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Burnout and Perceived Organizational Support Among Female Healthcare Social Workers

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Walden University

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Walden University

College of Social and Behavioral Health

This is to certify that the doctoral study by

Shukundala Clark Champion

has been found to be complete and satisfactory in all respects,
and that any and all revisions required by
the review committee have been made.

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Walden University
2025

Abstract

Burnout and Perceived Organizational Support Among
Female Healthcare Social Workers

by

Shukundala Clark Champion

MSW, University of Southern Mississippi, 2004

BSW, Jackson State University, 2002

Project Submitted in Partial Fulfillment
of the Requirements for the Degree of
Doctor of Social Work

Walden University

November 2025

Abstract

Healthcare social workers experience elevated levels of burnout, or psychological distress resulting from a prolonged mismatch between the individual and their work environment. The problem addressed in this generic qualitative study is that female healthcare social workers experience elevated rates of burnout but may not receive adequate perceived organizational support (POS) to help ameliorate burnout. This study concentrated on female healthcare social workers' descriptions and experiences of burnout and POS. The guiding theoretical framework for this study is the perceived organizational support theory (POST). The study was conducted with 14 female healthcare social workers working in various healthcare settings in the southeast region of the United States. Under the generic qualitative approach, the data were collected through semi-structured interviews. The interview data were transcribed and analyzed using thematic analysis steps, with resultant themes discussed concerning the research questions. Ten themes developed from the unique codes obtained via thematic analysis: burnout, workload/caseload, staffing, organizational support, supervisors, peer support, salary/pay, scheduling, resources, and visibility of leadership. Implications for potential positive social change include increasing assessment for burnout among employees, developing plans for equity in pay, and allowing mental health days or flexible scheduling.

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Dedication

I dedicate this work to past, present, and future social workers. May our work continue to provide a foundation of growth, support, and care for the individuals and families we serve. Social work is a calling – a ministry. I hope that calling pushes us all to show up each day, willing to assist another on life’s journey. This helping profession is one where intrinsic reward outweighs the outward accolades. Continue to accept the charge of grace and kindness to others.

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I am thankful to have received a lifetime love of education from my grandmother, Kathleen Gower Hamilton. It is her inspiration that fostered my growth in social work. To my parents, Hamilton, Clark, Gower, Osborne, and Tillman/Champion family, thank you for your support and prayers during this process. My great friends and wonderful coworkers – my editors, motivators, and cheerleaders – I love you all. Thank you for indulging me, assisting me in editing, providing support, and simply listening to me. Your kindness is like the air we breathe. Finally, thank you to my wonderful and supportive husband, Christopher, for tolerating the papers everywhere, maintaining our household, and providing unwavering care and support. This effort would still be a dream if you were not here to inspire and encourage me daily. I love you.

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Section 1: Foundation of the Study and Literature Review

Introduction

Healthcare social workers experience elevated levels of burnout, or psychological distress resulting from a “prolonged mismatch” between the individual and their work environment (Maslach & Schaufeli, 2017). Burnout can contribute to the healthcare social worker’s poor mental health and negative work attitudes and behaviors, consequently impacting the organization (Frieiro Padin et al., 2021; Negura & Lévesque, 2021). Perceived organizational support (POS) is the employees’ perception about organizational, supervisor, and coworker factors that reflect the extent to which the organization “*values and cares* about their well-being” (Sun, 2019, p. 156). The degree of POS in the workplace influences burnout rates and the rates of related outcomes, such as compassion fatigue and secondary traumatic stress, in healthcare professionals (Fukui et al., 2019; Myrvang, 2020; Prysmakova & Lallatin, 2021; Singh et al., 2020; Sun, 2019), including healthcare social workers (Aiello & Tesi, 2017). However, there has not been a qualitative examination of how female healthcare social workers describe burnout and how POS contributes to their burnout (Negura & Lévesque, 2021).

This study employs a generic qualitative research design to explore how female healthcare social workers describe their burnout and the POS surrounding their burnout. As is fitting for a generic qualitative design, the social phenomenon of burnout and POS surrounding it are under-researched in samples of female healthcare social workers. As generic qualitative studies have small sample sizes (Sandelowski et al., 2000, 2010), the study sample consists of 14 healthcare social workers. Data will be collected via semi-

structured interviews and analyzed using Braun and Clarke's (2006) six-step thematic analysis. Findings from this study will shed light on healthcare social workers' unique experiences regarding burnout and the POS surrounding burnout. The study will provide information that could be used to inform workplace policy, practices, and professional development opportunities that reduce burnout and improve POS, enhancing healthcare social workers' physical and mental health and resilience.

The proposal is organized into sections. In Section 1, after the introduction, the problem statement is presented, followed by the purpose statement and research questions. The nature of the doctoral project is then reviewed, as is the significance of the study. Section 1 subsections concern the guiding theoretical framework, perceived organizational support theory (POST; Eisenberger et al., 1986, 2020), and a discussion on social workers' values and ethics by the National Association for Social Workers (NASW). Substantial attention is given to the literature review, where research on burnout and POS within healthcare and social work is summarized. Section 1 concludes with a summary. Section 2 opens with an introduction and a review of the study's research design. Included in Section 2 is the methodology, which contains information about the study variables and data, study participants, and instrumentation. After a review of the planned data collection and analysis, the ethical procedures of the study are stated. A summary ends Section 2.

Problem Statement

The problem addressed in this generic qualitative study is that female healthcare social workers experience elevated rates of burnout but may not receive adequate

perceived organizational support (POS) to help ameliorate burnout. The study is designed to address the lack of qualitative research that has explored female healthcare social workers' descriptions of burnout and their POS surrounding burnout POS. The over-180,000 healthcare social workers in the American workforce are employed in high-stress settings (e.g., hospital/medical clinics, nursing homes), where their primary role is to advocate for the health and well-being of vulnerable populations, such as older adults and children (Frieiro Padin et al., 2021; Negura & Lévesque, 2021). Arduous and multi-faceted work tasks, the increasing complexities of the American healthcare system, low wages, and most recently, the COVID pandemic, have made healthcare social workers especially vulnerable to burnout (Frieiro Padin et al., 2021), defined as psychological distress resulting from workplace stressors, most often characterized by emotional exhaustion, depersonalization, and reduced personal efficacy/sense of accomplishment (Maslach, 2017). Rates of burnout among healthcare social workers can exceed 60% (Reitz et al., 2021). Moreover, burnout is more common among females (Frieiro Padin et al., 2021; Yi et al., 2019), and 77% of healthcare social workers are female (Laughlin et al., 2021).

Burnout can contribute to not only the healthcare social worker's poor physical and mental health (Mak et al., 2021; Tsaras et al., 2019; Wu et al., 2022) but can also lead to unpleasant work attitudes and behaviors (Brown et al., 2019; Falce, 2022; Frieiro Padin et al., 2021; Kang, 2012; Kuok, 2022). As such, the consequences of burnout often extend beyond the social worker, impacting the organization (Brown et al., 2019; Cuartero & Campos-Vidal, 2019). Costs to the organization may include hiring and

training new or temporary employees and revisiting and/or repairing incomplete or shoddy work completed by a worker who has separated from the organization (Foy et al., 2019; Fukui et al., 2019). Social workers' burnout can negatively affect organizational outcomes (Brown et al., 2019; Falce, 2022; Kuok, 2022).

POS, a perception that the organization values and cares for the employee, may help to reduce levels of burnout among health and mental health professionals (Fukui et al., 2019; Myrvang, 2020; Prysmakova & Lallatin, 2021; Singh et al., 2020; Sun, 2019), including social workers (Aiello & Tesi, 2017). However, the qualitative literature on healthcare social workers' burnout and POS is limited (Myrvang, 2020; Pavone, 2018). No study to date has explored female healthcare social workers' perceptions of their burnout vis-à-vis POS. In consideration of the high rates of burnout among healthcare social workers (Frieiro Padin et al., 2021) and the acknowledged benefits of POS in reducing burnout rates among healthcare professionals (Prysmakova & Lallatin, 2021; Singh et al., 2020), scholars have called for a need for studies that delve into social workers' descriptions and perceptions of the organizational supports (formal and informal), resources, and training made available to them and their perceived effectiveness and quality in reducing burnout (Levesque & Negura, 2021; Stanley & Sebastine, 2023). There is a further need for qualitative studies examining POS and burnout in consideration of employee variables, such as gender (Aiello & Tesi, 2017).

Purpose Statement and Research Questions(s)

This generic qualitative study explored female healthcare social workers' descriptions of burnout and their POS surrounding burnout. Burnout is a

multidimensional psychological construct characterized by emotional exhaustion, depersonalization, and a decreased sense of personal accomplishment (Maslach & Leiter, 2017). POS is “an employee’s perception that the organization values their contributions and cares about their well-being” (Sun, 2019, p. 156). This study uniquely contributes to the empirical body of literature specific to burnout and POS in social work. Study findings may be used to inform policy changes and develop initiatives to reduce burnout and enhance POS among healthcare social workers.

Research Questions

This generic qualitative study has two research questions (RQs). The RQs are informed by Maslach’s (1981) concept of burnout and Eisenberger et al.’s (1986) POST guiding theory. The study, by answering the RQs, will advance the body of empirical work on burnout and POS among healthcare social workers and will provide much-needed information that can be used to guide initiatives that reduce burnout and improve organizational supports for female healthcare social workers. The RQs are:

RQ1. What are female healthcare social workers’ descriptions of burnout?

RQ2. What are female healthcare social workers’ descriptions of their perceived organizational supports (POS) regarding burnout?

Nature of the Doctoral Project

A generic qualitative or qualitative descriptive design is a fitting methodological approach to explore healthcare social workers’ descriptions of burnout and POS regarding burnout. The generic qualitative design, also called the qualitative descriptive design, explores an under-researched social phenomenon experienced by a small and

distinct group of individuals (Magilvy & Thomas, 2009; Sandelowski, 2000, 2010). The under-examined social phenomena explored in this generic qualitative study are burnout and POS within the context of healthcare social worker burnout. A singular distinction of the generic qualitative design is its focus on the description rather than the interpretation of a phenomenon: the empirical intent is to capture participants' everyday real-life descriptions, not their subjective interpretations or psychological states, of the social phenomenon under study (Kim et al., 2017; Sandelowski, 2000, 2010). This study will inquire about healthcare social workers' descriptions - not interpretations - of burnout and the organizational supports made available to them that have helped to reduce burnout. A generic qualitative design is appropriate for this study.

According to the small sampling approach of the generic qualitative design (Kim et al., 2017; Magilvy & Thomas, 2009), the study sample consists of 14 healthcare social workers, all of whom will engage in a semi-structured interview. The semi-structured interviews will capture female healthcare social workers' descriptions of their burnout and POS, including their perceptions of their emotional exhaustion, depersonalization, decreased sense of personal accomplishment, and sources of burnout (see Appendix). The POS questions inquire about (a) organizational fairness and equitable treatment, (b) organizational conditions, practices, and resources; (c) organizational leader support; (d) supervisor support and advocacy; and (e) coworker support (see Appendix). The interviews will be transcribed, and the transcriptions will be analyzed using Braun and Clarke's (2006) six-step thematic analysis.

Significance of the Study

This generic qualitative study is significant to the field of social work, and the results of this research have implications for positive social change. Due to the exceedingly high rates of burnout among healthcare social workers, there is a need to identify work and organizational support that helps mitigate the effects of burnout in this population (Frieiro Padin et al., 2021), which this study will do. The study will contribute to the sparse qualitative research on POS vis-à-vis burnout among healthcare social workers and will shed light on healthcare social workers' POS surrounding burnout. While it is unclear how study findings may be used in the future, results may inform administrators at healthcare agencies and hospital organizations on what supportive and energizing relationships can be provided to healthcare social workers to improve their mental health and organizational functioning. Moreover, the results from this generic qualitative study will guide policy changes and develop and implement professional programs and initiatives that reduce healthcare social workers' burnout, improve POS, and enhance healthcare social workers' health, mental health, and organizational issues that can improve the healthcare organization.

There are additional implications for social change. Creating a social work policy informed by this study's results could address burnout and work overload and guide employees, supervisors/managers, and organizations to provide organizational support that improves healthcare social workers' mental health and workplace attitudes and behaviors. Open dialogue with agency leadership on creating environments that are not considered toxic and unhealthy for employees would positively affect absenteeism,

job/career changes, and turnover (Maslach & Leiter, 2017). Effecting social change regarding burnout would involve creating healthy work environments with opportunities for continued feedback, job duty adjustments, and work-life balance (Frieiro Padin et al., 2021; Maslach & Leiter, 2017). Directives to reduce burnout in working environments should be the driving force and promote employee self-care; the two should not be mutually exclusive (Maslach, 2017; Wilberforce et al., 2014). This study has numerous implications for positive social change.

Theoretical/Conceptual Framework

The guiding theoretical framework for this study is the perceived organizational support theory (POST), developed by Eisenberger and colleagues (Eisenberger et al., 1986, 2020; Kurtessis et al., 2015; Rhoades & Eisenberger, 2002). In developing the POST, Eisenberger et al. (1986, 2020) applied social exchange theory to the organization, arguing that the employee perceives the organization as they would with others in social relationships, personifying and developing cognitive attributions that shape their interactions with the organization (Eisenberger et al., 1986, p. 500). Central to the POST is perceived organizational support (POS), a cognitive attribution by the employee that the organization *values* their contributions and *cares for* their well-being (Eisenberger et al., 1986, 2020; Kurtessis et al., 2015). The degree to which employees perceive that the organization values and cares for them determines their attitudes and actions specific to the job (Eisenberger et al., 1986, 2020).

While scholars have posited various characteristics of POS (Singh et al., 2020; Wang & Wang, 2020), Eisenberger and colleagues (Eisenberger et al., 1986, 2020;

Kurtessis et al., 2015) have postulated that there are five critical antecedents of POS. Three pertain to the organization (i.e., fairness and equitable treatment, work conditions, practices, resources, and leadership support); the remaining two concern supervisor support and advocacy and coworker support. The theoretical argument of the study, supported by empirical literature (Eisenberger et al., 2020; Singh et al., 2020; Wang & Wang, 2020), is that POS reduces burnout, evidenced by emotional exhaustion, depersonalization, and a decreased sense of personal accomplishment, among healthcare social workers by providing them the needed supports, advocacy, and fair and equitable treatment at the organizational, supervisor, and coworker levels.

Values and Ethics

Social workers have ethical standards, professional values, and responsibilities to their community, clients, colleagues, and themselves, as delineated by the National Association of Social Workers (NASW; 2022). NASW (2022) ethical standards address social work professionals' knowledge base, competency, and conduct in all practice fields. These values are expected to be upheld and referenced often for continued fair and reasonable services to others regardless of race, culture, or socioeconomic status (NASW, 2022).

A social worker's personal ideals, work ethic, and hopes for change that were developed in the academic setting (college/university or field training) can quickly sour and turn into a misalignment of work performance versus job role expectations in employment because of burnout (LeRoux et al., 2018). As burnout and exhaustion while working continue, the social worker's knowledge and ability to complete duties may be

dampened, resulting in reduced effective change in the social worker-client/patient relationship. This change may present in the work environment as decreased empathy toward others, cynicism, and loss of purpose (Travis et al., 2016; Wilson, 2016).

Desensitized and disconnected interactions between social workers and clients/patients lead to a cursory exchange, where professionals are not typically present or as engaged while the work is being completed. This disengagement negatively impacts job performance and satisfaction (Travis et al., 2016). Negative evaluations and criticisms of the professional's job performance by their peers and superiors often affect salary and job growth due to absenteeism, illness, and decreased productivity (Foy et al., 2019; Park et al., 2021). These factors, combined with reduced self-motivation, can influence effective service delivery – an important aspect when meeting the needs of vulnerable populations (Eliacin et al., 2018). As discussed in the NASW *Code of Ethics* (2020) regarding ethical responsibilities as professionals, section 4.05 suggests that the impairment of a social worker can adversely affect the desired outcomes for clients or patients due to difficulties that impede or interfere with job performance. Burnout could be considered an impairment, as it may negatively affect the quality of services a patient or client receives while adding to the intense workload the social work professional must maintain (Dalphon, 2019; Pugh, 2016).

Review of the Professional and Academic Literature

The literature review entailed reviewing and synthesizing the pertinent peer-reviewed empirical literature on the study topics of POS and burnout among healthcare social workers. The review of empirical research was initiated in the summer of 2020,

with parameters set to the past five years (i.e., 2015-2020); as the review continued through the winter of 2023, the years were expanded to include research from 2021 to early 2023. Searches were electronic, with research accessed using the Walden University Library Services academic databases of *PsycINFO*, *Academic Search*, *EBSCO*, ProQuest, and *Google Scholar*. The key search terms, used singly and collectively, were: *organization, employee; medicine, healthcare, healthcare professional, social work, healthcare social worker; workplace stress, workplace burnout, burnout, cynicism, emotional exhaustion, depersonalization, reduced personal efficacy/sense of accomplishment, Maslach Burnout Inventory (MBI); perceived organizational support (POS), perceived organizational support theory (POST), organizational fairness and equitable treatment, organizational rewards and conditions, organizational leadership, supervisor support and advocacy, and coworker support.*

The literature review provides a comprehensive yet concise discussion and evaluation of the empirical research pertinent to the two primary study constructs: burnout and POS experienced by social workers and others in the helping professions. The first section pertains to burnout, with the first subsection providing information on its historical origin and definitions. Scholarly work presenting the components of burnout (i.e., emotional exhaustion, depersonalization, and reduced personal accomplishments), concepts related to burnout (i.e., compassion fatigue and secondary traumatic stress), and burnout among female professionals follows in respective subsections. Substantial attention is given to the empirical literature on burnout rates among social workers, including healthcare social workers, and studies that examined social workers' burnout

during COVID, presented in separate subsections. The final subsections on burnout include reviews of empirical findings from studies examining the effects of burnout on health and mental health and organizational/work outcomes specific to the social work domain.

The second significant literature review section presents the empirical work on perceived organizational support (POS) and perceived organizational support theory (POST). It opens with a subsection providing information on its definitions and dimensions. Results from research on the benefits of POS on organizational health and mental health outcomes for helping professionals and social workers are summarized in the subsequent subsections. A subsection is then dedicated to an empirical review of the research on POS about burnout among social workers. The literature review ends with a summary.

Burnout: History and Definitions

The historical origin of burnout is rooted in the pioneering organizational psychology research of Freudenberger and Maslach, who “independently and yet simultaneously” developed the concept of workplace burnout in the early 1970s (Schaufeli, 2017, p. 83). The two researchers separately arrived at a new social psychological concept that was not necessarily surprising: burnout was borne out of changes that impacted the human services field starting in the late 1960s (Schaufeli, 2017). The human services field had an influx of young adults who, having grown disillusioned with societal problems such as poverty, war, and racial and gender inequality, took on positions in counseling, healthcare, and teaching to better society

(Maslach & Schaufeli, 2017; Schaufeli, 2017). However, the human services field shifted from small-scale agencies - where employees considered their work a calling –to large bureaucratic companies with corporate and utilitarian environments (Maslach & Schaufeli, 2017; Schaufeli, 2017). The corporate and governmental control, oversight, and interference of human services fields clashed with the idealistic views of the employees, creating a perfect storm for workplace burnout (Schaufeli, 2017).

Freudenberger's Conceptualization of Burnout

Freudenberger is recognized as having coined the term *burnout* based on his experiences as a consulting psychologist at free clinics in New York City during the early 1970s (Fontes, 2020; Schaufeli, 2017). Working in the addiction clinic, Freudenberger noticed that the clinic staff, after experiencing highly stressful work situations, behaved similarly to the patients who came to the free clinic for substance abuse treatment (Fontes, 2020; Schaufeli, 2017). Freudenberger noticed behavioral/emotional (e.g., irritation, anxiety, sadness) and physical (e.g., exhaustion, fatigue, insomnia) issues among not only free clinic volunteers but also himself when working in a high-stress clinic environment; moreover, the physical and behavioral problems of staff often worsened in the face of organizational changes and lack of supervisory support (Fontes, 2020). In response, Freudenberger applied the colloquial term of chronic drug abuse in the 1970s – being ‘burned out’ – to the workplace (Fontes, 2020).

Freudenberger (1974) defined workplace burnout by its behavioral/emotional and physical indicators. Volunteers who were “burned out” had elevated levels of depression and apathy; they were quick to anger and often responded with “instantaneous irritation

and frustration” (Freudenberger, 1974). Additional characteristics of burnout identified by Freudenberger (1974) included rigid and inflexible thinking, an inability to progress and change positively, and a cynical perspective of the world. The most damaging indicators of burnout, as conceptualized by Freudenberger (1974), were the physical ones: exhaustion and fatigue, poor immune functioning, and numerous gastrointestinal (e.g., dyspepsia, stomach ulcers), neurological (e.g., headaches, insomnia), and cardiovascular (e.g., tachycardia, hypertension) disturbances. Freudenberger (1974) further noticed that volunteers responded to burnout in an unhealthy fashion, often resorting to the same drug use that patients were there to overcome. However, Freudenberger approached burnout as a practitioner, having more interest in preventing or ameliorating it rather than investigating it as a research phenomenon (Fontes, 2020; Schaufeli, 2017).

Maslach’s Conceptualization of Burnout

The field of burnout research itself was established by Maslach, whose research interests concerned how people emotionally and physically responded to their employment and coped with stressful work situations (Schaufeli, 2017). Like Freudenberger, Maslach came across the term ‘burnout’ when human services workers were interviewed for her research. Maslach noted that workers often used it to describe their emotional and behavioral responses to high-stress work situations (Schaufeli, 2017).

Initially, burnout was considered a pseudoscientific concept and rejected by psychological researchers as a fad (Schaufeli, 2017). However, Maslach’s research throughout the 1970s and the development and validation of the Maslach Burnout

Inventory (MBI) in 1981 gave the concept of burnout theoretical and empirical credibility. According to Maslach (2017), burnout results from a long-term mismatch between the individual and their work environment. Burnout occurs when an employee faces excessive workload and demands with insufficient work resources and a lack of financial, social, or intrinsic rewards (Maslach & Schaufeli, 2017; Schaufeli, 2017). Burnout is often the result of a deficient work support system, work inequities, and work values that conflict with those of the individual (Maslach & Schaufeli, 2017). The overload of assigned tasks and overbearing demands that could be considered bullying behaviors only separate the individual from the work mindset (Foy et al., 2019). At its simplest, burnout is “emotional and behavioral impairment in response to the prolonged and high level of exposure to occupational stress” (Sweileh, 2020, p. 16).

Dimensions of Burnout. Maslach (1981) defines burnout as a multidimensional construct comprising three components: *emotional exhaustion*, *depersonalization*, and a *decreased sense of personal accomplishment* (Maslach & Leiter, 2017). Emotional exhaustion is a depletion of emotional investment and energy (Larsen et al., 2017; Palenzuela et al., 2019). Emotional exhaustion is the inverse of resilience (Larsen et al., 2017; Palenzuela et al., 2019). Depersonalization is viewed as an avoidance coping mechanism in response to highly charged environments; it is an attempt “to staunch the depletion of emotional energy by treating others as objects ... rather than people” (Lee & Ashforth, 1990, p. 744). A decreased sense of personal accomplishment pertains to a reduced sense of efficacy and worth regarding work (McFadden et al., 2019; Eliacin et

al., 2018; Kagan, 2021). Lack of personal accomplishments involves a lack of control over perceptions and motivations (Eliacin et al., 2018; Kagan, 2021).

Burnout: Similarities/Differences to Compassion Fatigue and Secondary Traumatic Stress

Burnout shares commonalities and differences with other psychological concepts: compassion fatigue and secondary traumatic stress (i.e., vicarious trauma). Compassion fatigue and secondary traumatic stress are empathy-based stress-related disorders that result from specifically collaborating with traumatized individuals (Henson, 2020; Rauvola et al., 2019; Sweileh, 2020). Burnout also comes from working with vulnerable populations (Frieiro Padin et al., 2021). The three psychological states may be experienced at one time due to the unique characteristics of burnout, compassion fatigue, and secondary traumatic stress (Sweileh, 2020).

Compassion fatigue pertains to a state of psychological distress and affective emotional fatigue due to working in situations where one is constantly “in a demanding relationship with a needy individual” (Sweileh, 2020, p. 2) and in situations where one “come[s] into contact with, or knows, about the distress and suffering of others” (Huggard et al., 2017, p. 66). The most considerable outcomes of compassion fatigue are reduced empathy (Ostadhashemi et al., 2019; Sweileh, 2020) and “a diminished capacity for compassion” (Kreitzer et al., 2020, p. 1943). Compassion fatigue has more of an impact on the person’s affect, often leading to emotional blunting, making it distinct from burnout (Kreitzer et al., 2020).

Secondary traumatic stress is a psychological reaction following exposure to a traumatic event experienced by someone else, and wanting to help that individual (Rauvola et al., 2019). The unique aspect of secondary traumatic stress is that it involves three psychological/cognitive symptoms: (a) intrusive thoughts, which result in the individual re-experiencing the traumatic experience; (b) cognitive avoidance of the traumatic experience; and (c) psychological arousal, resulting in increased anxiety, sleeping, and eating issues, and irritability (Virga et al., 2020). As intrusion, avoidance, and arousal are the ongoing cognitive and emotional aspects of secondary traumatic stress, it can eventually progress to post-traumatic stress disorder or PTSD (Rauvola et al., 2019). While often used interchangeably with burnout, secondary traumatic stress is more situation-specific and emotionally traumatizing (Henson, 2020; Sweileh, 2020).

Studies conducted with healthcare social workers have shown that burnout, compassion fatigue, and secondary traumatic stress correlate to a high degree (Clark et al., 2022; Sweileh, 2020; Virga et al., 2020). Virga et al. (2020), examining burnout and secondary traumatic stress in 183 (88% female) Romanian social workers, found significant correlations between the emotional exhaustion component of burnout and the three elements of secondary traumatic stress: intrusion ($r = .54, p < .01$), avoidance ($r = .62, p < .01$), and arousal ($r = .67, p < .01$). In a study with 158 (83.5% female) social workers in America, Clark et al. (2022) found all three workplace stress-based disorders to be significantly correlated: compassion fatigue with secondary traumatic stress, ($r = .89, p < .001$); compassion fatigue with burnout ($r = .88, p < .001$); and secondary stress with burnout ($r = .57, p < .001$). Compassion fatigue and secondary traumatic stress,

though driven more by empathy-driven relationships in work than more global stressors, share conceptual similarities to burnout (Clark et al., 2022; Sweileh, 2020; Virga et al., 2020). While burnout, compassion fatigue, and secondary traumatic stress are distinct conditions that develop individually, they can and often do interact with one another, leading to impairments in the workplace (Clark et al., 2022; Sweileh, 2020; Yi et al., 2019).

Burnout and the Female Gender

Burnout is recognized more frequently in women than men, possibly due to often unwritten rules regarding gender roles and expectations outside of professional life (Hwang & Jung, 2021; Reitz et al., 2021). Work and non-work roles (e.g., spouse, parent, friend) are sometimes not in harmony, where increased activity in one area could negatively impact the other (Foy et al., 2019). Work-life imbalance or conflicts may present in ways where the duties of one area permeate into different regions, such as working longer hours or allowing the stress and frustrations of familial or work duties to affect one's behavior during other activities (Foy et al., 2019). Historically, supposed caring qualities, such as empathy, were attributed to women, and roles of employment that require nurturing, such as nursing, teaching, and social work (Kagan, 2021). Presenteeism becomes a reality in many work environments and could be considered as a precursor to burnout for many female employees (Hwang & Jung, 2021). Burnout characteristics may present in male and female employees, but familial responsibilities may fall on females more than males, especially childbirth and rearing (Hwang & Jung,

2021). Females experience higher workplace burnout rates (Foy et al., 2019; Hwang & Jung, 2021).

Studies conducted with helping professionals outside the field of social work have noted gender differences; notably, these differences were found despite the varying instruments utilized to assess burnout (Allwood et al., 2022; Granek et al., 2016). Granek et al. (2016), conducting a quantitative study with 178 Israeli clinical oncologists, found that female gender was significantly correlated with higher rates of burnout, as assessed using a single item from the MBI (i.e., “How often do you feel burned out from your work?”) ($r = .29, p < .05$). In a quantitative correlational study with 828 clinical psychologists in Sweden, Allwood et al. (2022) also found a significant relationship between female gender and increased burnout ($r = .23, p < .05$). There is empirical evidence that burnout is experienced at higher rates among females in the helping professions (Allwood et al., 2022; Granek et al., 2016).

Burnout among Social Workers

Social work is a female-predominant position (Frieiro Padin et al., 2021; Salsberg et al., 2020; US Department of Labor, 2023). Data has shown that, in 2019, 90% of social work graduate students in the United States were female (Salsberg et al., 2020), and 2022 labor data documented that approximately 80% of social workers were female (US Department of Labor, 2023). While there are slightly more males in healthcare social work, females remain the majority: the % of female healthcare social workers is 73% (Deloitte, 2023). There are gender disparities in salary between male and female

healthcare workers: on average, female healthcare workers make at least \$1,000 less than male healthcare workers (Deloitte, 2023).

The research on burnout in social work has often included female samples (Frieiro Padin et al., 2021; Kimes, 2016; Salsberg et al., 2020). In their literature review, Frieiro Padin et al. (2021) reported that females comprised the majority (i.e., 73% to 86%) of participants in studies specific to burnout among healthcare social workers. As noted by Frieiro Padin et al. (2021), “There is a need to identify some of the characteristics of burnout that affect mostly women” in the empirical literature (p. 1062). This study focuses on female healthcare social workers due to the likely high rates of burnout experienced by this group and the need for research on burnout specific to this population.

In response to research “that has failed to produce broad statistics on the rates of burnout among social workers” (Kimes, 2016, p. 16), some scholars have examined emotional exhaustion, depersonalization, and a reduced sense of personal accomplishment utilizing the Maslach Burnout Inventory (MBI; Maslach et al., 1997). The MBI, frequently used in burnout research, assesses the conceptual elements of burnout: (a) emotional exhaustion, (b) depersonalization, and (c) a reduced sense of personal accomplishments (Kimes, 2016; Wang et al., 2019; Walters et al., 2018). Each MBI subscale has unique scoring (Maslach et al., 1997). MBI emotional exhaustion subscale scores between 1 and 16 denote low burnout, scores between 17 and 26 indicate moderate exhaustion, and scores of 27 or higher indicate elevated exhaustion levels. Scores between 1 and 8 on the MBI depersonalization subscale indicate minimal

depersonalization, while scores between 9 and 13 denote moderately severe depersonalization; a score of 14 or higher indicates extreme depersonalization (Maslach et al., 1997). The MBI personal accomplishment subscale score is the opposite in value of the two other subscales, with a lower score denoting lower levels of perceived accomplishment (Kimes, 2016; Maslach et al., 1997). Scores of 37 or higher on the subscale are demonstrative of elevated levels of personal accomplishment, scores between 31 and 36 indicate a moderate level of accomplishment, and scores between 0 and 30 denote deficient levels of perceived personal accomplishment (Kimes, 2016; Maslach et al., 1997).

Studies with social workers have documented various estimates of emotional exhaustion, depersonalization, and a reduced sense of personal accomplishment, with rates influenced by era and cultural, organizational, and individual factors (Kimes, 2016; McFadden, 2015). For example, in an early study, McFadden (2015) reported the burnout rates of 1,359 (83% female) social workers in the United Kingdom. Of the social workers, the majority (62%) were frontline workers, with 33% working in child protection services and 25% with adults with medical issues. The MBI subscale scores were high: 33.61 for emotional exhaustion, 9.22 for depersonalization, and 15.55. Translating this to percentages, 91% of the social workers had high rates of emotional exhaustion and reduced sense of personal accomplishment, and 61% reported high rates of depersonalization (McFadden, 2015). Due to the demographics of the participants - many of whom worked with children or disabled adults - McFadden (2015) argued that

working in especially high-stress social work positions contributed to the high burnout rates.

Building off McFadden's (2015) work, Kimes (2016) systematically reviewed the literature using the MBI in social work samples published between 1980 and 2015. Kimes' (2016) review yielded only 16 studies, with the first one published in 1990. Of the 16 studies, most (75%) were conducted with child welfare workers, mental health social workers, or general social workers, while 25% pertained to medical social workers, and the samples were international, representing countries such as Australia, America, Sweden, and Spain (Kimes, 2016). Kimes (2016) calculated the sample's mean scores on the three MBI subscales. The emotional exhaustion subscale score was $M = 24.64$, indicative of moderate levels of burnout (Kimes, 2016). However, the depersonalization subscale score was $M = 7.89$, and the sense of personal accomplishment score was $M = 37.45$, indicating that the social workers had low levels of these characteristics of burnout (Kimes, 2016). Kimes (2016) cautioned that only two studies used quasi-experimental designs, and the samples varied in culture and job type, which may have muddied the findings and suggested additional research exploring burnout among social workers.

Additional international studies have examined the rates of burnout in social workers, with some research denoting average rates of burnout among social workers (Ben-Porat & Itzhaky, 2014; Dima et al., 2021; Walter et al., 2018). In an early study, Ben-Porat and Itzhaky (2014) used a measure developed by Pines (1984) to assess burnout among 214 trauma social workers in Israel, finding that they had a mean score of 2.32, indicative of average rates of burnout. Some studies, such as those by Walter et al.

(2018) and Dima et al. (2021), utilized the Copenhagen Burnout Inventory (CBI). In a study validating the CBI in a national sample of social workers in the United States, Walter et al. (2018) reported the CBI mean to be 47.0, indicating average burnout rates among American social workers. Dima et al. (2021) found that, in their study with 83 (93% female) Romanian social workers during the pandemic, the CBI score was $M = 52.5$, also indicative of average burnout rates among the workers. However, in a study with 16 (69% female) Nigerian healthcare social workers, Fajimi (2023) noted high rates of burnout (54%) as assessed by their self-developed instrument. Studies across various countries have pointed out both average and high rates of burnout in social workers (Ben-Porat & Itzhaky, 2014; Dima et al., 2021; Fajimi, 2023).

Burnout among Healthcare Social Workers

While some burnout studies have included healthcare social workers, “few studies have explicitly addressed burnout in health social work” (Frieiro Padin et al., 2021, p. 1051). In a literature review on burnout among healthcare social workers, Frieiro Padin et al. (2021) found only 14 studies (93% quantitative) published between 2000 and 2020. The MBI and the Oldenburg Burnout Inventory (OBI) were the most common instruments to assess burnout. Frieiro Padin et al. (2021) included studies that utilized the Secondary Traumatic Stress Scale (STSS). Regardless of the instrument used, Frieiro Padin et al. (2021) reported that a high percentage of participants had high burnout and secondary traumatic stress rates, with the percentages of burnout and secondary traumatic stress ranging from 20% to 47% in studies.

In Gonzalez-Rodriguez et al.'s (2020) study with Spanish healthcare social workers, the MBI burnout subscale scores denoted that emotional exhaustion was high ($M = 27.50$), and depersonalization was moderately severe ($M = 9.50$). However, the MBI personal accomplishment subscale denoted moderate levels ($M = 34.20$) of personal fulfillment for healthcare social workers (Gonzalez-Rodriguez et al., 2019). Based on findings from Gonzalez-Rodriguez et al. (2019), social workers in the healthcare setting have moderate to elevated levels of emotional exhaustion and depersonalization, but a relatively sound sense of personal accomplishment.

While Frieiro Padin et al.'s (2021) work was a literature review and Gonzalez-Rodriguez et al. (2019) conducted a quantitative study, Li's (2022) research was qualitative. Li (2022) explored how burnout impacted 12 Chinese healthcare social workers' role conflict and ambiguity using a qualitative descriptive design. Li (2022) conducted a thematic analysis of data gathered from semi-structured interviews and observation of the social workers' on-the-job behavior. Thematic results showed that healthcare social workers in China experienced substantial problems in two areas: *social worker role ambiguity* and *social worker role conflict*. The ambiguity and conflict stemmed in part from the lack of patients' awareness of the job responsibilities of healthcare social workers. As stated by Li (2022), "Healthcare social workers are not a formal career at hospitals, and people know little about their roles ... this has led to great frustration among social workers" (p. 3). Additional factors that contributed to healthcare social workers' role ambiguity and conflict were (a) the clients' inability to engage with the social workers, including participating in interventions; (b) lack of time during the

work shift to engage in work responsibilities adequately; and (c) lack of evaluation protocols and standards that outline the roles and responsibilities of social workers working in hospital settings in China. Li's (2022) research underscored the relevance of role ambiguity and conflict in contributing to burnout among healthcare social workers.

Burnout among Social Workers during COVID

Burnout predictors and symptoms in healthcare systems were on display for all to see during the infancy of COVID-19. A strained healthcare system facing a global pandemic could be a 'hotbed' for symptoms of burnout, especially those on the front lines (Gomez-Garcia et al., 2020; Martinez-Lopez et al., 2021; Reitz, 2021). During COVID-19, laypersons, patients, families, and professionals could see and interpret burnout symptoms in real time, from a lack of materials needed for patient care to a lack of resources to mitigate or offset healthcare professionals' daily stress (Martinez-Lopez et al., 2021; Reitz, 2021). Shuttering businesses and quarantine mandates reduced personal gatherings/supports, and activities that could be considered outlets to release stress (Reitz, 2021). Increased organizational support during unprecedented crises, such as the COVID-19 pandemic, helps prevent burnout symptoms and anxiety (Kranke et al., 2023; Lewinson et al., 2023).

Recent international research using the MBI conducted in Spain examined burnout rates among social workers, including those working in healthcare, during the COVID-19 pandemic (Gomez-Garcia et al., 2020; Martinez-Lopez et al., 2021). Gomez-Garcia et al. (2020) utilized the MBI to document the burnout rates among 947 (87% female) Spanish social workers, finding that 33% had scores indicating elevated levels of

emotional exhaustion, 21% had high depersonalization scores, and 54% reported a significantly reduced sense of personal accomplishment, based on low scores. Gomez-Garcia et al. (2020) further found that full-time employment was predictive of high rates of depersonalization, and being specialized in healthcare social work predicted a low sense of personal accomplishment. In their quantitative study with a sample of 273 (89% female) Spanish social workers during the beginning of the COVID pandemic, Martinez-Lopez et al. (2021) found higher rates, likely due to the severity of the pandemic: 70% of the social workers noted that they had high levels of emotional exhaustion, 49% reported high rates of depersonalization, and 37% stated a significantly reduced sense of personal accomplishment (Martinez-Lopez et al., 2021). Considering the percentages reported by Gomez-Garcia et al. (2020) and Martinez-Lopez et al. (2021), social workers in Spain during COVID-19 had high rates of burnout. Research on burnout in social work during the COVID pandemic not only highlighted the increasing burnout rates among this labor population but also documented the lack of an adequate organizational response to healthcare social workers' burnout rates (Kranke et al., 2023; Lewinson et al., 2023).

Effects of Burnout on Social Workers' Physical and Mental Health

Few topics have received such empirical attention as the health and mental health effects of burnout among healthcare workers and those in helping professions. Indeed, Freudenberger (1974) and Maslach (1981) were the first ones to identify the mental (e.g., anxiety, irritability) and physical (e.g., fatigue, excessive or decreased sleep) symptoms of burnout. Burnout has been shown to negatively impact the health of healthcare and helping professionals: the increased emotional exhaustion and depersonalization and

reduced sense of personal efficacy elements of burnout have been shown to predict poor sleeping and eating habits and increased risk for gastrointestinal (e.g., ulcers, poor appetite), neurological (e.g., headaches, insomnia) and cardiovascular (e.g., tachycardia, hypertension) issues (Brand et al., 2017; Lizano, 2015; Maslach, 2017; O'Connor et al., 2018; Yang & Hayes, 2020) and reduced use of health services (Tuithof et al., 2017). Studies have also consistently documented that burnout contributes to increased psychological distress, psychosomatic issues, anxiety, depression, and even PTSD in healthcare workers and mental health professionals (Brand et al., 2017; Chirico et al., 2021; Huang & Simha, 2018; Khammisa et al., 2022; Lizano, 2015; Maslach, 2017; O'Connor et al., 2018; Tuithof et al., 2017; Yang & Hayes, 2020). There are numerous negative physical and mental health consequences of burnout for helping professionals (Maslach, 2017; O'Connor et al., 2018; Tuithof et al., 2017; Yang & Hayes, 2020).

Research has documented the adverse effects of burnout on social workers' mental health (Mak et al., 2021; Tsaras et al., 2019; Wu et al., 2022). In a unique study that examined the relationship between burnout (assessed using the MBI) and the outcomes of depression and generalized pain across different Hungarian helping professionals (i.e., 300 social workers, 399 teachers, 399 paramedics, 35 doctors, and 68 medical assistants), Mak et al. (2021) found that the relationship between burnout and depression (*Odds Ratio* = 2.56, $p < .001$) and burnout and generalized pain (*Odds Ratio* = 2.40, $p < .01$) was most predictive for the sample of 300 social workers. Tsaras et al. (2019) examined the linkages between the three burnout dimensions and numerous mental health outcomes in a study with 123 Greek social workers (81% female).

Correlational findings from Tsaras et al. (2019) showed that (a) emotional exhaustion significantly predicted anxiety ($r = .43, p < .001$), depression ($r = .25, p < .01$), and poor mental functioning ($r = .52, p < .001$); depersonalization significantly predicted anxiety ($r = .22, p < .05$), depression ($r = .31, p < .001$), and poor mental functioning ($r = .26, p < .01$); and (c) a reduced sense of personal efficacy emotional exhaustion significantly predicted anxiety ($r = .27, p < .01$), depression ($r = .44, p < .001$), and poor mental functioning ($r = .44, p < .001$).

Wu et al. (2022) explored burnout and mental and physical health outcomes in 182 Chinese social workers (92% female) during the COVID-19 pandemic. Conducting SEM, Wu et al. (2022) utilized the MBI to assess burnout as a latent construct, finding that higher levels of burnout significantly predicted reduced levels of well-being ($\beta = -.60, p < .05$) and increased rates of negative emotions ($\beta = -.33, p < .05$). Empirical evidence consistently confirms the adverse effects of burnout on social workers' physical and mental health (Mak et al., 2021; Tsaras et al., 2019; Wu et al., 2022).

Few current studies have documented the damaging physical and psychological consequences of burnout specific to samples of social workers (Mak et al., 2021; O'Connor et al., 2018; Tsaras et al., 2019; Wu et al., 2022). The research specific to healthcare social workers is even more limited (Frieiro Padin et al., 2021). In their literature review on healthcare-related burnout, Frieiro Padin et al. (2021) found only four studies published since 2000 that examined linkages between burnout and well-being. Findings were consistent across studies, with research showing that burnout was predictive of depression, anxiety, memory issues, and poor health ($rs > .25, ps < .001$)

(Frieiro Padin et al., 2021). The consistent negative emotional consequences of burnout among healthcare social workers led Frieiro Padin et al. (2021) to state a need for studies, especially those using qualitative and “multi-method methodologies” that “address the reality” of burnout as experienced by healthcare social workers (p. 1063).

Effects of Burnout on Social Workers’ Organizational and Work Outcomes

There is a small body of empirical work examining the effects that burnout has on organizational and work outcomes among social workers (Brown et al., 2019; Falce, 2022; Kang, 2012; Kuok, 2022), with very few focusing on healthcare social workers (Frieiro Padin et al., 2021). The burnout research specific to work and job outcomes is piecemeal and conducted with diverse methods, samples, and instruments (Brown et al., 2019; Falce, 2022; Frieiro Padin et al., 2021; Kang, 2012; Kuok, 2022). However, studies have confirmed that burnout can negatively affect organizational outcomes (Brown et al., 2019; Falce, 2022; Kuok, 2022).

Burnout and Organizational Commitment. Most organizational empirical literature on burnout has examined corporate or work commitment among social workers (Brown et al., 2019; Falce, 2022; Kang, 2012; Kuok, 2022). Kang (2012), in an early quantitative correlational study with 342 (70% female) Korean social workers, used the MBI to measure the components of burnout (i.e., emotional exhaustion, depersonalization, and diminished personal accomplishment) and examined their links to organizational commitment and organizational citizen behaviors. Results from structural equation modeling (SEM) analyses showed that all three elements of burnout (i.e., emotional exhaustion, $\beta = -.25, p < .05$; depersonalization, $\beta = -.45, p < .05$; and

diminished personal accomplishment, $\beta = -.19, p < .05$) were significantly predictive of organizational commitment: as burnout increased, social workers' organizational commitment decreased (Kang, 2012). Moreover, depersonalization ($\beta = -.37, p < .05$) and diminished personal accomplishment ($\beta = -.19, p < .05$) were negatively and significantly predictive of organizational citizenship behavior (Kang, 2012). Kang's (2012) early findings suggested significant associations between high burnout levels and low organizational commitment and citizenship behaviors.

There has been additional and more current research by Brown et al. (2019), Tan and Yeap (2021), Falce (2022), and Tu et al. (2022) that supported the early findings by Kang (2012). Brown et al. (2019) conducted a quantitative correlational study with 1,786 (81% female) social workers across the United States, assessing if burnout was significantly associated with their organizational commitment. Brown et al.'s study (2019) measured burnout using CBI, a self-developed corporate commitment instrument employed to assess work commitment. Utilizing SEM, the authors found that healthcare social workers' burnout was significantly and negatively predictive of their organizational commitment ($\beta = -.38, p < .05$): as burnout increased, organizational commitment decreased (Brown et al., 2019). Tan and Yeap (2021) found negative and significant relationships between the three components of burnout (i.e., depersonalization, $\beta = -.26, p < .01$; emotional exhaustion, $\beta = -.67, p < .001$; and minimized personal accomplishments, $\beta = -.67, p < .001$), assessed using the MBI, and work engagement, measured using the Utrecht Work Engagement Scale (UWES), in a quantitative correlational study with 530 healthcare social workers (93% female) in New

Zealand. Utilizing a self-developed instrument to assess burnout and organizational commitment, Falce (2022) examined the linkages in a quantitative correlational study with 151 (64% female) healthcare social workers in Brazil. SEM findings revealed a highly significant association between burnout and organizational commitment ($\beta = -.70$, $p < .001$), with commitment decreasing as burnout increased. Studies have shown that, despite having different samples of social workers, there are significant linkages between burnout and organizational commitment among healthcare social workers (Brown et al., 2019; Falce, 2022; Tan & Yeap, 2021; Tu et al., 2022).

As “the social work industry has grown exponentially in tandem with China’s increasing economy” (Tu et al., 2022, p. 1), there has been emerging research on burnout and organizational commitment among Chinese healthcare social workers (Kuok, 2022; Tu et al., 2022). Kuok (2022), in a study with 199 Chinese social workers (80% female), explored the relationships between the three components of burnout measured by the MBI (i.e., emotional exhaustion, depersonalization, and diminished personal accomplishment) and organizational commitment, assessed using the Organizational Commitment Scale (OCS) as well as job satisfaction, measured using the Job Descriptive Index (JDI). Correlational findings showed that as social workers’ emotional exhaustion ($r = -.33$, $p < .05$), depersonalization ($r = -.27$, $p < .05$), and diminished personal accomplishments ($r = -.28$, $p < .05$) increased, their work commitment decreased. Tu et al. (2022), in a study with 537 Chinese social workers (85% female), utilized the Oldenburg Burnout Inventory (OBI) and the UWES-9 to assess the relationship between burnout and work engagement. Tu et al.’s (2022) correlational findings indicated a highly

significant correlation between burnout and work engagement ($r = .51, p < .001$). The findings are consistent in the literature: burnout is significantly predictive of lower organizational commitment among healthcare social workers, despite differences in samples and instruments utilized (Brown et al., 2019; Falce, 2022; Kang, 2012; Kuok, 2022; Tu et al., 2022).

Burnout and Other Organizational Outcomes. The organizational literature on job outcomes other than organizational commitment is sparse and varied, with scholars examining such outcomes as job-related demands, work-related support, satisfaction, and turnover/quit intentions (Evans et al., 2006; Gómez-García et al., 2021; Sanchez et al., 2018; Travis et al., 2016). In an early study with 145 (61% female) social workers in the United Kingdom, Evans et al. (2006) examined differences in perceived job demands and work social support using the MBI to assess the three components of burnout. Evans et al. (2006) categorized the participants by burnout rates: of the 145 participants, 55.8% had high emotional exhaustion and reduced personal accomplishment, while 58.6% had high rates of depersonalization. Conducting a series of one-way ANOVAs, Evans et al. (2006) found that social workers with increased rates of emotional exhaustion and depersonalization and low rates of personal accomplishments reported a significantly higher number of job-related demands ($M = 2.64$) and lower levels of work-based social support ($M = 21.03$) as compared to those with low job-related demands ($M = 2.19$, social support $M = 23.00$) or moderate (job-related demands $M = 1.97$, social support $M = 24.50$) rates. Evans et al.'s (2006) findings showed that burnout can result in an increased sense of job demands and reduced support.

One study by Sanchez et al. (2018) examined social workers' burnout about their job satisfaction (Sanchez et al., 2018). Sanchez et al. (2018), using the MBI in a study with 59 prison social workers in Spain, found significant correlations between emotional exhaustion and overall job satisfaction ($r = .34, p < .01$) and a reduced sense of personal accomplishments and overall job satisfaction ($r = .32, p < .05$); however, the relationship between depersonalization and job satisfaction was not significant ($\beta = .06, p > .05$). Sanchez et al.'s (2018) small sample size possibly influenced the findings.

Additional research has explored relationships between burnout and turnover/quit intentions (Frieiro Padin et al., 2021; Travis et al., 2016). In a three-year longitudinal study with 362 child welfare social workers in the United States, Travis et al. (2016) explored the predictive relationship between burnout, measured using just the emotional exhaustion and depersonalization subscales of the MBI, and job exit-seeking behaviors. Path analysis findings showed that emotional exhaustion significantly predicted exit-seeking behaviors ($\beta = .27, p < .05$); depersonalization was also considerably predictive of exit-seeking behaviors ($\beta = .19, p < .05$) (Travis et al., 2016). In their literature review, Frieiro Padin et al. (2021) reported on three (out of 14, 21%) studies documenting the adverse effects of burnout on turnover intentions in samples of healthcare social workers. All three studies discussed by Frieiro Padin et al. (2021) found that higher burnout rates significantly predicted increased turnover intentions, with one study (Pugh, 2016) reporting that burnout explained 21% of the variance in turnover intentions.

More current research on burnout and quit intentions has been conducted with Chinese social workers (Jia & Li, 2022; Wang et al., 2021). Wang et al. (2021), in a study

with 616 Chinese social workers, found that the three components of burnout as measured by the MBI (i.e., emotional exhaustion, $\beta = .26, p < .01$; depersonalization, $\beta = .34, p < .01$; reduced sense of personal accomplishment, $\beta = .18, p < .01$) significantly predicted increased quit intentions, with depersonalization being the most significant ($\beta = .34, p < .01$). Wang et al. (2021) found that burnout, measured globally using the MBI, significantly predicted increased turnover intentions ($\beta = .31, p < .001$) in a sample of 1,414 Chinese social workers. There is empirical evidence of the hostile work outcomes, including increased quit/turnover intentions, of burnout among social workers (Frieiro Padin et al., 2021; Jia & Li, 2022; Wang et al., 2021).

Perceived Organizational Support (POS)

POS is the core concept of Eisenberger and colleagues' (Eisenberger et al., 1986, 2020; Kurtessis et al., 2015; Rhoades & Eisenberger, 2002) perceived organization support theory (POST). The POST was informed by social exchange theory, with Eisenberger et al. (1986) applying it to the organization, positing that the employee exchanges their "effort and loyalty" to the company for "tangible benefits and social resources" offered by the organization (Kurtessis et al., 2015, p. 3). Through this social exchange, the employee views the organization as they would with others in social relationships: they personify and develop cognitive attributions about the organization (Eisenberger et al., 1986, p. 500). POS is a cognitive attribution, a belief made by the employee that the organization *values* their talent, time, efforts, and contributions and *cares* about their well-being (Eisenberger et al., 1986, 2020; Kurtessis et al., 2015; Rhoades & Eisenberger, 2002). As the employee feels valued and cared for, their POS

“fulfills [their] socioemotional needs” and leads to their increased identification with and commitment to the organization (Kurtessis et al., 2015, p. 3).

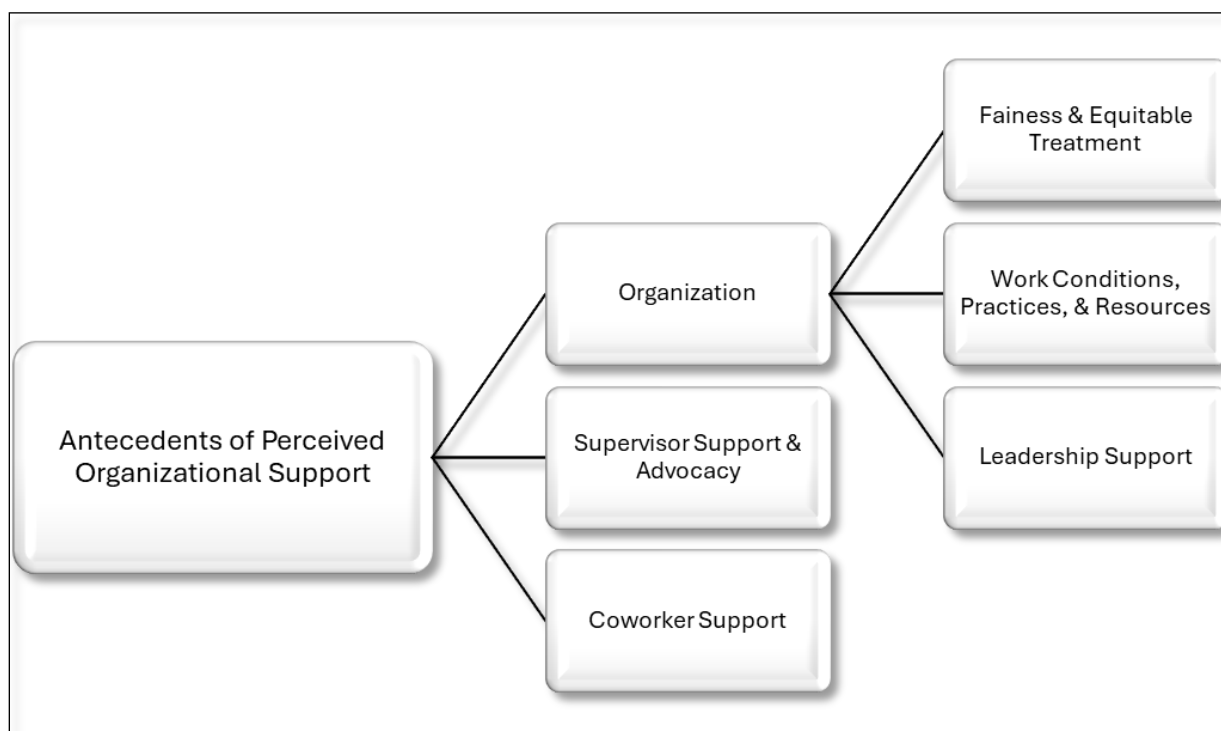
The degree to which employees believe their employer values and cares for them is driven by organizational, supervisor, and coworker factors. Eisenberger et al. (2020) identified and defined these organizational, supervisor, and coworker factors as antecedents of POS (see Figure 2). Three antecedents of POS are at the organizational level: (a) fairness and equitable treatment; (b) work conditions, practices, and resources; and (c) leadership support (Eisenberger et al., 2020; Kurtessis et al., 2015; Sun, 2019). Organizational fairness and equitable treatment emphasize the importance of “treating employees with dignity and respect” and pertain to actions of the organization concerning distributive (i.e., the distribution of resources) and procedural (i.e., fair decision-making and transparency) justice. Work conditions, practices, and resources concern organizational practices regarding employees’ pay and promotion, job security, and support around balancing work with family obligations (Eisenberger et al., 2020; Kurtessis et al., 2015). Human resources (HR) are vital in work conditions, practices, and resources (Eisenberger et al., 2020; Kurtessis et al., 2015). Leadership support is the third organizational antecedent of POS, and it concerns the directive actions and supportive attitudes and behaviors of those running the organization (Eisenberger et al., 2020).

There are additional antecedents of POS: *supervisor support*, *advocacy*, and *coworker support* (Eisenberger et al., 2020; see Figure 2). The supervisor's antecedent of POS pertains to types of support offered by the supervisor, including (a) emotional (e.g., active listening), (b) informational (e.g., guidance), (c) appraisal (e.g., providing

feedback), and (d) instrumental (e.g., task support). Supervisor advocacy pertains to fair treatment and actions surrounding employee promotions or demotions; advocacy also entails the supervisor's actions as a mediator between the employee and administrators in higher positions (Eisenberger et al., 2020; Sun, 2019). The final antecedent of POS is coworker support, which encompasses fair treatment and emotional, informational, appraisal, and instrumental support (Eisenberger et al., 2020).

Figure 1

Perceived Organizational Support: Organizational, Supervisor, and Coworker Antecedents



Note. Original figure, with information obtained from “Perceived organizational support: Why caring about employees counts,” by R. Eisenberger, L. Rhoades Shanock, and X. Wen, 2020, *Annual Review of Organizational Psychology and Organizational Behavior*, 7, 101-124. <https://doi.org/10.1146/annurev-orgpsych-012119-044917>; “Perceived organizational support: A meta-analytic evaluation of

organizational support theory, “by J. N. Kurtessis, R. Eisenberger, M. T. Ford, L. C. Buffardi, K.A. Stewart, and C. S. Adis, 2017, *Journal of Management*, 43(6), 1854-1884. <https://doi.org/10.1177/0149206315575554>; and “Perceived organizational support: A literature review,” by L. Sun, 2019, *International Journal of Human Resource Studies*, 9(3), 155-175. <https://ideas.repec.org/a/mth/ijhr88/v9y2019i3p155-175.html>

Perceived Organizational Support (POS) and Beneficial Professional Outcomes

The empirical literature on the beneficial employee outcomes of POS is substantial enough to warrant numerous meta-analyses and literature reviews (Ahmed et al., 2015; Kurtessis et al., 2017; Onn & Lung, 2014; Prysmakova & Lallatin, 2023; Rockstuhl et al., 2020); Conducting random effects K analyses (with the ρ population correlation reported) of the data from 492 empirical research articles on POS published between 1986 and 2011, Kurtessis et al. (2017) found that, across 492 studies, POS predicted employees’ positive orientation toward work and organization, proactive work-based based behavior, and work-based well-being; Most predictive in the work/organizational outcomes domain were employee trust in the organization ($\rho = .75, p < .001$), management ($\rho = .74, p < .001$), and employee affective commitment. POS was most predictive of employee job satisfaction ($\rho = .65, p < .001$) and job-based self-esteem ($\rho = .53, p < .001$) of all the mental health outcomes. Notably, POS significantly and negatively predicted burnout ($\rho = -.46, p < .001$) and emotional exhaustion ($\rho = -.47, p < .001$). POS had the most robust predictive relationships with the behavior outcome of quit intentions ($\rho = -.51, p < .001$) and employee organizational citizenship behavior ($\rho = .42, p < .001$). Interestingly, the most substantial effects of POS were seen on work/organizational outcomes (based on the ρ population correlation reported). At the

same time, its influence was equivalent to employees' mental health and behavior outcomes (Kurtessis et al., 2017).

Kurtessis et al.'s (2017) POS employee outcomes categories of employee orientation toward work/organization, well-being, and behavioral outcomes have been validated by Sun (2019) in a review of the empirical literature on POS and by Prysmakova and Gallatin (2023) in their meta-analysis. Furthermore, Rockstuhl et al. (2020), using data from 827 studies across 45 countries, confirmed the positive POS effects on employee outcomes, with the relationships being more pronounced in Western countries. The impact of POS on numerous employee outcomes has been confirmed in empirical literature (Ahmed et al., 2015; Kurtessis et al., 2017; Prysmakova & Lallatin, 2023; Rockstuhl et al., 2020; Sun, 2019).

Figure 2

Perceived Organizational Support: Employee Orientation toward Work/Organization

Outcomes, Employee Work-Based Well-Being Outcomes, and Employee Work-Based Behavioral Outcomes

Employee Orientation toward Work/Organization Outcomes	Employee Work-Based Well-Being Outcomes	Employee Work-Based Behavioral Outcomes
<ul style="list-style-type: none"> •Employee-Organization Exchange <ul style="list-style-type: none"> •Social •Economic •Employee felt obligation •Employee identification with the organization •Employee commitment <ul style="list-style-type: none"> •Affective •Normative •Employee job involvement •Employee Trust <ul style="list-style-type: none"> •Organization •Supervisor •Management •Coworkers 	<ul style="list-style-type: none"> •Work-family balance/conflict •Job Stress •Job-based self-esteem •Job self-efficacy •Job satisfaction •Burnout <ul style="list-style-type: none"> •Emotional exhaustion 	<ul style="list-style-type: none"> •Job effort/performance •Organizational citizenship behavior •Counterproductive work behavior •Work withdrawal activities <ul style="list-style-type: none"> •Absenteeism •Tardiness •Quit intentions •Job seeking behavior •Turnover

Note. Original figure, with information from “Perceived organizational support: A meta-analytic evaluation of organizational support theory,” by J. N. Kurtessis, R. Eisenberger, M. T. Ford, L. C. Buffardi, K.A. Stewart, and C. S. Adis, 2017, *Journal of Management*, 43(6), 1854-1884.

<https://doi.org/10.1177/0149206315575554>; and “Perceived organizational support in public and nonprofit organizations: Systematic review and directions for future research,” by P. Prysmakova and N. Lallatin, 2023, *International Review of Administrative Sciences*, 89(2), 467-483.

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Perceived Organizational Support (POS) and Burnout among Social Workers

The literature on POS and burnout among social workers is sparse and primarily quantitative. As with the research on burnout, the empirical work on POS is complicated by measurement: it can be assessed as a global construct, or the various dimensions of

POS can be evaluated (Kurtessis et al., 2017). The POS quantitative research has primarily utilized Eisenberger et al.'s (1986) Survey of Perceived Organizational Support (see Figure 4), which captures only two (i.e., organizational fairness and equitable treatment and organizational rewards, resources, and conditions) of the five POS dimensions (Jolly et al., 2021). Aspects related to organizational leadership, supervisor support and advocacy, and coworker support are not measured on the SPOS, limiting the generalizability of findings in studies using the measure (Jolly et al., 2021).

Figure 3

Eisenberger et al.'s (1986) Survey of Perceived Organizational Support

Item
1. The organization values my contribution to its well-being.
2. The organization strongly considers my goals and values.
3. Help is available from the organization when I have a problem.
4. The organization really cares about my well-being.
5. The organization wishes to give me the best possible job for which I am qualified.
6. The organization cares about my general satisfaction at work.
7. The organization takes pride in my accomplishments at work.
8. The organization would forgive an honest mistake on my part.
9. The organization is willing to extend itself to help me perform my job to the best of my ability.
10. The organization cares about my opinions.

Note. From “Perceived organizational support,” by R. Eisenberger, R. Huntington, S. Hutchison, and D. Sowa, 1986, *Journal of Applied Psychology*, 71(3), 500–507, <https://doi.org/10.1037/0021-9010.71.3.500>. Copyright 2020 by Journal of Applied Psychology. Reprinted with permission.

Quantitative Research. The literature on POS and burnout among social workers is remarkably lacking, with a review of the literature revealing few studies, most of which were quantitative (Frazier, 2020; Fukui et al., 2019; Myrvang, 2020; Pavone, 2018; Stanley & Sebastian, 2023). Some research (Myrvang, 2020; Pavone, 2018) has assessed

POS as a global construct using Eisenberger et al. (1986). SPOS. Pavone (2018) set POS using the SPOS and burnout using the MBI in a quantitative correlational study with 100 (79% female) social workers in Missouri. Results from Pavone's (2018) correlational analyses showed that increased levels of POS were significantly predictive of reduced levels of emotional exhaustion ($r = -.21, p < .001$) and depersonalization ($r = -.35, p < .05$) and an increased sense of lack of personal accomplishment ($r = .31, p < .001$). In a quantitative correlational study with 450 (81% female) Indian healthcare social workers by Myrvang (2020), the researcher used the SPOS to measure POS; burnout was measured using the full-scale MBI. Correlational analyses showed that higher levels of POS were significantly associated with lower levels of overall burnout ($r = -.56, p < .05$); increased burnout rates were furthermore considerably related to higher levels of emotional exhaustion ($r = -.56, p < .05$), increased desensitization ($r = -.52, p < .05$), and a decreased sense of personal accomplishment ($r = -.60, p < .05$). Pavone's (2018) and Myrvang's (2020) findings indicated a significant link between POS and all components of burnout in social workers.

In some research with social workers, POS has been operationally defined as supervisor support (Frazier, 2020; Fukui et al., 2019; Stanley & Sebastine, 2023). Fukui et al. (2019), in their quantitative study with 195 direct care social workers, measured supervisor support using the Survey of Perception of Supervisory Support (SPSS). Burnout was assessed as emotional exhaustion using the MBI subscale (Fukui et al., 2019). Results from growth curve modeling indicated a significant relationship between higher levels of supervisor support and reduced rates of burnout ($\beta = .12, p < .05$). The

relationship between POS, measured as supervisor support using the Multidimensional Scale of Perceived Social Support (MSPSS), and burnout, assessed using the burnout subscale of the Professional Quality of Life Scale (PQLS), was the focus of Stanley and Sebastine's (2023) quantitative correlational study with 73 (54% female) direct care social workers in India. Results of Stanley and Sebastine's (2023) study showed a significant correlation between higher supervisor support and decreased levels of burnout ($r = -.43, p < .01$). Despite the minimal empirical work on POS and burnout in social workers, there is evidence that one component of POS, supervisor support, contributes to reduced rates of burnout (Fukui et al., 2019; Myrvang, 2020; Stanley & Sebastine, 2023).

One of the most comprehensive examinations of POS and burnout among social workers was a dissertation conducted by Frazier (2020), who assessed POS as organizational support, measured using the SPOS, and supervisor support, evaluated using the SPSS. Fraizer (2020) utilized the MBI to measure the three components of burnout (i.e., emotional exhaustion, depersonalization, and a reduced sense of personal accomplishment). Conducting hierarchical multiple linear regression from data gathered from 115 (91% female) social workers, Frazier (2020) found that both organizational support ($\beta = -.18, p < .05$) and supervisor support ($\beta = -.23, p < .05$) were significantly predictive of emotional exhaustion. Organizational support was also significantly related to depersonalization ($\beta = -.12, p < .05$). However, neither organizational support nor supervisor support was significantly predictive of a decreased sense of personal accomplishment (Frazier, 2020). Frazier's (2020) results suggested that POS may differentially impact aspects of burnout.

Qualitative Research. POS about burnout has received minimal qualitative attention, and a literature review revealed no studies examining social workers' perceptions of their organization's support regarding their burnout. A work relevant to this study was Howard's (2015) dissertation, the topic of which was organizational support related to professional burnout. Howard (2015) conducted a qualitative descriptive study with eight social workers in Minnesota. Thematic analysis of semi-structured interviews revealed six themes. The first was a *lack of organizational awareness* of the social worker's trauma, as noted by 100% of the participants (Howard, 2015). The second and third themes were the *importance of supervisory and coworker support*, which were reported by 100% of the participants (Howard, 2015). The fourth theme concerned the *importance of training*, noted by 75% of the participants. The fifth theme emphasized the *importance of an organizational culture of support*, reported by 62.5% of the participants. The sixth and last theme was the *impact on client services*, with 62,5% of participants voicing their concern that the lack of organizational support for their professional burnout had negative implications for their clients (Howard, 2015).

An additional qualitative study was conducted by Levesque and Negura (2021), who examined the impact of organizational constraints on personal distress as experienced by 30 female healthcare social workers in Canada. Thematically analyzing data from semi-structured interviews, in which the participants discussed their perceptions of the organization, its provisions, supports, and constraints within their work distress, Levesque and Negura (2021) found three overarching themes. The first theme was *hardships related to time, resources, and workload*, noted by 49% of the

participants: the social workers had limited time and resources to do their work, which was excessive. The second theme was *conflicts between the social worker and management*, as noted by 67% of the participants: the social workers voiced concerns surrounding management's perceived lack of care, guidance, training, and supervision. The third theme was *paradoxical autonomy*, or confusion surrounding one's professional role, reported by 96% of the participants. Levesque and Negura's (2021) findings emphasized the negative consequences of organizations that lack a climate of support and place constraints on their employees.

Summary

The problem addressed in this generalized qualitative study is the lack of qualitative research that has explored female healthcare social workers' descriptions of their perceived organizational supports (POS) regarding burnout. The rationale for the study was supported by the literature reviewed in this section. The literature review opened with a presentation on burnout, which has a history of over 70 years and emerged from workplace issues that impacted the human services field starting in the late 1960s (Schaufeli, 2017). Attention was given to the definitions of burnout described by Freudenberger (1974), who is recognized for developing the concept of burnout, and Maslach (1981), whose work on burnout has informed much of the literature. Maslach (1981) posited that burnout, a result of a mismatch between the employee and the organization, comprises three dimensions: emotional exhaustion, depersonalization, and a lack of a sense of personal accomplishment. Burnout and its three dimensions are often

assessed by the Maslach Burnout Inventory (MBI), validated by Maslach in 1981, and give the construct theoretical and empirical credibility.

The elevated levels of burnout among those in the helping profession have led to an examination of the rates, context, and meaning of burnout among social workers (Kimes, 2016; Li, 2022; Martinez-Lopez et al., 2021). When trying to establish how well-represented the phenomenon of burnout is with social workers in general and specifically healthcare social workers, numbers vary (Frieiro Padin et al., 2021; Kimes, 2016). Burnout in the social work field – and especially among healthcare social workers - is treated and discussed as a ‘well-known secret’ (Frieiro Padin et al., 2021; Lewinson et al., 2023). However, the research on burnout among social workers has indicated that social workers experience higher rates of burnout than their peers (Frieiro Padin et al., 2021; Kimes, 2016).

There is consistent evidence that burnout has physical and psychological consequences, with higher rates of burnout being significantly predictive of gastrointestinal, neurological, and cardiovascular issues (Brand et al., 2017; Lizano, 2015; Maslach, 2017; O’Connor et al., 2018; Yang & Hayes, 2020), reduced use of health services (Tuithof et al., 2017), and anxiety, depression, and even PTSD, in healthcare workers and mental health professionals (Brand et al., 2017; Chirico et al., 2021; Huang & Simha, 2018; Khammisa et al., 2022; Lizano, 2015; Maslach, 2017; O’Connor et al., 2018; Tuithof et al., 2017; Yang & Hayes, 2020) and social workers (Mak et al., 2021; O’Connor et al., 2018; Tsaras et al., 2019; Wu et al., 2022). The burnout research specific to social workers’ work attitudes and behaviors is piecemeal

and conducted with diverse methods, samples, and instruments (Brown et al., 2019; Falce, 2022; Frieiro Padin et al., 2021; Kang, 2012; Kuok, 2022). However, studies have confirmed that burnout can negatively affect organizational outcomes (Brown et al., 2019; Falce, 2022; Frieiro Padin et al., 2021; Kang, 2012; Kuok, 2022).

POS can reduce burnout (Frazier, 2020; Fukui et al., 2019; Myrvang, 2020; Pavone, 2018; Stanley & Sebastine, 2023). The concept of POS was developed by Eisenberger and colleagues, who defined it as a cognitive attribution of employees in which they perceive that their talent, time, and efforts – and their well-being – by the employing organization is valued and cared for (Eisenberger et al., 1986, 2020; Kurtessis et al., 2015; Rhoades & Eisenberger, 2002). According to Eisenberger et al. (1986, 2020), POS comprises five dimensions. Three dimensions of POS are at the organizational level: (a) organizational fairness and equitable treatment, (b) organizational rewards, resources, and conditions, and (c) organizational support (Eisenberger et al., 1986, 2020). The remaining two are supervisor, advocacy, and coworker support (Eisenberger et al., 1986, 2020).

There is remarkably little research on social workers' perceptions of POS and minimal examination of POS and burnout among social workers. The existing quantitative studies have documented that increased levels of POS contribute to decreased burnout (Frazier, 2020; Fukui et al., 2019; Myrvang, 2020; Pavone, 2018; Stanley & Sebastine, 2023). Two qualitative studies (Howard, 2015; Levesque & Negura, 2021) explored POS about burnout, with both researchers documenting a lack of organizational support, which may have implications for social workers' work

engagement and subsequent client outcomes. There is a need for research that explores social workers' POS within the context of their burnout. No study to date has explored female healthcare social workers' perceptions of not just the availability and accessibility of POS regarding burnout, but also their descriptions and level of satisfaction with the POS made available to them during times of duress.

Section 2: Research Design and Data Collection

Introduction

The problem addressed in this generic qualitative study is that female healthcare social workers experience elevated rates of burnout but may not receive adequate perceived organizational support (POS) to help ameliorate burnout. The study is designed to address the lack of qualitative research that has explored female healthcare social workers' descriptions of burnout and their POS surrounding burnout. This study addresses an empirical gap pertinent to the empirical literature on burnout and POS among social workers, and it will shed light on healthcare social workers' descriptions of burnout and the potential organizational supports that could reduce their burnout. Findings from this study can inform policy changes and initiatives aimed at reducing burnout and improving POS, enhancing healthcare social workers' mental health and resilience.

Section 2 opens with an introduction. Section 2 then continues with a presentation of the research design, which is the generic qualitative design. The study methodology, including the constructs examined and data to be collected, participants, and instrumentation, is then summarized. The proposed data analysis is reviewed, followed by a discussion of the ethical procedures to be employed in the study. Section 2 ends with a summary.

Research Design

The problem addressed in this generic qualitative study is that female healthcare social workers experience elevated rates of burnout but may not receive adequate

perceived organizational support (POS) to help ameliorate burnout. This generic qualitative study aims to explore female healthcare social workers' descriptions of burnout and POS surrounding burnout. Burnout is emotional and psychological distress resulting from workplace stressors, typified by emotional exhaustion, depersonalization, and a decreased sense of personal accomplishment (Maslach & Leiter, 2017). As demonstrated by organizational, supervisor, and coworker factors, POS pertains to an employee's perception that they are valued and cared for by the employer (Eisenberger et al., 2020). The nature of the study is qualitative, and the study will employ a generic qualitative design to address the study's two RQs:

RQ1. What are female healthcare social workers' descriptions of burnout?

RQ2. What are female healthcare social workers' descriptions of their perceived organizational supports (POS) regarding burnout?

The generic qualitative design is a fitting approach for this study, as it intends to capture social workers' descriptions of burnout and POS surrounding burnout. The generic qualitative design, also known as the qualitative descriptive design, allows researchers to obtain straightforward yet rich descriptions of a poorly understood and under-researched phenomenon(a) as apprehended by a specific social group (Kim et al., 2017; Magilvy & Thomas, 2009; Sandelowski, 2000, 2010). This study will advance understanding of female healthcare social workers' burnout and POS surrounding burnout, phenomena that have received minimal attention in the empirical literature on social work. The generic qualitative design is distinct in that it is used to capture participants' descriptions - not their interpretations - of a social phenomenon(a) "in

everyday terms” (Sandelowski, 2000, p. 336). Capturing female healthcare social workers’ descriptions of their burnout and POS surrounding burnout is the study's intent; it will not detail participants’ interpretations (e.g., internal states or subjective thoughts). Generic qualitative studies have sample sizes “smaller than in other qualitative designs” – as few as three and as many as 15 (Magilvy & Thomas, 2009, p. 299). The sample size in this study is small: 14 female healthcare social workers. Data are typically obtained through semi-structured interviews and analyzed using content or thematic analysis in generic qualitative studies (Kim et al., 2017; Sandelowski, 2000, 2010). The data source in this study will be semi-structured interviews with the social workers, and the interviews will be transcribed and analyzed using Braun and Clarke’s (2006) six-step thematic analysis. The study meets the requirements for a generic qualitative study.

Methodology

The methodology in this generic qualitative study involves collecting data from semi-structured interviews with 14 female healthcare social workers from the southeast region of the United States. The sample of participants in this study will represent the general population of female healthcare social workers in the United States. According to the Bureau of Labor Statistics (2022), approximately 180,000 healthcare social workers, of whom over 70% are female, advocate for the health and well-being of vulnerable populations in various medical, hospital, and nursing settings. The study constructs under examination are burnout, or psychological distress due to workplace stressors characterized by emotional exhaustion, depersonalization, and a decreased sense of personal accomplishment (Maslach & Leiter, 2017), and POS, or cognitive attributions of

an employee that their organization values and cares for them, as evidence by organizational, supervisor, and coworker factors (Eisenberger et al., 2020). Data will be collected through semi-structured interviews, and interview data will be transcribed and analyzed using Braun and Clarke's (2006) six-step thematic analysis.

Participants

Generic qualitative research has small sample sizes, often less than other qualitative studies, especially interpretivist ones (Kim et al., 2017; Magilvy & Thomas, 2009). Magilvy and Thomas (2009) stated that generic descriptive studies commonly have between three and 20 participants. Kim et al. (2017) reported that the sample sizes were typically between 11 and 20 participants in their systematic review of 55 generic qualitative descriptive studies in nursing. In generic qualitative studies, *saturation*, or the point at which no added information is gleaned from the data, is usually achieved with a sample size of between 10 and 15 participants (Kim et al., 2017; Sandelowski, 2000, 2010). Based on recommendations regarding sample size for generic qualitative studies (Kim et al., 2017; Magilvy & Thomas, 2009; Sandelowski, 2000, 2010), the sample size for this study is 14 female healthcare social workers.

There are criteria for participation in the study. The participants must meet the study criteria of (a) being an adult, age 18 or older; (b) identifying as the female sex; (c) holding a position of healthcare social worker; and (d) being employed as a healthcare social worker for at least one year. The participants can be of any race/ethnicity and age and can be employed in various healthcare settings, if they hold the position of healthcare social workers.

I employed two sampling plans to achieve the sample size of 14 healthcare social workers. The primary sampling plan for this study was *convenience sampling*.

Convenience sampling is a non-probability (non-random) method commonly used in qualitative research studies (Etikan et al., 2016). Convenience sampling, also called *accidental sampling*, is selecting study participants who meet pre-selected study criteria, are accessible to the researcher, and are willing to participate (Etikan et al., 2016). A secondary sampling plan utilized was *snowball sampling*. Snowball sampling, also called the chain method model of sampling, refers to having existing participants recruit others in their networks who meet the study criteria (Ghaljaie et al., 2017). Snowball sampling was employed in coordination with convenience sampling to achieve the sample size of 14 participants.

I utilized social media groups specifically for social workers and personal contacts to recruit participants. I created a post that contained an invitation to participate in the study, asking that those interested – and who met study criteria – contact me by phone or email. I also sent email invitations to those I knew personally who agreed to participate in the study; from there, I asked participants to share the information with colleagues and other female social workers they knew who also met the study criteria. The invitation email had (a) a brief description and purpose of the study and semi-structured interview (i.e., to gain an understanding of healthcare social workers' burnout and POS regarding burnout); (b) the length of the interview (i.e., 60 to 90 minutes); (c) the available interview modalities (i.e., face-to-face, phone, or Zoom); and (d) the study informed consent form.

Once potential participants were identified, I coordinated the time and modality of the interview with the participant and confirmed the interview day and time one day before the interview. The participant downloaded, completed, and returned the informed consent form before the interview. I completed the interviews in the modality (i.e., Zoom, phone, in person) preferred by the participant. I reminded participants that the interview would be audiotaped but not video recorded. The interview was recorded according to the modality, and a backup recorder was used to capture the information. I followed an interview protocol to ensure the interviews were conducted similarly. At the start of the interview, I asked the participant demographic and work questions included in the study to provide a more comprehensive and descriptive picture of the participants. After the interview, I asked the participants if they had any questions and thanked them for participating.

Instrumentation

The semi-structured interview is the primary data source for the study. A semi-structured interview is an informal, in-depth process commonly used in generic qualitative studies wherein the researcher follows a specific interview protocol (Sandelowski, 2000, 2010). The interview protocol allows the researcher to engage in a focused, structured, and systematic approach to gathering interview data (Sandelowski, 2000, 2010).

I followed the interview protocol, and asked the participants the same core and follow-up questions (see Appendix). Some interview questions inquired about participants' descriptions and experiences of burnout. The questions inquired about

participants': (a) definitions of burnout, severity of burnout, and the physical and mental health consequences of burnout; (b) experiences of emotional exhaustion, depersonalization, and a decreased sense of personal accomplishment; (c) sources of burnout; and (d) the work consequences of burnout. There were also interview questions that asked about participants' experiences of POS in relation to their burnout. Questions pertained to POS in general and the four POS organizational (i.e., fair and equitable treatment, work conditions, practices, and rewards, leadership support), supervisor (i.e., support and advocacy), and coworker (i.e., support) antecedents. The interview protocol is presented in the Appendix.

There is an additional source of data, a brief survey completed by the participants that contains demographic and work questions asked for descriptive purposes (see Appendix). The participants were asked to provide answers to questions regarding (a) their age group (i.e., 1 = 20-29, 2 = 30-39, 3 = 40-49, 4 = 50-59, 5 = 60-69, 7 = 70 or older); (b) their race/ethnicity (i.e., one = African American/Black, 2 = Asian American, 3 = Caucasian/White, 4 = Hispanic/Latino(a), 5 = Native American, 6 = other); (c) the type of healthcare setting in which they work (i.e., 1 = hospital, 2 = community-based healthcare clinic/setting, 3 = nursing home/long term care, 4 = other); (d) highest level of education (i.e., 1 = BSW, 2 = MSW, 3 = DSW) and (e) the number of years they have worked as a healthcare social worker (see Appendix). The participants completed these questions with me at the beginning of the interview.

Data Analysis

This generic qualitative study examines female healthcare social workers' descriptions of burnout and POS regarding burnout. A thematic analysis of the semi-structured interview data using Braun and Clarke's (2006) six-step process was conducted to address this question. Descriptive information on the study participants augments the thematic findings.

Demographic and Work Questions: Descriptive Information

Before the interview data was analyzed, the descriptive information of the study participants' demographic and work information was entered into an Excel spreadsheet, summarized, and reported. Four of the five questions were categorical: (a) age group, (b) race/ethnicity, (c) highest level of education, and (d) type of workplace. The frequencies and percentages of the categorical demographic and work were reported. As the years of work experience variable is an interval, the mean (average) number of years worked, and the range of years are reported. The descriptive information provides a more comprehensive picture of the study participants.

Thematic Analysis of Interview Data

The thematic analysis of the interview data was conducted per the thematic analysis steps outlined by Braun and Clarke (2006). The thematic analysis involves the systematic process of data familiarization through recognition of patterns, codes, and themes, with the results providing a cohesive and comprehensive summary of thematic findings (Braun & Clarke, 2006). Braun and Clarke's (2006) thematic analysis procedure has five specific steps.

Step 1: Familiarization with the Data. The first step is familiarization with the interview data (Braun & Clarke, 2006). The interview transcripts were organized at this step, with each participant assigned an ID number. The key activities at the familiarization with the data step are reading and re-reading the transcripts, taking observational notes, and relistening to the audiotapes of the interviews to ensure clarity and obtain familiarity with the data (Braun & Clarke, 2006). At the end of the first step, I will have a general understanding of the information presented in the interviews and will have developed initial ideas regarding the data.

Step 2: Generation of Codes. The second step is the generation of codes from the interview data; it is the starting point of the thematic data analysis. Codes are the smallest unit of information that denotes an aspect or element of the phenomenon under examination (Braun & Clarke, 2006). The type of coding was semantic, as it identifies codes that present the “explicit meaning” of a concept, assessed “at the surface level of the data” (Terry et al., 2017, p. 22). Coding was completed manually. The generation of codes involved (a) reading transcribed data for as many potential codes as possible; (b) highlighting each non-repetitive and non-overlapping code per interview, and (c) creating a Word document where each participant’s codes are pulled from the transcribed data and presented by participant ID in a table. The generation of codes step ended with “a compiled list of codes that adequately identify both patterning and diversity of relevant meaning within the dataset” (Terry et al., 2017, p. 23).

Step 3: Search for Themes. The search for themes is the third step of the thematic analysis: it aims to analyze the interview data at a broader level and construct

themes (Braun & Clarke, 2006). The search for themes step aimed to aggregate codes around a “central organizing concept,” or theme (Terry et al., 2017, p. 23). I reviewed the codes listed by participant ID in the Word document. I created another Word document where I aggregated and grouped codes by similarity and created a theme that aligned with the cluster of codes. I concluded this step by having a Word document with a table that lists the themes and the codes associated with the respective themes.

Step 4: Review of Themes. The fourth step in the thematic analysis is the review of themes, which aims to refine and arrive at final themes. The review of themes step acts as a means of quality control, “to ensure that the themes work well in relation to the coded data, the dataset, and the research questions” (Terry et al., 2017, p. 29). According to Braun and Clarke (2006), the review of themes has two levels: a review of themes specific to the interview data and a review of themes that pertain to the entire data set. In the first level of the review of themes, I reviewed each theme and the codes connected with the theme to determine if the theme is distinctive and has a central organizing concept that adequately captures the diversity of codes associated with the theme (Terry et al., p. 30). The review of themes resulted in the deletion of themes (e.g., due to an insufficient number of associated codes), the creation of new themes, and the collapse of themes into newer thematic groupings. I then reviewed the themes in consideration of the entire data set, checking to see if the “themes work well across the whole dataset ... [and] meaningfully and usefully captured the dataset itself” (Terry et al., p. 30). The Word document containing the themes and associated codes table was adjusted and revised as needed in this step. The review of themes step concluded when I was confident that the

themes (a) had an adequate number of codes that are clearly linked to the theme; (b) were diverse and distinct from one another yet corresponded to each other vis-à-vis the study topics; (c) told the overall story that emerged from the data; and (d) addressed the RQs.

Step 5: Define Themes. The fifth step, defining themes, was initiated when a satisfactory list of themes was created. The central purpose of the fifth step is to define, validate, and name themes (Terry et al., 2017). At the define themes step, I moved away from “a summative position” (i.e. seeing themes as “lists of codes and collated data”) to “an interpretive orientation” where I could tell a story that is “based on ... the data that makes sense of the patterning and diversity of meaning” (Terry et al., 2017, p. 30). In the Word document of themes, I gave each theme a definition that captured its core meaning; the definition expounded upon the *essence* of each theme (Braun & Clarke, 2006). The define themes step concludes with a list of themes, the definitions, and the codes associated with each theme, which are presented in the Word document.

Step 6: Producing the Report. The last step, producing the report, entails organizing the study results to present a coherent and consistent account supported by the data. The thematic findings are defined, explained, and discussed in alignment with the RQs. The thematic findings are supported by data extracts (i.e., examples from the data that support the theme) that illustrate and support the theme. The production of the report concludes with a presentation of the thematic findings in alignment with the two RQs.

Trustworthiness

A qualitative study's trustworthiness, or rigor, is central to the quality of its findings (Stahl & King, 2020). Pertinent to studying trustworthiness is *credibility*, or the

“congruence of study findings to reality.” Trustworthiness concerns the truthfulness of study findings (Stahl & King, 2020, p. 26). While “qualitative research does not (and cannot) aim for replicability,” such empirical work does need to have *transferability*, or the ability to transfer and apply findings from one sample or setting to another; transferability is a vital component of a qualitative study’s trustworthiness (Stahl & King, 2020, p. 27). Dependability also determines the trustworthiness of a qualitative study, or the consistency and credibility of study findings (Stahl & King, 2020). Finally, a qualitative study demonstrates trustworthiness through the *confirmability* of study findings: “getting as close to objective reality as qualitative research can get” (Stahl & King, 2020, p. 27). A qualitative study's credibility, transferability, dependability, and confirmability enhance its trustworthiness.

Credibility. This study implements specific practices to enhance the credibility or truthfulness of the findings. As data credibility hinges upon participant honesty, it is essential to implement practices that allow the participant to feel comfortable voicing honest answers (Korstjens & Moser, 2018). The informed consent process, which provides assurances of confidentiality, helps to increase the likelihood that participants will be more honest in their responses (Korstjens & Moser, 2018). In this study, participants were required to provide informed consent, which included assurances that participant confidentiality would be maintained.

Establishing rapport and clarifying statements with participants increases the credibility of study findings (Sun et al., 2020). I engaged in small talk and developed rapport with participants before I asked interview questions. Moreover, during the

interview, I clarified any statements that were confusing or lacked context. The credibility of study findings is further enhanced via *member-checking* or eliciting participants' feedback to ensure that their comments are accurately interpreted (Sun et al., 2020). I emailed or shared in-person transcripts of each participant's interview and asked them to review the transcript to ensure its accuracy. Informed consent, developing rapport and clarifying statements, and utilizing member-checking hopefully enhanced the credibility of data findings.

Transferability. I engaged in specific practices to improve the transferability (i.e., applicability of study results to other groups or contexts) of study findings. The transferability of study findings is ensured when a large enough sample size allows for data saturation, which is the point in the thematic analysis where no additional codes or themes are uncovered (Korstjens & Moser, 2018). The sample size for this study is 14 participants, which should ensure data saturation. The total sample size was determined based on the point at which data saturation was achieved; it was determined that all 14 participants were needed for the study. Detailed, rich, and comprehensive findings improve the transferability of study results (Sun et al., 2020). In this study, I provided rich and thick descriptions of the thematic findings, augmented with participants' demographic and work information. Obtaining a large enough sample size to achieve data saturation and providing rich and thick descriptions of the thematic findings and descriptions of the study participants will enhance the transferability of study findings.

Dependability. Specific activities improve the study findings' dependability or truthfulness. One way to improve the dependability of findings is to field-test the semi-

structured interview questions. Field testing allows the researcher to (a) revise, remove, or add interview questions; (b) determine if the interview questions elicit an adequate and engaging response; (c) assess if the questions allow for a rich description of all concepts examined; and (d) determine that all interview questions can be asked within the expected parameters of the desired time frame (Sun et al., 2020). In this study, I field-tested the interview questions with two healthcare social workers (who are not participants) and adjusted the questions based on their feedback. Dependability is improved if the study methodology details the data collection and analysis procedures; methodological clarity allows for replication (Korstjens & Moser, 2018). This study has detailed and comprehensive information on the sampling of participants, the recruitment process, the data collection and analysis procedures, and study findings. Field testing the interview questions and providing detailed information on the study methodology will improve the dependability of the study findings.

Confirmability. I implemented specific practices to enhance the confirmability and the accuracy of study findings. Using an interview protocol improves the confirmability of qualitative research findings as it helps to reduce biases in the study (Sun et al., 2020). An interview protocol was used in this study. Confirmability of findings is also enhanced through reflexivity, or conducting an internal scan of one's values, ideas, and opinions concerning the topic under study, and bracketing, or acknowledging and then putting aside one's biases or judgmental attitudes (Sun et al., 2020). I engaged in reflexivity and bracketing before conducting each semi-structured

interview. The confirmability of study findings was enhanced using an interview protocol, engaging in reflexivity, and bracketing.

Ethical Procedures

Ethical procedures for research with human subjects were followed per the Belmont Report of 1979 (OHRP, 2019) and the Walden University IRB. According to the Belmont Report, research with human subjects should be conducted considering the ethical principles of *respect for persons*, *beneficence*, and *justice* (OHRP, 2019). The respect for persons principle emphasizes the need to conduct fair and non-deceitful research practices, especially regarding informed consent, which ensures the participants' autonomy (OHRP, 2019). Participants were provided informed consent, had the right not to answer any questions, and could end their participation in the study at any time. The second ethical principle of beneficence emphasizes the importance of doing no harm, as denoted in the Hippocratic oath (OHRP, 2019). The study offered no risks beyond what the person would experience. The third ethical principle pertains to justice, which is inherent to assurances of participant confidentiality (OHRP, 2019). As healthcare social workers were recruited directly by me, they are anonymous; however, all information gathered from participants were kept confidential.

Additional study activities were conducted ethically, following the recommendations of the Belmont Report (OHRP, 2019). The signed consent forms were downloaded and printed, then stored as paper documents in a locked file cabinet maintained in my home office. The Doc-U-Sign emails were deleted. The interviews

were recorded on a digital recording device and then transcribed verbatim. The transcriptions were printed and are stored in a locked file cabinet in my home office.

Procedures regarding disseminating findings and destroying study materials ensured the study was conducted ethically. Findings were reported at the group, not the individual, level: qualitative descriptive study findings typically include aggregate-level information and thematic examples from the data (Kim et al., 2017). When detailing the study findings in the dissertation, participants are identified by an ID number (and not their names). Study materials will be destroyed (e.g., informed consent forms shredded, recorded data and any materials stored on a computer deleted) five years after the publication of the dissertation as mandated by Walden University.

Summary

Due to the high burnout rates among healthcare social workers (Frieiro Padin et al., 2021; Singh et al., 2020), coupled with the acknowledged benefits of POS in reducing burnout (Kurtessis et al., 2017), scholars have called for a need for qualitative studies that explore social workers' descriptions and perceptions of burnout and the organizational supports made available to them (Aiello & Tesi, 2017; Frieiro Padin et al., 2021; Khizar et al., 2021). The problem addressed in this generic qualitative study is that female healthcare social workers experience elevated rates of burnout but may not receive adequate perceived organizational support (POS) to help ameliorate burnout.

This generic qualitative study examined female healthcare social workers' descriptions of burnout and POS surrounding burnout. The study was conducted with 14 female healthcare social workers working in various healthcare settings in the southeast

region of the United States. Convenience sampling was employed to recruit participants who were adults aged 18 or older, identified as female sex, held a position as a healthcare social worker, and were employed as a healthcare social worker for at least one year. Participants provided informed consent. Following the generic qualitative approach, the data were collected through semi-structured interviews, following an interview protocol. The interview questions inquired about participants' descriptions of their burnout and their POS surrounding burnout. The interview data were transcribed and analyzed using the thematic analysis steps outlined by Braun and Clarke (2006). Thematic findings are presented and discussed vis-à-vis the research question. Descriptive information on the participants' age group, race/ethnicity, highest level of education, type of workplace, and years of experience augment thematic findings.

This study sheds light on healthcare social workers' burnout and the potential organizational support that could reduce their burnout. The study addresses an empirical gap in the literature on burnout and POS. Results provide guidance for the development and implementation of initiatives and professional development opportunities aimed at reducing burnout and improving organizational support among female healthcare social workers.

The study findings are the focus of Section 3. Section 3 will open with a restatement of the data analysis techniques. Substantial attention will then be given to the thematic and descriptive findings. A summary will conclude Section 3.

Section 3: Presentation of the Findings

Introduction

The problem addressed in this generic qualitative study was that female healthcare social workers experience elevated rates of burnout, or workplace-based distress characterized by emotional exhaustion, depersonalization, and reduced personal efficacy/sense of accomplishment, but may not receive adequate perceived organizational support (POS) to help ameliorate burnout (Maslach, 2017). As the role of the healthcare social worker is to engage in arduous and multi-faceted work tasks, including advocating and caring for vulnerable patients, they are especially vulnerable to burnout (Frieiro Padin et al., 2021). Low wages coupled with the COVID pandemic have only helped to increase rates of burnout among healthcare social workers, with burnout rates exceeding 60% (Frieiro Padin et al., 2021). Moreover, burnout is more common among females (Frieiro Padin et al., 2021; Yi et al., 2019), and 77% of healthcare social workers are female (Laughlin et al., 2021). Burnout can contribute to not only the healthcare social workers' poor physical and mental health (Mak et al., 2021; Wu et al., 2022) but can also lead to negative work attitudes and behaviors (Falce, 2022; Frieiro Padin et al., 2021; Kuok, 2022). As such, the consequences of burnout often extend beyond the social worker to impact the organization (Brown et al., 2019; Kuok, 2022).

For those in the mental health and social work fields, burnout can be lessened by perceived organizational support (POS), a perception that the organization *values* and *cares* for the employee (Myrvang, 2020; Prysmakova & Lallatin, 2021). Despite the importance of POS in reducing burnout, these variables have received minimal research

attention, especially in samples of healthcare social workers (Frieiro Padin et al., 2021; Myrvang, 2020). No qualitative study to date has explored female healthcare social workers' perceptions of their burnout and how POS may act to reduce burnout among this population. In consideration of the high rates of burnout coupled with low POS among healthcare social workers, Frieiro Padin et al. (2021) noted a need "to identify some of the characteristics of burnout [vis-à-vis POS] that affect mostly women" in the empirical literature (p. 1062).

This generic qualitative study explored female healthcare social workers' descriptions of burnout and their POS surrounding burnout. This generic qualitative study had two research questions (RQs), which were informed by Maslach's (1981) concept of burnout and the guiding theory of Eisenberger et al.'s (1986) POST. The RQs, which had no hypotheses as the study was qualitative, were:

RQ1. What are female healthcare social workers' descriptions of burnout?

RQ2. What are female healthcare social workers' descriptions of their perceived organizational supports (POS) regarding burnout?

The generic qualitative design is distinct in that it is used to capture participants' descriptions - not their interpretations - of a social phenomenon(a) using everyday language (Sandelowski, 2000). In line with the generic qualitative design, this study captured fourteen female healthcare social workers' descriptions - not their interpretations - of the social phenomena of burnout and POS in "everyday terms" (Sandelowski, 2000, p. 336). Data were captured through 60-to-90-minute semi-structured interviews with the participants, who also provided demographic information

(e.g., age group, race/ethnicity) for descriptive purposes. I transcribed and analyzed interviews using Braun and Clarke's (2006) six-step thematic analysis. The study, by answering the RQs, can advance the body of empirical work on burnout and POS among healthcare social workers and will provide much-needed information that can be used to guide initiatives that reduce burnout and improve organizational supports for female healthcare social workers.

The purpose of Section 3, structured in subsections, is to present and review the study findings comprehensively. The purpose of the study, research questions, and data collection methods have been discussed. The section then turns to the data analysis techniques, which included (a) information on the data collection process, and the sample, including recruitment and response rates of participants; (b) Braun and Clarke's (2006) six-step thematic analysis, the data analysis used in the semi-structured interview process; (c) validation activities used in the interview to ensure data trustworthiness; and (d) limitations experienced by the researcher when collecting and analyzing data. Substantial attention is then given to the study findings, with results reported by RQ. Tables and figures augment the study findings. Section 3 ends with a summary and provides transitional material to Section 4.

Data Analysis Techniques

The data analysis procedures for this generic qualitative study were fourfold. First discussed are the data collection and sampling plan, with information provided on the sample, recruitment, and response rates. The second step entailed a summary of the data analysis procedures, with a discussion of the semi-structured interview process and the

steps taken for Braun and Clarke's (2006) six-step thematic analysis. Validation procedures to ensure the trustworthiness of study findings are the topic for the third step of the data analysis techniques. Study limitations are discussed in the fourth and last step.

Data Collection, Sample, Recruitment, and Response Rates

After obtaining approval from the Institutional Review Board for Walden University (Approval 11-05-24-0727193) to conduct my study, I began the recruitment process in December 2024. Recruitment involved a flyer shared online via social media groups for social workers, asking women to respond via email or phone if they were interested in participating. While the posts were looked upon favorably, the posts were reacted to positively, as the post was "liked" – responses by email or phone were slow initially. It was not until a former classmate/work colleague elected to participate in the study that word-of-mouth referrals occurred, and additional interview interest was expressed.

My capstone chair reviewed the completed and transcribed initial interview. After receiving feedback and approval to continue, I completed the remaining thirteen interviews over the next 4 months. I had to work around each participant's work and home-life schedules to find periods where interviews could be completed confidentially. My capstone chair encouraged me to gather examples and engage in follow-up questions to gather additional rich information while I spoke with participants (Korstjens & Moser, 2018). During and after each interview, I made short notes of my overall impression of the conversation and the participants' views on burnout and organizational support. I

noted that burnout may or may not have been as problematic for the interviewees as feeling supported by the organizations that employed them.

Between participants 8-10, I started to feel I was reaching saturation with participant responses, but I wanted to remain within my sample size goal of interviewing 10 to 15 participants (Kim et al., 2017). I also realized that my participants worked in varying areas of healthcare social work, and there was a mixture of time participants were employed as healthcare social workers. With that curiosity, I continued through the last four interviews (14 interviews total); I wanted to see if continued variations in age and length of time in the field would yield different responses.

Data Analysis Procedures: Braun and Clarke's (2006) Six-Step Thematic Analysis

The data analysis used in this study was Braun and Clarke's (2006) six-step thematic analysis. Braun and Clarke's (2006) thematic analysis requires the researcher to systematically identify codes, which are merged into themes by recognizing patterns in the codes. Braun and Clarke's (2006) thematic analysis is best for analyzing data for codes that are descriptive as opposed to interpretive purposes (Vaismoradi et al., 2013). As this study was generic and qualitative, the six-step thematic process fit the study's intent well. As there were two research questions, the process occurred twice, with the data being analyzed regarding participants' descriptions of burnout of the POS surrounding it.

Step 1: Familiarization with Data

To become familiar with the data, I listened to each participant's interview while following along, reading the interview in the order it was obtained. The thematic analysis

process first entailed transcribing interviews by hand. After listening to it for the first time, I worked on transcription—the transcription process sometimes required repeatedly listening to parts of interviews. While listening, I began writing notes in the margins of the transcripts, noting my initial ideas and reflections. I listened to the interviews and read/re-read transcripts, as I printed the interviews and wrote notes in the margins of each interview for markup purposes. I spent substantial time transcribing the interviews: the average time for transcription of one interview took approximately 5 hours. The transcription was written verbatim in the Word document, the exception being personal information (e.g., naming a coworker or identifying a specific organization) spoken in the interview. At the end of the transcription, each participant had a transcribed interview, numbered for identification purposes, and kept on a Microsoft Word document.

Step 2: Generation of Codes

I did not find the generation of codes a painless process. However, after listening to recordings and re-reading transcripts a few times, I began writing down short phrases line-by-line. Codes were developed for the first research question concerning the healthcare social workers' descriptions of burnout. Forty-three codes were developed. There were fewer for the POS codes – forty-one.

Step 3: Searching for Themes

Among the unique phrases, I began to review and group the codes and origin phrases in the transcript to develop themes. I created word columns to place codes with titles as the themes. As the themes were developed, I grouped phrases from interviews placed under the themes and ensured that the themes encompass all thoughts expressed

by the participants. The following themes were similar. From this grouping process, 10 themes were developed: burnout, workload/caseload, staffing, organizational support, supervisors, peer support, salary/pay, scheduling, resources, and leadership visibility.

Steps 4 and 5: Reviewing and Defining Themes

After developing the themes from codes, I again reviewed phrases that led to the codes and the grouping of codes, to ensure the information shared was consistent with the themes I listed. Names of themes changed a few times to ensure I had a clear boundary for each group of thought.

Step 6: Write the Report

The findings and themes related to my research questions in the interviews are listed in the next section.

Validity

Multiple strategies were employed to strengthen the *validity* and *trustworthiness* of this qualitative study. I took the time to develop rapport with each participant, encouraging truthful answers to all questions, and allowed for partial playback of the interviews to participants for authenticity. Braun and Clarke's (2006) thematic analysis approach was applied across all 14 interviews. A codebook was developed with 84 unique codes; this provided a record of the meaning of phrases interpreted from each participant's responses to questions in each interview. Patterns across interviews were noted, which allowed for the development of themes. There were multiple iterations of themes to ensure each theme reflected the information given by the participants and the

meaning of the answers. Direct quotes from the interviews are given for each theme, lending credibility to the themes developed.

Limitations

This study includes a small and relatively localized sample of 14 participants, which would limit generalizability to all healthcare social workers. Participant bias should also be considered, as sensitive topics about burnout and organizational support were discussed and would involve shared personal information that may be filtered by the participants, especially if the participants knew the researcher in another capacity outside of the interview. In this case, participants were trusted to share information honestly (Sun et al, 2020). In contrast, the participants trusted me as the researcher to collate and share information without using my perspectives and experiences.

Findings

Study Participants

Demographic and work information was gathered on the fourteen healthcare social workers who participated in the study (see Table 1). A large majority (57.14%) of participants were between 30-39 years of age; there were equal participants in age ranges of 20-29, 50-59, and 60-69 (14.29%); there were no participants in the age range of 40-49. The majority (57.14%) were Caucasian; 42.85 % were African American. Most participants (85.71%) currently work in inpatient hospitals. The participants worked on average 11.93 years in healthcare social work, with years ranging from 2 to 41 years. All healthcare social workers interviewed held a Master of Social Work degree.

Table 1*Participant Demographics*

Participant	Age Group	Ethnicity	Level of Education	Healthcare Setting Where Work	Number of Years as Healthcare Social Worker
1	30-39	African American	MSW	Hospital	3
2	50-59	Caucasian	MSW	Hospital	23
3	20-29	African American	MSW	Hospital	3
4	50-59	Caucasian	MSW	Hospital	26
5	30-39	African American	MSW	Locum Tenens (Traveling SW)	7
6	30-39	African American	MSW	Hospital	2
7	30-39	Caucasian	MSW	Hospital	7
8	30-39	Caucasian	MSW	Hospital	8
9	20-29	Caucasian	MSW	Hospital	4
10	30-39	African American	MSW	Hospital	5
11	30-39	Caucasian	MSW	Hospital	8
12	60-69	African American	MSW	Hospital – Mental Health - Hospital	18
13	60-69	Caucasian	MSW	Hospital - Rehab	41
14	30-39	Caucasian	MSW	Hospital – Nursing Home	12

Thematic Findings

This generic qualitative study aimed to explore female healthcare social workers' descriptions of burnout and their POS surrounding burnout. The generic qualitative study had two RQs, guided by Maslach's (1981) theoretical concept of burnout and Eisenberger et al.'s (1986) POST. There were two RQs, one inquiring about female healthcare social workers' descriptions of burnout and the second about female healthcare social workers'

descriptions of their perceived organizational supports (POS) regarding burnout. The thematic analysis provided the unique results for the two RQs via Braun and Clarke's (2006) six-step approach.

RQ1. What are Female Healthcare Social Workers' Descriptions of Burnout?

Burnout and Emotional Exhaustion, Depersonalization

Many female healthcare social work participants in this study described their burnout as chronic. Of the burnout symptoms, emotional exhaustion was the most universal symptom, often accompanied by depersonalization (Maslach & Leiter, 2017). Compassion fatigue – distress experienced from continued work with clients that affects one's emotional investments (Sweileh, 2020), and rumination about patient cases after working hours were consistent emotional patterns. Participants described feeling mentally drained, with exhaustion carrying into their home lives.

Burnout often accumulated over time without early detection by the participant or the use of an intervention; it was sometimes only noticed by loved ones. Ongoing emotional toll from patient interactions and organizational stressors. As interviews were reviewed, burnout presented as a dominant

As mentioned by participant 4:

By midweek, I'm already running on empty. The emotional toll of what we deal with daily doesn't go away when you leave work. It's like there's a weight on your shoulders all the time, and you can't shake it even on your days off.

Similarly, participant 8 discussed the same weariness:

There are weeks when I feel like I'm just pushing through a fog. The exhaustion is constant, and it's not something you can fix with a good night's sleep...It's more than tiredness — it's feeling emotionally spent to the point where you don't have anything left for yourself.

Although multiple participants did not identify themselves as “burned out”, many shared symptoms of burnout – compassion fatigue and overwork that leads to a cycle of stress, invested energy, and depletion of personal/emotional resources (Huang & Simha, 2018). “By the end of the week, I'm mentally and physically drained, like I've run a marathon I didn't train for” (Participant 14). Similarly, the cycle of stress and exhaustion was mentioned by participant 7: “Sometimes I wake up and dread going in, not because I don't care, but because I don't have anything left to give”. Participant 2 continued with daily stress concerns: “It's constant – by Friday I'm just a shell of myself, and I still have to come back Monday and do it all again”. Emotional exhaustion was a strong response of the majority of those interviewed.

Caseload and Responsibilities

A compounding factor identified by participants that impacts burnout is workload and role confusion (Foy et al., 2019; Li, 2022). Participants mentioned frequently taking on tasks beyond their training and filling organizational gaps. Large caseloads and documentation overload the employees, reducing the work quality (Huang & Simha, 2018). Many expressed feeling like a “hamster on a wheel,” where each day became a source of stress, and/or being treated as the “default fixer” of difficult or inconvenient situations, even if it was not a social work issue. Participants felt tasks accumulated faster

than they could complete them. Staff regularly covering for absent coworkers or covering areas where there are staff vacancies experienced increased stress, as noted by participant 1:

We're always covering for someone else, so your own caseload is doubled. It's not just the number of patients; it's the variety and complexity that makes it overwhelming.

Participant 5 echoed the same sentiment:

There are days when I feel completely exhausted before lunchtime. It's not just physical tiredness — it's mental and emotional fatigue that sticks with you even after you get home... You get to a point where you're running on autopilot, just trying to get through the day without falling apart.

There was a noted sense of work never-ending. Participant 9 referred to the workload using a metaphor: "It's like playing whack-a-mole — you finish one thing and other pops up right away". Participant 12 noted, "There's this constant pressure to move faster, but no one is taking anything off our plates," representing continued work stress and overload (Sweileh, 2020). Of all the interviews completed, not one participant opined that their caseload suited them, as reflected by participant 11: "They keep increasing our caseloads without increasing staff, and we're the ones drowning."

Structural and Staffing Stressors

While speaking of caseloads, it is important to note that if smaller caseloads are recommended for healthcare social workers, more employees are needed for the organization. Participants spoke of insufficient coverage on health care units, but

expectations of job duties did not change, leading to burnout (Freudenberger, 1986; Fontes, 2020). “Policies keep shifting, but the support never improves. It feels like we’re set up to fail (Participant 10)”. Similarly, Participant 6 discussed staffing challenges:

We are always short-staffed, so every shift feels like a sprint. You’re trying to get to everyone, but there’s never enough time...The constant switching between urgent and routine cases wears you out...The bureaucracy slows everything down – we spend more time fighting the system than helping people.

Staffing was a consistent complaint of the participants, even if the participant did not self-identify as someone with burnout. Negative beliefs about staffing, with no resolution for the issue, lead to a low sense of empowerment and ability in the work environment (Eliacin et al, 2018). “We don’t have enough staff, and the system is broken. Even when we raise concerns, nothing changes (Participant 7)”. “Every barrier is structural – staffing, rules, resources – it’s like we’re set up for burnout (Participant 13)”. Staffing issues lead to continued stress and overload of social workers with no promise of swift improvement, leading to burnout symptoms.

RQ2. What Are Female Healthcare Social Workers’ Descriptions of Their Perceived Organizational Supports (POS) Regarding Burnout?

Organizational Support

Organizational support from some of the participants’ opinions reflected aloofness from upper management and executives, while others discussed being supported primarily by their immediate supervisors. Some participants acknowledged that their employers have addressed burnout and compassion fatigue by implementing

wellness programs or using appreciation gestures like food, lunch bags, and t-shirts.

While appreciated, participants reflected that these actions failed to address the root causes of burnout. “When we do speak up, the response is often a token gesture, not real support” (Participant 4).

The wellness initiatives participants mentioned were sometimes inaccessible to all workers due to the timing of activities or workload; while noted as an effort to address burnout by some, some still noted an absence of support from the organization: “There’s a lack of recognition – we give everything and it feels like it disappears into the void” (Participant 8). In this regard, a negative perception of organizational support is formed (Kurtessis et al., 2015). “I don’t feel seen or supported by leadership. It’s like we’re invisible until something goes wrong” (Participant 14). “Support from the organization feels more like checking a box than actually helping us” (Participant 9).

Participants felt like a number in large organizations, aligning with the belief that outside of peers and immediate supervisors, she was not known or recognized by the organization. While participants acknowledged the healthcare values the role of social workers, the workers do not feel seen and valued. Of the participants, only 1 participant, 13, spoke of support and acknowledgment by the organization where she is employed, as she mentioned during her interview that she is known to the entire organization, due to the low number of social workers that service the entire organization.

Supervisors

From the participants’ perspective, responses about relationships with supervisors were mostly positive; supervisors were typically accessible and supportive of staff

(Eisenberger et al., 2020). Conversely, while participants felt supported by supervisors, several responses mention the limitations of supervisors' ability to change aspects of the job that may directly impact burnout, such as staffing, pay, daily caseloads, and schedules. "My supervisor listens, but their hands are tied. It doesn't feel like they can advocate for us (Participant 2)". "Sometimes it feels like supervisors are just messengers, not leaders (Participant 6)".

Participants discussed that the support of peers and immediate supervisors was a buffer to burnout. Supervisors varied in impact — from emotionally supportive to retaliatory, or as employee advocates when interacting with organizational leadership. "Supervisors are stuck between staff and administration, but often they side with admin (Participant 10)". Those supervisors with social work backgrounds were more likely to be seen as helpful. Examples of supportive supervisors: encouraged mental health days, advocated for pay increases, and provided positive feedback (Eisenberger et al., 2020). Participant 5 spoke positively about her supervisor, saying:

My supervisor is approachable and tries to help, but I know they're limited in what they can do. I appreciate it when they check in without prompting a problem. It shows genuine care.

It is noted from the interviews that some immediate supervisors of the participants are not social workers. This may or may not impact social workers' beliefs of being understood and supported. "I've had good supervisors and bad ones – the difference in how supported you feel is night and day (Participant 11)". Supervisors were frequently seen as sympathetic but lacking the power to change larger structural issues. However, they were

helpful and validating in day-to-day functions, such as informally checking in with employees.

Peer support

Peer support was the most consistent burnout buffer for the healthcare social workers interviewed. “If it weren’t for my coworkers, I wouldn’t make it through most days. We lean on each other because nobody else gets it (Participant 8)”. Participant 2 also spoke of peer support cheerfully:

We’ve built this informal support network where we check on each other throughout the day. It’s what keeps me going. If someone is swamped, we’ll jump in without being asked. We just know when someone needs backup.

Participant 11 continued, “We vent, we laugh, and we survive together. It’s the only real support we have”. From the participants’ point of view, coworkers are essential for emotional processing, task sharing, and validation. Many described their colleagues as lifelines or family, lacking upper leadership support (Eisenberger et al., 2020).

“Coworkers are like family – we pick each other up when the system beats us down (Participant 1). There’s an unspoken understanding that we all have each other’s backs, as was described by participant 14.

There was one participant (14) who had limited peer support, primarily because of her role as an independent therapist in nursing home settings; another participant (14) had only one social work peer in the organization where she worked. Limited peer support or poor “social capital” can lead to burnout due to an inability to vent and share in the complexities of their roles (Eliacin et al, 2018). The support of peers is often what

prevents job exiting, as noted by participant 3: “Peer support is the one thing keeping me from quitting. Without that, I’d be gone”.

Pay/Salary

From the interviews, there were discussions that pay is not commensurate with job duties for social workers. “The pay doesn’t reflect the emotional toll of this job. It’s demoralizing (Participant 1)”. Salaries and pay discussions were remarkably similar across many participants, noting that healthcare social workers are not paid as much as their registered nurse case manager colleagues, who have similar work responsibilities, but make more money. This pay disparity, especially between social workers and nurses, appears to have created resentment. Per participant one, “We are not respected the way we should be — even with a master’s degree.” Participant 11 noted, “The pay does not match the level of work or stress”. “We are doing professional-level work without professional-level pay” ... We’re doing critical work, but it feels like we’re at the bottom of the pay ladder”, said participant 13.

Many participants also cited a lack of promotion pathways and title stagnation that may be tied to pay gaps and/or lack of growth in job roles financially; all these factors drive burnout and can lead to staff turnover (Maslach, 2017). “It’s hard to justify staying when the pay is so low compared to the stress we endure (Participant 12)”. “Money shouldn’t be everything, but when you’re struggling to pay bills, it adds insult to injury (Participant 9)”. Only two participants felt their pay was within a fair range for the caseload they manage.

Work Schedules

Participants frequently provided insight into rigid schedules, which impacted their work-life balance. “The scheduling makes it impossible to balance work and home life. There’s no consideration for burnout (Participant 9)”. Participants spoke about requested days off for self-care or personal time, and the requests were denied due to staffing shortages. “Even when I request time off in advance it’s a fight to get coverage (Participant 5).” One participant (6) mentioned a request for a schedule change to adjust to her children’s school schedule; the request was denied.

“The lack of flexibility is a big problem. Life happens, but the schedule doesn’t allow for that. We’re constantly short-staffed, so schedules change last minute and disrupt everything” per participant 4. Participant 2 had the same sentiment: “The lack of flexibility in scheduling makes the job harder than it already is”. Most participants find self-care or mental health days difficult to schedule at the last minute. Two participants who are allowed to schedule meeting times with patients and families are given more flexibility, where they can take a self-care day with limited notice, but will add the responsibilities of the day missed to the next workday.

Limited Resources

In some hospitals, social workers have limited resources to complete daily tasks. Several participants spoke of multiple people sharing office space daily, and others spoke of upgrades to software/equipment needs. Participant 7 expressed the difficulty of multiple social workers in one office: “The setup here means you’re constantly interrupted, which makes it impossible to focus on one task for long.” Participant 9

spoke of the difficulty of having “private conversations” with others due to the number of employees in confined spaces.

Technological and physical resources (desk, computer, office supplies) were sometimes finite (Park et al, 2021). Per participant 2, “The systems we use are outdated and slow, which adds extra time to everything. It’s frustrating when technology is supposed to make things easier but doesn’t.” Participant 3 echoed the frustration: “When I’ve asked for resources, I’ve been told to ‘make do’ with what we have. That’s not support.”

Leadership Visibility

While it is acknowledged that upper leadership of hospitals and healthcare systems is not frequently seen, there is the belief that the lack of visibility of leadership by employees reflects limited connection and concern with employees’ duties and concerns (Singh, et.al., 2020). “Upper leadership is not present on the floor to see what we’re dealing with,” per participant 5. “We feel invisible, like our contributions don’t matter to those at the top,” according to participant 14. Participant 6’s sentiments align with the majority: “It’s like leadership doesn’t even know what we do day-to-day—they’re disconnected”.

Negative connotations were noted when discussing the presence of leadership in work areas. “Leaders show up when they want something, not when we’re struggling” (Participant 12). “The only time leadership notices us is when something goes wrong” (Participant 7). There are also some dissenting opinions among the participants about

human resources' implementation of new policies and procedures. Participant 10 described it as policies being "written without input from people doing the job."

Participant 13 was the only one who spoke of the CEO of the healthcare organization knowing her by name and interacting with her from time to time; she mentioned being thanked for the work she does, which she appreciates. Having moments such as these is what the other participants did not have: relationship building and trust between leadership and employees.

Summary

A generic qualitative study of fourteen interviews with female healthcare social workers explored burnout and perceived organizational support. Using thematic analysis, the two research questions were answered:

RQ1: What are female healthcare social workers' descriptions of burnout?

RQ2: What are female healthcare social workers' descriptions of their perceived organizational supports regarding burnout?

Semi-structured interviews were conducted with each participant for 60-90 minutes, with recordings of each interview on a password-protected computer. Interviews were reviewed and transcribed for coding, with 84 unique codes. Using Braun & Clarke's (2006) six-step thematic analysis, 10 themes (burnout, caseload, structural and staffing stressors, organizational support, supervisors, peer support, pay, scheduling, leadership visibility, limited resources) reflected participants' descriptions of burnout. Burnout symptoms, which were widespread amongst those interviewed, showed varied degrees of emotional exhaustion, depersonalization, and reduced personal accomplishment noted

amongst the participants. Perceived organizational support (POS), developed by Eisenberger et al. (2020), was not entirely positive for the participants. Participants felt measures taken by leadership, such as wellness activities and appreciation token gifts, ignored the concerns of female healthcare social workers and their burnout symptoms, personal well-being, work-life balance, work environment, low pay, and inadequate staffing. The collegiality of peers in work groups for the participants was the primary positive organizational support that also served as a buffer for burnout symptoms.

The final chapter of this research project is a discussion of application to professional practice and implications for social change in relation to the information obtained in this study.

Section 4: Application to Professional Practice and Implications for Social Change

Introduction

This study aimed to explore female healthcare social workers' descriptions of burnout and how it is influenced by perceived organizational support. The nature of the study is a generic qualitative design, which explores under-researched areas or phenomena that impact a distinct group of people. This type of study is intended to capture participants' real-life descriptions, unfiltered. The goal was to obtain and understand healthcare social workers' descriptions of burnout and perceived organizational support. While the caveats of burnout may appear similar across professional disciplines, work that directly impacts another's health and well-being from a social work perspective for this study is unique, coupled with the participant's opinions on organization support, and how that support impacts burnout.

Burnout affects social workers emotionally, physically, and mentally. Symptoms of burnout frequently occur over time, and because of this, employees may not see the warning signs that burnout is occurring. While not every study participant readily self-identified as "burned out", many experienced day-to-day stressors that contribute to symptoms of burnout. A disconnect between front-line patient care employees and organization leaders was also a consensus of many participants. Social workers reflected feelings of not being seen or heard outside of their colleagues or supervisors.

Peer support was the consistent and most valued mitigator of burnout amongst the participants interviewed. Implementation of burnout surveys/inventories to gauge the level of burnout and questions from leadership regarding implementing programs that are

easily accessible and utilized by staff are among the recommendations discussed in this chapter. Organizational support should be noticeable at every level of healthcare, where the well-being of patients and employees is uplifted. A discussion on how to apply the study's findings to professional ethics in social work practice, recommendations for social work practice, and implications for social change are included.

Application to Professional Ethics in Social Work Practice

As professionals, social workers have ethical standards that apply to themselves and their professional interactions with clients, colleagues, and the community (NASW, 2021). For this study, all interview participants maintained a licensure in social work – meaning they are held to the highest standard of social work knowledge, ethics, and values in their respective fields of practice. Burnout symptoms and the support of peers, management, and organization leaders impact multiple ethical standards, as noted in the National Association of Social Workers' Code of Ethics (NASW, 2021). An efficient and ethically responsible social worker must recognize that burnout can negatively impact commitment to clients, colleagues, and competent practice. It is also important for social workers in leadership roles to understand their duty in addressing their employees' burnout symptoms and recognizing/verbalizing the concerns of their employees to administrators and executives to maintain quality service delivery.

Competence (Standard 1.04)

Social workers must have an educational background and, in most cases, licensure to reflect their competence and function in the role. All participants in this study hold a Master of Social Work degree and are either licensed master social workers or licensed

certified social workers within the state where they are employed. From a competence standpoint, each participant meets the characteristics of a social worker who is aware of the values and ethical standards set forth by the NASW (2021).

Burnout symptoms can affect a person's function in the workplace, as noted throughout this study. (Maslach, 2017). From an ethical standard of competence, some burnout symptoms can impair decision-making and professional judgment. The Code provides directives for social workers to continually develop and enhance their professional expertise via continuing education opportunities required to maintain licensure (NASW, 2021). Continuing education can assist social workers and peers in noting burnout symptoms and how to address them. Employers can facilitate maintaining competence by providing ongoing professional development classes, supervision, and adequate resources. These provisions could also improve perceived organizational support – reflecting a sense of the organization caring about its employees and efforts to remedy burnout.

Commitment to Clients and Colleagues (Standards 1.01 and 2.01)

As social work professionals, the NASW Code of Ethics (2021) stresses prioritizing the clients' well-being. That same responsibility is extended to peers in the workplace. It is mandated that social workers commit themselves to the services of others – clients, peers, the community, and so on – by assisting peers who may be experiencing burnout and have difficulty completing work tasks. This mandate does not mean social workers should ignore their own symptoms of burnout as they are presented. Instead, utilizing the resources of colleagues and management is recommended, where teamwork

and helping each other are fostered. Any risks to providing sufficient care to patients and families, such as emotional exhaustion, workload strain, and staffing shortages, should be shared with leadership. Burnout mitigation strategies, such as manageable caseloads and adequate staffing, directly support this ethical standard.

Supervision and Consultation (Standard 2.05)

The study findings revealed that supportive supervisors and team leaders can sometimes buffer employee burnout symptoms. However, there are limitations in their authority to create desired changes that would mitigate burnout. It is management's responsibility to express the needs and desires of employees to leadership, such as systemic improvements (staffing, pay). Ethical practice requires supervisors to provide staff guidance, support, and advocacy. It would be prudent for supervisors to have additional training in recognizing burnout symptoms and providing trauma-informed leadership. There are times when employees may require further intervention than support; having a manager or leader who is accessible would be advantageous.

Social Workers' Ethical Responsibilities as Professionals and to Employers (Standard 3.09 and 4.05)

The Code of Ethics (2021) recognizes a dual responsibility to clients and employing organizations. When systemic issues such as inadequate pay, inflexible scheduling, and limited resources undermine service quality, social workers are ethically obligated to advocate for changes that align workplace conditions with professional values and prevent burnout symptoms. The burnout symptoms reported in this study highlight the ethical requirement for social workers to seek assistance and take

appropriate steps when personal problems or work stress interfere with professional performance. Organizational cultures that normalize burnout or fail to provide accessible support place their workers and clients at risk of inferior quality of services and harm.

Recommendations for Social Work Practice

Addressing the systemic factors contributing to burnout aligns with the profession's ethical commitment to social justice, dignity, and worth of the person, as well as the importance of human relationships. The findings of this study have several important implications for professional social work practice within healthcare settings. First, routine burnout screenings should be implemented in healthcare organizations' policies to identify emotional exhaustion and related symptoms before they escalate. When paired with supervision emphasizing self-care planning, such assessments may help social workers establish realistic workload boundaries and maintain professional well-being.

Second, organizations should clarify social work roles to reduce confusion and ensure staff are not tasked with responsibilities outside their professional scope. Reasonable caseload standards, aligned with professional guidelines, should be adopted and regularly monitored. Addressing staffing shortages is also critical; increasing hiring or having part-time, as-needed staff could alleviate excessive workloads. Including social workers in staffing and scheduling discussions may improve morale and service quality. Utilization of human resources to look at ways to attract new employees to help with caseloads would benefit the organization and the team of workers (Kim & Oh, 2025).

Next, perceived organizational support (POS) can be strengthened in many of the ways discussed previously: supervisor advocacy for employees, structural changes (e.g, flexible scheduling), access to mental health resources, and policy adjustments that address the root causes of burnout - which are recommended for social workers but would be effective across all healthcare employees (Astuti et.al, 2024; Kim & Oh, 2025). Salary inequities must be addressed. Advocacy for pay parity between social workers and comparable healthcare professionals and providing career advancement avenues could encourage and retain employees. In addition, healthcare organizations should ensure adequate infrastructure and resources for employees, including private workspaces, up-to-date technology, and sufficient supplies to enable social workers to fulfill their professional responsibilities.

Supervisors play a pivotal role in shaping social workers' experiences of organizational support. Providing supervisors with training in trauma-informed management and reflective supervision can enhance their capacity to address staff needs effectively. Supervisors need options of services to offer employees who may be experiencing burnout without the appearance of being punitive. Those leaders with social work backgrounds should be encouraged to mentor less experienced staff to foster professional development and resilience to the daily challenges of healthcare social work.

Finally, leadership visibility should be increased to bridge the gap between executives, team leaders/supervisors, and frontline staff. Regularly scheduled leadership walking rounds or "open door" hours where various staff can meet as individuals or small groups with healthcare leadership could lend toward including social workers in policy

development processes or organization decisions that reflect employees' service delivery and on-the-ground realities.

Impact of Findings as an Advanced Practitioner

As a social worker of over 20 years, I have noted symptoms of burnout at various times during my career. In each case, I saw a work-life imbalance and tried to correct it via self-care, self-advocacy, or a change in employment. What I felt was challenging, and what inspired me to complete this doctoral study was to put into words what burnout looked like, and whether I was not alone in my experience. Healthcare settings are unique, as they rely on multiple specialties to provide holistic quality care for patients and families. Now that burnout is increasingly discussed and acknowledged in professional spaces, I hope agencies will assess employees' burnout symptoms and be willing to collaborate with employees to find relief.

Well-being of the Workforce

During the interviews, some participants spoke of well-being measures or departments in their healthcare organization. All healthcare employees' well-being should be considered to maintain quality service delivery. Staffing, work schedules, leave, and benefits are all determinants for hiring and maintaining employees. Well-being programs are an asset to maintaining a positive work environment and assisting employees when work-life stressors hinder employee success (Blake et al, 2020).

Employee Retention and Support

Support from leadership, recognition, and pay were a few of the participants' concerns that directly influence employee burnout and, in some cases, turnover.

Leadership support is frequently in tandem with employee recognition. The knowledge that employees are valued and cared about by those in middle to upper management allows for the continued buy-in of employees. If recognition of satisfactory progress is achieved, pay should be one of the measures that reflects the diligence of good employees. Turnover is reduced in areas where the organization supports work-life balance, and equally, there is adequate financial investment in its employees.

Utilization of Self-care

Self-care is promoted as the primary extinguisher of burnout (Dalphon, 2019). While social workers may recognize burnout symptoms, the ability to conduct self-care methods might be limited according to the demands of one's work and personal responsibilities. Organizations can promote their support of self-care by offering programs, education, and protected times for self-care to be utilized. Continuing education on self-care methods, such as yoga, meditation, or mindfulness, would help employees – not only social workers – find ways to relieve stress and improve mental fortitude when faced with challenging cases or life events. Offering flex hours or protected times to allow workers to decompress without interrupting phone calls or meetings could also be valued.

Transferability to Social Work Practice

In the completion of this study, participants' reflections regarding burnout are not unique from the prior research of Maslach (2017), which shows high emotional exhaustion and workloads, poor work-life balance, and thoughts that organizations overlook employee concerns. The results of this project can be a means of discussion

within various professional settings and challenge organizations to change their approach to burnout from an educational and policy perspective. Findings should be reviewed considering the descriptions of participants, the research process, and verbatim quotes, as readers evaluate whether findings from this student can be helpful in their work environment. The ability to hear about burnout and organizational support from the perspective of the healthcare social worker is valuable, as it humanizes and gives a voice to burnout beyond a concept considered for nurses and doctors in healthcare settings.

Findings from this study mirror those showing healthcare organizations are moving toward being proactive in the employee “self-care” process (SAMHSA, 2022) by offering “mental health days” to take off when needed, education on burnout and ways to combat it, and providing employee assistance and other interventions that could address burnout and compassion fatigue. As healthcare organizations work toward trauma-informed and wellness services for employees, creating new policies for these settings regarding caseload, pay, and reward systems could substantially impact employee well-being and retention.

The primary role of healthcare settings is the delivery of quality services to patients and families. Positive interactions between organizations and their employees will directly impact patient care. The utilization of peer and supervisory support could be further enhanced by creating programs across disciplines within healthcare settings, fostering the growth of teamwork, and completing team goals for service delivery. Improved quality of care can be tied to the health and well-being of an organization’s employees.

Limitations

This study had a small group of participants (14) and cannot be generalized to all female healthcare social workers' perceptions of organizational support and burnout. The study participants are licensed social workers in their respective states and residents of the United States; findings may not align with ethical standards and expectations of healthcare social workers outside of the country. There is potential for sampling bias, as noted by Braun & Clarke (2019), where some opinions shared may be overrepresented (or underrepresented) due to the area of recruitment or lack of considerable variety in age, race, years of experience, and so on.

Researcher Bias Limitations

As a licensed clinical social worker (LCSW), limiting bias and reflecting the participants' views only while compiling and coding information obtained during interviews could be considered a limitation. While considerable time, reflection, and effort were made to limit researcher bias, it must be acknowledged that coding and development of themes may not have developed within a pure sense of neutrality.

Further Research

Replicating this study with more participants is encouraged to gather valuable and needed information on burnout, perceived organizational support, and whether the results would be the same, regardless of where the participant resides. There also may be differing results if this study were expanded to include male participants. It would be helpful to note the differences in male and female participants' opinions on perceived

organizational support and note if males experience fewer burnout symptoms than females.

Further research could be completed on this topic while utilizing burnout inventories or surveys on perceived organizational support in a mixed-methods study. Inventories and surveys could provide a more accurate account of the intersectionality between individuals with burnout symptoms and how those results influence organizational support perceptions. Prevention of burnout and ways to improve perceived organizational support could also be an area of future research, as each topic could positively impact the quality of patient healthcare.

Finally, research addressing burnout is another way to continue the discourse on this varied topic. As noted earlier in the study, burnout is not a phenomenon exclusive to social work; there may be studies and findings on burnout in other fields of employment that may apply to social work, such as the financial or hospitality industries.

Sharing Information

Ways to disseminate the information from the study would include publishing and/or presenting it to organizations and individuals interested in reducing burnout and increasing positive perceptions of organizational support. I hope to share information from this study in the form of a presentation for fellow social work practitioners via my local NASW chapter, or as part of the ongoing series of podcast episodes on social work topics that occur in a live interview format within the social media social work groups that I have joined.

Implications for Social Change

Burnout: Not a Source of Personal Weakness

The results of this study reinforce the need to shift professional discourse away from framing burnout as a personal failing toward recognizing it as a systemic problem in many professions, requiring organizational and policy reform. This reframing can guide training programs, supervision models, and public messaging to reduce stigma, encourage help-seeking behaviors, and strengthen the profession's collective advocacy stance. COVID-19 brought the burnout experience to the forefront of healthcare, as discussed frequently in the media and healthcare facilities. It is encouraged that dialogue about this complex issue continues.

Workplace Equity Across Job Duties

Social change involves transformation and cultural shifts that bring about parity and justice. Salary inequities identified in the study between healthcare social workers and other professionals with similar responsibilities, such as nurse case managers, highlight a need for advocacy to achieve pay equity. At the professional level, social workers and professional associations can use the findings of this study to initiate campaigns and policy proposals that address wage disparities and promote equitable compensation per position and education.

Improved Organizational Support and Response to Burnout

The study's findings support a shift toward holding healthcare organizations accountable for identifying and managing work-related causes of burnout, such as excessive workloads, staffing shortages, and inadequate resources. Professional bodies for social

workers, such as the National Association of Social Workers (NASW), can use this evidence to advocate for the implementation of standards that require organizations to implement burnout prevention programs, intervention services, such as EAP – employee assistance programs, and demonstrate ongoing staff well-being efforts.

Improved Leadership Visibility

As reported by participants, leadership invisibility reveals a disconnect between decision-makers and frontline workers. Professional advocacy can focus on developing standards for leadership engagement with employees, patients, and families. A sense of care and concern creates a cultural shift within the healthcare agency. Scheduled leadership walk-rounds

The Power of Peer Support

A well-established reconciler of burnout symptoms is peer support. From this study, coworker support plays a strong role in buffering burnout; colleagues are frequently front-line workers for patients, but with colleagues as well. The peer support concept could be utilized as an organizational standard via team building exercises, mentoring, and cross-training. This would advance social change by strengthening the workforce by “sharing the load” of work assigned, providing emotional support, and fostering a positive work environment. Teamwork at its core is the power of colleagues pledging to work together to meet the demands of the workplace (NASW, 2021). Planning activities safe for debriefing after challenging work weeks or colleague-led exercises that occur away from the workplace.

Summary

Burnout and perceived organizational support for 14 female healthcare social workers were assessed via a qualitative study. The study was completed to answer two research questions: What are female healthcare social workers' descriptions of burnout? What are female healthcare social workers' descriptions of their perceived organizational supports (POS) regarding burnout?

Burnout affects social workers emotionally and physically; symptoms may occur over time, not all at once. Burnout symptoms: emotional exhaustion, depersonalization, and reduced personal achievement (Maslach, 2017) were not all recognized by participants collectively; there were individual symptoms of burnout noted for each participant. Emotional exhaustion was the symptom that most participants identified with; they felt physically and mentally drained but continued with their duties.

The needs of the participants in this study appear simple: lower caseloads, schedule flexibility, peer support, supervision, and being heard by leadership. Morale can be damaged when employees' hard work goes unnoticed, and there is inadequate recognition by leadership, such as recognition, promotion, or increased pay. Social workers demand respect for their role in treating patients and families. Participants mentioned a lack of consistent recognition for their role, or little to no recognition during national observances of social workers.

Colleague/Peer support and supportive supervisors or "middle management" are strong mitigation factors for burnout. Actions taken by healthcare organizations to show they are serious about listening to employees, creating competitive wages/salaries for

social workers, and gauging and reducing burnout symptoms will result in less turnover and more investment in meeting the organization's goals.

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Appendix: Semi-structured Interview Protocol

1. Interview Setup and location.

Location: The interviews will be conducted online via Zoom, by phone, or in person. The face-

to-face interviews will be conducted at the participants' location of choice, most likely their work office.

Materials: The materials will include hard copies of interview questions. If conducted by Zoom

or phone, the researcher will email the participants a copy of the interview questions. If conducted in person, the researcher will provide a copy of the interview questions to the participants. Additional materials will include pens and a composition book to take field notes during the interview.

Recording Apparatus: Zoom interviews will be saved as a digital file using Zoom tools. Phone and in-person interviews will be audiotaped utilizing a cell phone and saved as digital files. A backup recorder will be used to document the interview conversation.

2. Preliminary Activities.

1. The researcher will ensure the participant has signed and submitted the Study Interview Informed Consent.
2. The researcher will ask participants the five demographic/work questions: (a) What is your age group? (i.e., 1 = 20-29, 2 = 30-39, 3 = 40-49, 4 = 50-59, 5 = 60-69, 7 = 70 or older) (b) What is your race/ethnicity? (i.e., 1 = African American/Black, 2 = Asian American, 3 = Caucasian/White, 4 = Hispanic/Latino(a), 5 = Native American, 6 = other) (c) What is the type of healthcare setting in which you work? (i.e., 1 = hospital, 2 = community-based healthcare clinic/setting, 3 = nursing home/long term care, 4 = other) (d) What is your highest level of education? (i.e., BSW, MSW, DSW) (e) How many years have you worked as a healthcare social worker? (open-ended, answered in years). The participants will complete these questions with the researcher at the beginning of the interview.

3. Interview

1. The researcher will tell all participants: *Thank you for taking time out of your schedule to participate in this interview. This interview aims to understand better how perceived organizational support you receive as a healthcare social worker that helps reduce your burnout. The information you provide in this interview will provide invaluable*

information about healthcare social workers' organizational supports and how they may help to ameliorate burnout.

I confirm that you have informed consent to participate in this interview, including being recorded. I will be digitally recording this interview. To ensure participants' privacy, I ask that you not use your or anyone else's name during the interview. Please do not mention another person by name; use a fake name instead. I will not identify any of you in person in the study. If you are quoted, an alias name

will be assigned for anonymity. Your confidentiality will be maintained if/when any information from the interview is published in the final study. All transcripts and recordings of the interview will be housed on a private, password-protected computer, accessible only to me.

This interview should take about 60 to 90 minutes. I will give you plenty of time to answer the questions I pose, and I will ask follow-up questions if necessary. You can choose to end this interview at any time without penalty. Do you have any questions?

4. Interview Questions: The researcher will go through the interview questions.

Interview Questions

1. It is known that social workers experience elevated levels of burnout. Can you discuss your burnout in relation to your job?
 - a. When you think of burnout, what does it mean to you?
 - b. How do you describe your burnout?
 - c. Can you describe the severity of your burnout?
 - d. What are some of your experiences regarding burnout?
 - e. What physical and/or emotional symptoms do you feel are consequences of your burnout?

2. Burnout has three characteristics: emotional exhaustion, depersonalization, and a reduced sense of personal accomplishment/personal efficacy.
 - a. Can you discuss your emotional exhaustion in relation to your job?
 - b. Can you discuss your depersonalization in relation to your job?

- c. Can you discuss your reduced sense of personal accomplishment/personal efficacy in relation to your job?
3. What are some sources of burnout you experience at work?
4. How has your burnout affected your job? Your interactions with your supervisor? Your interactions with coworkers?
5. Perceived organizational support is an organizational concept that emphasizes valuing and caring for employees.
 - a. Do you feel that organizations you have worked for throughout your healthcare social work career, or those you have heard about, have valued and cared for you or their employees in general? Why or why not?
 - b. Can you discuss, in general, the ways that organizations you have worked for throughout your healthcare social work career or those you have heard about have valued and cared about you as an employee or employees in general?
 - c. How does an organization's value and care (or lack thereof) influence feelings of burnout?
6. Can you discuss fair and equitable treatment (or lack thereof) on the part of organizations you have worked for throughout your healthcare social work career or those you have heard about and how this plays a role in feelings of burnout?
7. Can you discuss fair and equitable treatment concerning salary? Time off? Opportunities for growth? How does this affect burnout?
8. In organizations you have worked for throughout your healthcare social work career or those you have heard about were human resources (HR) practices fair and equitable? Why or why not? How do HR practices affect your feelings of fair and equitable treatment and burnout?
9. In organizations you have worked for throughout your healthcare social work career or those you have heard about was there fair and equal treatment across employees? Across different positions? Concerning job roles and responsibilities? How does this affect burnout?
10. Describe how organizational support is exemplified through work conditions. Through work practices? Through resources? How does this affect your feelings of burnout?
11. What are some work conditions and practices that help to reduce your feelings of burnout? What are some work conditions and practices that increase your feelings of burnout?

12. Are HR practices beneficial or harmful to your perceptions of organizational support? How is organizational support exemplified through HR practices? How is it not? How do HR practices affect your feelings of burnout?
13. Have organizations you have worked for throughout your healthcare social work career, or those you have heard about, supported you or employees in general through an organizational reward system? By providing resources and opportunities? Through changing or improving work conditions and schedules? How do these factors affect feelings of burnout?
14. Can you discuss organizational leadership and its role in helping reduce employee burnout rates? Organizations you have worked for throughout your healthcare social work career or those you have heard about:
 - a. Has organizational leadership taken burnout seriously? Have they assessed the degree of burnout among employees?
 - b. Has organizational leadership developed initiatives and programs to reduce burnout? If so, what are these programs?
 - c. What support, resources, and guidance has organizational leadership taken to help reduce burnout among employees?
15. Can you discuss the types of support your organizational leaders have provided in the organizations you have worked for throughout your healthcare social work career or those you have heard about? Discuss the emotional support, such as the sense of “being heard,” as well as provision of counseling or time off, that organizational leaders provided that help reduce feelings of burnout. Discuss the Instrumental (i.e., financial) supports (e.g., regarding salary, promotion, comp time) your organization leaders provided that help reduce your burnout. Discuss the appraisal (e.g., feedback) the organization leader provides that helps reduce burnout?
16. Can you discuss supervisor support and advocacy, and the role your direct supervisors played in organizations you have worked for throughout your healthcare social work career, or those you have heard about, in helping to reduce burnout?
 - a. Discuss how direct supervisors provided emotional support (e.g., active listening, feedback)? Informational support (e.g., guidance)? Appraisal support (e.g., providing feedback)? Instrumental support (e.g., task support)?
 - b. What role did supervisors play in affecting your level of burnout?

17. Can you discuss how supervisors advocated other than by providing support? Think about advocacy surrounding the job, job responsibilities, work conditions and practices, and opportunities for advancement and growth. How have supervisors' advocacy implemented support and reduced feelings of burnout?
18. Describe how your coworkers' attitudes and actions in organizations you have worked for throughout your healthcare social work career, or those you have heard about affected feelings of burnout?
19. Can you discuss the support received from coworkers and how that helped to reduce burnout?
 - a. What kind of support have your coworkers offered?
 - b. Discuss how coworkers provided emotional support (e.g., active listening, feedback)? Informational support (e.g., guidance)? Appraisal support (e.g., providing feedback)? Instrumental support (e.g., task support)?
20. Do you want to add anything about burnout? About organizational support?

5. Summary/Closing. Participants will be thanked for their participation and time. The researcher will ask if the participant would like a summary of their interview and the final study findings, and if so, the best way to deliver this information to the participant.