 2003, p. 48). Without question, debilitating flashbacks can cause terror, as evidenced by a respondent who spoke of the anniversary of 9/11—and could just as easily have been describing the terror and grief accompanying the ravages of the COVID-19 pandemic or the impact of the brutal attacks and expressions of hate given 24/7 coverage:

I suffered the most intensely when I worked in the 9/11 program at the time of the anniversaries. Our staff volunteered each year at the site and in the family room (a makeshift memorial . . . [area for] family members that overlooked the site). These were taxing times. I felt dread, fatigue, tearfulness, irritability, helplessness, physical aches, and moments of [being] overwhelm[ed]. (*respondent 14*)

The suffering of grieving families during and following a national crisis can cause social workers to struggle to maintain energy and concentration while navigating appropriate boundaries. This trauma is compounded when the personal is also professional, such as when a social worker has been exposed to the same trauma (Tosone, Nuttman-Shwartz, & Stephens, 2012). In cases of “shared trauma,” an extra layer of difficulty is encountered. This extra layer of personal–professional union has been ever present in 2020–2021, which brought seemingly endless scenes of violence, murder, injustice, and death; the brutal invasion of our nation’s Capitol by domestic terrorists; a presidential inauguration held under armed guard; continual threats by right-wing terrorists that their rampage remains unfinished—as evidenced by ongoing racially induced attacks and murders of American citizens.

Of course, social workers have ever been exposed to the human capacity for cruelty and inhumanity. Social workers, psychiatrists, psychologists, and those in related fields have always known that sadistic pathology exists all around us, that there are those who find release and pleasure in tormenting, terrorizing, and killing. We know that cruelty can be found in those from all cultures and socioeconomic backgrounds; that although we may have hints and clues, no one can truly know the lives of others behind closed doors; and that the same person capable of brutalizing the innocent may be described by others as mild mannered, kind, funny, or generous. Before 2020, however, many Americans believed abuse and brutal acts were far more isolated in our own communities than they actually are.

Part of a social worker’s belief is that everyone can change; that said, we also know there are those who have no desire to change. We have seen inhumanity up close—rape, incest, violence, murder. We work with parents and caretakers who have abused their children emotionally, physically, and sexually, yet deny their cruelty and refuse help. We have seen rodent-infested

homes where money for children's meals is used for drugs. We have seen children who have never been taken to a doctor or dentist. We have seen children who have been starved, tormented, and tortured, who have been chained to their beds, whose genitalia have been burned as punishment for masturbating, and whose bodies have been used as human ashtrays. We have seen the ravages of domestic violence—blindness, body impairment, loss of limb. We have seen death—of partners and of children.

What social workers see firsthand, to paraphrase respondent 17, "You just can't make up!" And what we see can be very difficult, if not impossible, to communicate with those in unrelated professions, even those who care deeply for us. We understand why attempts to alleviate our anxiety by sharing the shocking acts we have witnessed might be met with discomfort or an abrupt change in subject. We want to protect those we love from this discomfort, which is why we are often circumspect when asked, "How was your day?" Conversely, because of what we see, many of us find that simple acts of kindness move us deeply, sometimes to tears.

A related dynamic exists when those who have served in the battlefield of war return home. Most want to forget what they have witnessed, been part of, and endured and never attempt to discuss it, even with family members. In the words of one of my clients regarding his three tours of duty in Vietnam, "Who will want to hear about it? Who could believe what I have seen? How can I ever tell anyone the shame I feel for what I have done?" The father of a friend, who had served in World War II, fell into a deep depression after *The Greatest Generation*, by Tom Brokaw, was published in 1998. Brokaw's book, which gave enormous praise to the courage and grit of those who carried the Allies to victory, was published to rave reviews. My friend's father, however, refused to read it; the praise heaped on him drove him to despair: "They do not understand what really happened. To the readers, the war was a contest we won, like something they have seen on TV. I am praised undeservedly! I did not want to remember what was necessary, what it took, to win." He told his son, angrily, "I did not ever want to allow my thoughts to go back to these times." He continued, "When people began telling me what a hero I was, their compliments made me remember all I had pushed out of my mind: the death of fellow soldiers, the killing of other human beings, endless terror and suffering. I began to feel sick and slip once again into what I have tried for decades to escape—the bloody hell of war."

Moral Distress and Injury

The violence and abomination of war calls attention to the fourth attendant syndrome: moral distress and injury. Moral distress was first observed in the nursing field, where it was defined as the "distress of being in a situation in which one is constrained from acting on what one knows to be right"

(Jameton, 1984, p. 6). An important addition to the concept, moral injury, was added in reference to war veterans who had been involved in “perpetrating, failing to prevent, bearing witness to, or learning about acts that transgress deeply held moral beliefs and expectations” (Litz et al., 2009). The term “moral injury” was then applied to the lives of social work practitioners, such as those involved in removing children from their homes (Reamer, 2014). Maslach and Leiter (2017) also focused on human services, highlighting the relationship between moral injury and burnout. In a slightly expanded context, Talbot and Dean (2018) introduced the concept of moral injury more completely into health care: “The moral injury of health care is not the offense of killing another human in the context of war. It is being unable to provide high-quality care and healing” (para. 6).

In this regard, social psychologist Dana Kaminstein, who teaches in the Organizational Dynamics Program at the University of Pennsylvania, sheds light on a double bind that we as a profession know well:

Social workers are recognized as the primary professional bridge between our most vulnerable citizens and societal obligations to them. Yet, with regularity, politicians, bureaucrats, and the citizens who support them, ignore and scapegoat the vulnerable, refusing to designate vital funding to sustain them. Unable to provide necessary resources and adequate professional staff in this withholding environment, and rarely given the administrative support they require and deserve, staff social workers are then held responsible when tragedy strikes. I have often wondered if their notoriously low salaries and the ease of blaming, or more specifically “scapegoating” them for circumstances beyond their control, is because social work is a profession founded and remains largely staffed by women. It is little wonder that skilled and devoted social workers become morally stressed, deeply discouraged, burned out, and believe their only recourse is an exit. (*personal communication, March 14, 2021*)

According to Litz et al. (2009), moral injury and distress can result from four unique but related phenomena: (1) perpetrating acts that transgress deeply held moral beliefs; (2) witnessing acts that transgress deeply held moral beliefs; (3) failing to prevent acts that transgress deeply held moral beliefs; and (4) learning about acts that transgress deeply held moral beliefs.

Finally, for an eloquent summation of this attendant face of burnout, I turn to the words of Frederic G. Reamer, whose groundbreaking book on this subject was published in 2020:

Recognition of moral distress, moral harm, moral injury, and demoralization has come of age in human services. Today’s practitioners recognize that, throughout history, human services professionals have

struggled with feelings of guilt and remorse associated with their efforts to help people. Only recently, however, have human services professionals formally recognized these phenomena and developed the vocabulary and conceptual scaffolding necessary for practitioners to address them constructively. Across the helping professions, we now know more than ever about the diverse ways in which moral distress, moral harm, moral injury, and demoralization manifest themselves. (*p.* 29)

The 2020 onslaught of COVID-19 offers a vivid example of demoralization of social workers, physicians, nurses, and other front-line American workers. In addition to treating COVID victims, these workers were further demoralized by the lack of planning and preparation on the federal level resulting in a dearth of personal protective equipment (PPE), intensive care beds, and ventilators, making the provision of high-quality care next to impossible. Confidence in effective care and the necessary protection of patients and staff was replaced by rampant exhaustion and fear.

A devastating example of the unconscionable overload professionals faced is the April 26, 2020, suicide of 49-year-old Dr. Lorna Breen. This tragic loss of a dedicated professional serves as a potent example of the dangers of burnout, specifically moral distress and moral injury. Dr. Breen was a Manhattan emergency room physician supervisor at a hospital devoted to the underprivileged, a setting where supplies were rapidly depleting and personnel becoming ill.

Dr. Breen knew that the February 2020 assurances made by elected officials that the virus was not a serious threat were false. Like many who work tirelessly, Dr. Breen was raised to believe that a vocation should be centered around service to others. Her devotion to her patients was paramount. To quote her father, Dr. Philip C. Breen, “She tried to do her job and it killed her.”

Dr. Breen developed COVID-19 and never fully recovered. Neurological impairment from the disease is suspected. She returned to work after convalescing for about a week and a half. But the hospital sent her home. In the last months of her life, she was devastated “by the sheer number of people she could not save.”

This tragedy demonstrates the necessity of the interactive union between personal and professional well-being and political regard, as well as the destructive impact of moral distress when public policy disregards this fundamental requirement. The cost has been documented by Pulitzer Prize-winning journalist and bestselling author, James B. Steele, who has devoted many years of his professional life to his study of countless Americans who strive in frustration and desperation to attain a middle-class lifestyle. As Steele wrote to me:

For decades, I have reported on and written about the impact of financial greed in our society and the failure—indeed the betrayal—of government leadership to rein in such forces to protect average

Americans. I have watched as middle-class families have been destroyed and hardworking citizens forced into poverty through no fault of their own. I've seen firsthand the burnout that has afflicted Americans who have been cast aside by the current system and who blame themselves for their circumstances rather than public policies that could alleviate their condition if we face the causes of their distress. (*personal communication, November 18, 2020*)

In chapter 3 and in the second half of our book, when we discuss addressing the attendant syndromes of burnout, we will find that activism, clear-headedness, and resilience combine to create what is in effect an antidote. The antidote to moral distress and injury is referred to in the literature as *moral courage*. According to Reamer (2020), this term was first coined in the 19th century and is defined as the willingness of people to face “the pain and dangers of social disapproval in the performance of what they believe to be duty” (Sidgwick, cited in Reamer, 2020). Moral courage may be conceived as social action with four essential components: (1) it is animated by a strong set of personal convictions; (2) it transgresses established customs or attitudes; (3) it is carried out in the face of high social risks or costs; and (4) it is normatively driven conduct in which certain norms are accepted as binding, even as other norms are flouted and ignored (Press, 2018).

Or, as Barlett and Steele succinctly express in the prologue of their book, *America: What Went Wrong? The Crisis Deepens*, by quoting Justice Louis Brandeis, “We can have concentrated wealth in the hands of a few or we can have democracy. But we cannot have both” (Barlett & Steele, 2020, p. xi). Steele continues this theme in personal correspondence:

We know what must be done to help average Americans. The crisis in which millions of Americans find themselves is not inevitable: It is the direct result of policies that reward the rich and penalize the poor (or ignore the needs of average Americans). Public and private interests need to work together to restore balance in our system. If we restore balance, then we restore hope by giving everyone a chance to realize their potential and become full participants in the American dream. (*J. Steele, personal communication, November 18, 2020*)

Few realize that in 1967, Martin Luther King, Jr., encouraged adoption of the specific quality of antidote Steele proposes to address societal inequality. Included in Dr. King's proposed initiative was what he referred to as a “Freedom Budget” (Bennett, 2015): full employment opportunities for all Americans, in which fair wages were provided. Through united efforts of an interracial coalition of religious, civil rights, and labor representatives, King hoped that all Americans might achieve the dream brought to life in his iconic speech at the foot of the Lincoln Memorial at the March on Washington, on August 28, 1963.

What Is Burnout? A Case Study

The inability to share our work with friends and loved ones and our own lack of awareness of the professional and personal cost of the inhumane violations we witness can lead to isolation, exhaustion, and hopelessness. An example follows from work with Connie, a second-year MSW student, placed in a prison setting for her field work:

In her first year of graduate school, Connie excelled in both her academic work and her work with clients. However, as skilled as she was, certain cases in her second year of training caused her to feel ill and repulsed. During this period, Connie developed an ongoing skin condition that she had not had before graduate school. For reasons her doctors could not determine, large pustules began to erupt all over her arms.

Connie considered dropping out of graduate school. An English major in college, she was offered a job in a highly regarded public relations firm. It was an unsolicited offer, made by one of her former English professors who now worked in the firm. The job was described as “draining and pressured, but fun and lucrative.” Only the first half of this description seemed to apply to what awaited her as a social worker! Still, Connie decided to persist with her MSW degree and a placement that she knew would continue to ask a great deal of her. During her field placement in prison, Connie was assigned James, a client who was accused not only of embezzlement, but also of killing his wife so that he could marry his mistress. James faced the death penalty. Connie was expected to work with him throughout her second year and then to return to the prison following graduation (as partial payment toward the scholarship and living stipend she had received from the center that employed her).

James had become very close to a priest who visited the prison weekly, and through this trusted relationship, Connie was assigned as James’s social worker. There was always a guard with Connie during her time with James, but he was a kind and discreet one, who liked James and was as unobtrusive as possible during their biweekly meetings. In their work together, Connie learned that James had been abandoned by his father when his mother was pregnant with him. She also learned that James’s mother was a drug-addicted prostitute who at times tried to be clean but could not maintain sobriety of any sort. Her pimp was a ruthless monster, but was the only available father figure during James’s formative years. In James’s words:

I learned everything awful from him, including how to treat women, but at least he was there. No one else was. He often made me scrambled eggs for breakfast. No one else ever did that, and on the days I went to school, he was the one who took me. Then after school, he and I would have catches. This was the only fun I ever knew as a kid.

Not all inmates on death row become introspective. Obviously, some become more hardened, furious, and bitter, taking no responsibility for their

actions. Some claim their innocence throughout their internment. And as we know from the latest DNA investigations and new, refined research, some are truly innocent, and their arrest, internment, and death are a travesty. But none of these examples was the case with James. He knew that all he had done was vile, and he was deeply sorry. He had no doubt that the kindness and love shown him by the priest made this self-reflection, assessment, and attempts at repentance possible. In his words, "Father John was the first man in my life to be kind and decent in every aspect of his dealings with others." James added, "Plus, Father brought Connie into my world, and she has been a blessing."

With Connie as his social worker, James was able to recount the horror and ruthlessness that marked his existence, and Connie learned, through superb supervision, to listen, care, and show the compassion that only she and Father John had given to James. She learned the importance of a coping strategy her professors and supervisor referred to as "compassionate judgment." In her words, "What James did was awful, horrific, but during his most important formative years, 'awful and horrific' was all he knew."

There were many appeals to save James's life, and Father John and Connie always wrote and testified on his behalf, but James would not be spared. In the second year of Connie's employment at the prison, James died in the electric chair. Father John and Connie were allowed to be with him for an hour before his walk to the death chamber. They promised to look right at him through the glass as he took his final breath. And they did.

Through this work with James, Connie grew to understand that in her future as a social worker she would not be able to erase the horrors many of her clients faced as children or their full impact. What she could do, however, was provide a healing presence to her clients. She could be there with them, hear and understand them, believe in them, and advocate for them. Further, through her strong social work relationship with James, Connie forged a new definition of forgiveness that extended well beyond her work with clients. In her words, "I learned the essential difference between 'to condone' and 'to forgive,' and that one way to forgive is to work hard to understand why people do what they do, as well as how they developed to be the human beings they have become."

Facing Challenges and Protecting Our Selves

One thing is clear: Through the syndromes of compassion fatigue, countertransference, vicarious and secondary trauma, and moral distress and injury, burnout can systematically erode not only our ability to find meaning, direction, and fulfillment in our own lives, but also our ability to relate successfully to our clients and coworkers. Each of these manifestations can make it impossible to maintain the essential distinction between practitioner and client and prevent us from doing our jobs well, thus striking at the heart of

our self-identification as one who cares about healing and contributing to the health of our community.

Compounding this frustration, societal resources may stagnate or even worsen, increasing our stress, frustration, and disaffection for our work, leading to disconnection and isolation, both professionally and personally.

When we examine, define, and understand the challenges before us in terms of arenas of burnout and attendant syndromes, we begin our journey into self-care. In the second half of our book, essential self-care behavior and strategies will be introduced. Stress and frustration, part and parcel of our professional lives, will be eased by the approaches and framing put forth. Moreover, perspective will ease our anxieties: Most of our clients will heal slowly, often taking two steps forward and one or more steps backward. *We must recognize this as part of the process of growth and change.*

Still further, it is important to keep in mind that compassion fatigue, countertransference, vicarious and secondary trauma, and moral distress and injury offer four challenges that every social worker and those in related fields will experience repeatedly in our professional lives. We will reduce our stress and frustration by understanding and recognizing their impact and the ways in which they overlap and influence each other. Through this awareness, it will be easier to keep in mind that despite how deeply we care, each client's past, present, and future belong only to the client. And as important, we will see how essential it is to integrate the care strategies in the second half of our book into day-to-day life.

Questions for Reflection

The following are several questions for reflection you may want to consider as you assess your own current state of burnout. As you reflect, you may want to express your thoughts through writing.

- Do you self-medicate with drugs or alcohol? Do you find that your intake of such substances increases on more stressful days when you experience an intense schedule or a particular session that hits too close to home?
- What is the impact on you when sessions leave you unsettled because they did not go as you had hoped?
- How do you deal with sessions in which you recognize that you have missed some important client signals?
- Even if exhausted, when you leave work, do you feel satisfied that you have worked hard and to the best of your ability? Or do you feel dizzy with exhaustion, nearly unable to function or incapable of functioning in your personal world?
- Do you watch other people in their jobs and assume they are happier or more fulfilled than you are?

- Do you have intrusive thoughts during a session, wishing you were somewhere else, doing something else?
- Do you have angry outbursts at home or with the people whom you love and who love you, seemingly for no reason? Or do you find yourself withdrawing from those you care for?
- Do you daydream about being able to retire from your profession or move on to doing something different with your life in the future, perhaps the very near future?
- Are you often late for work? Do you take the opportunity to call in sick when nothing is seriously wrong?
- Have you experienced a large fluctuation in your weight recently (either gain or loss)?
- Do you feel that no one really understands what you go through at work? Do you long for someone to be able to understand what you cope with day in and day out?
- Do you have trouble falling asleep or sleeping through the night? Do you need medication to help you sleep?
- Does the news of the day overwhelm you and intrude on your capacity to think clearly and relate to others?
- Are there people important to you, either in the mental health field or not, who are experiencing some of the symptoms and reactions noted?