

Burnout, Informal Social Support and Psychological Distress among Social Workers

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Abstract

Previous research has shown that social workers are a profession at risk of suffering a high incidence of so-called burnout syndrome. Burnout is in turn related to psychological distress. Social support from informal sources is a factor with potential to reduce the psychological distress caused by burnout. However, the previous research has not considered informal social support in sufficient detail. This article, using a cross-sectional study, analyses the relationship between burnout, informal social support and psychological distress in a sample of social workers in Spain ($n = 189$). The results show a high incidence of psychological distress and burnout, above all in terms of Emotional Exhaustion (EE). The results of the hierarchical regression analysis confirm the importance of informal social support as a variable negatively related to distress, even in the presence of burnout. Surprisingly, organisational variables were not associated with distress. Longitudinal and qualitative research is necessary to examine the nature of this relationship in detail.

Keywords: Burnout, social workers, distress, social support

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Background

Burnout syndrome relates to professions whose daily work has to do with systematic and direct contact with people in need of care (Pines *et al.*, 1981). Maslach and Jackson (1982; Maslach, 1976), working on Freudenberg's (1974) proposals, established the grounds for psycho-social research on burnout. The authors define the syndrome as a response to chronic work stress, mainly related to those professions and services characterised by constant, systematic and intense attention paid to people in need of care. Faced with this situation, workers frequently develop a sense of professional failure, in addition to a series of negative attitudes towards those people. It is important to emphasise that burnout is not a form of psychological stress. Rather, it is a response to chronic work stress resulting from the relationships established between professional and client/user on the one hand, and professional and institution on the other. Burnout is, moreover, a tri-dimensional process composed of Emotional Exhaustion (EE), Depersonalisation (DP) and reduced sense of Personal Accomplishment (PA), being defined by the presence of feelings of EE, attitudes of DP towards clients and reduced feelings of PA.

Bearing this definition in mind, social workers constitute an at-risk group for burnout, since these professionals must cope with complex situations where distress and suffering are characteristics of target groups for professional intervention on a constant and systematic basis. There is a body of international literature establishing social workers as an at-risk group and analysing the incidence of burnout for this group (Barak *et al.*, 2001; Cohen and Gagin, 2005; Kim *et al.*, 2011; Yürür and Sarıkaya, 2012). Research conducted by Gibson *et al.* (1989) focusing on social workers in Northern Ireland found that 47 per cent of respondents showed DP and an even higher percentage reported high levels of reduced PA. In New York, Martin and Schinke (1998) found that social workers in the mental health and family fields frequently developed burnout. Specifically, 57 per cent of mental health and 71 per cent of family social workers presented high burnout levels. In Chile, Barría (2002) found a burnout prevalence of 30.8 per cent among social workers, and almost every respondent showed high levels of at least one of its dimensions. Thus, social workers have a strong tendency to suffer the phenomena studied. The same conclusion is valid for the study conducted by Evans *et al.* (2006) in England and Wales, in which they found high levels of EE and stress and that 19 per cent of respondents had low job satisfaction levels. In Spain, research conducted to assess the prevalence of burnout is scant (Lázaro, 2004; Grau and Suñer, 2008; Hombrados and Cosano, 2013). In spite of this, some articles do state the importance of the syndrome for social workers. Research designed by Morales *et al.* (2004) for crisis intervention and social services professionals found that half of respondents showed high levels for at least one dimension of burnout, 23 per cent for two

dimensions and 11.5 per cent for all three dimensions. Along the same lines, a study completed by [Jenaro et al. \(2007\)](#) found that 20.4 per cent of workers in human services were at risk of suffering burnout.

In summary, previous research has shown that social workers perform their professional duties in a stressful social and organisational context ([Pines and Kafry, 1978](#); [Acker, 1999](#); [Kim and Stoner, 2008](#); [Pasupuleti et al., 2009](#)). For this reason, burnout usually becomes a key dimension of professional intervention. Some determinants in the emergence and development of burnout among social workers are the constant social, demographic and political changes affecting and modifying both client/user problems and professional competences ([Lloyd et al., 2002](#)), scant social status and recognition for social work, low salaries and resources for social intervention ([Rupert and Morgan, 2005](#); [Acker, 2008](#)), and problems related to organisational structure and environment determining role conflict and role ambiguity, lack of supervision and coordination for work groups, and high staff turnover ([Bennet et al., 1993](#); [Bradley and Sutherland, 1995](#)).

In general terms, previous research is reasonably supportive of the idea that burnout plays a role in the development of psychological distress and emergence of psychological disorders ([Pillay et al., 2005](#); [Milfont et al., 2008](#); [Shanafelt and Dyrbye, 2012](#); [Kozaka et al., 2013](#)). Results from several studies focusing on social workers indicate that the incidence of mental disorders associated with burnout is considerably higher for social workers than for other professions ([Bennet et al., 1993](#); [Lloyd et al., 2002](#)). In this vein, [Caughey \(1996\)](#) found that 72 per cent of social workers surveyed could be defined as possible psychiatric cases, given the high levels of psychological distress reported in relation to their professional performance. These findings are very similar to those of [Balloch et al. \(1998\)](#) for the same professional group and those of [Collins and Parry-Jones \(2000\)](#), who also noted that psychological distress was associated with high levels of anxiety and depression. In summary, previous research shows that burnout has significant negative consequences for social workers' mental health.

Given this relationship, a number of studies have focused on those variables that may play a moderating role in the appearance of psychological distress following the development of burnout. In this sense, one of the most important variables is social support. There is abundant research considering social support as a mediating variable between burnout processes and mental health ([Bennet et al., 1993](#); [Pines et al., 2002](#); [Collins, 2008](#); [Yildirim, 2008](#)). Moreover, perceptions of both availability and lack of social support are related to the development of burnout ([Acker, 1999](#); [Hamama, 2012a](#)). Most studies have focused on the formal social support networks maintained by workers. These networks usually include co-workers, peers and supervisors ([Leiter and Maslach, 1988](#); [Farber, 2000](#); [Thomas and Rose, 2010](#); [Hamama, 2012b](#)). However, [Baruch-Feldman et al. \(2002\)](#) have pointed to the importance of close personal relationships (family and friends). A few studies ([Maslach and Jackson, 1985](#); [Greenglass et al., 1994](#); [Huyhn et al., 2013](#)) have

in fact shown that informal networks and relationships have important implications for the development of burnout, and could even offer more effective help than formal social support systems in alleviating this phenomenon (Broadhead *et al.*, 1983; House *et al.*, 1988; House, 1991).

Informal social support focuses on a level of intimacy constructed within the context of an interpersonal help system that shapes an ecological daily help process in which people usually play complementary and interrelated roles (Umberson and Montez, 2010). This level of social support involves feelings of commitment and mutual exchanges and relationships with shared responsibility for one another's well-being. The level of social support is thus beneficial precisely because of the functions it fulfils. As a result, informal social support is widely accepted as a key variable for health and well-being (Sánchez-Moreno and Barrón, 2003).

As reported by Collins (2008), social support becomes a major coping strategy, since it enables the individual to deal with both instrumental (seeking information, advice, etc.) and emotional (seeking affection, moral support, etc.) issues, the latter relating to qualitative aspects of informal support. In the context of formal systems and groups, support is based on an exchange of resources aimed at satisfying the specific needs that can be met within the most intimate relationships with family and friends. We therefore see the importance of informal social support as a potential work–stress reducing variable.

The general aim of this study consists specifically of examining the relationship between informal social support, burnout and psychological distress among social workers in Madrid (Spain). Given the scarcity of existing research in Spain, one of the specific aims is to evaluate the incidence of burnout and psychological distress in a sample reflective of the socio-demographic composition of the profession in the aforementioned city. We also seek to analyse the roles played by burnout and by social support emanating from informal sources in psychological distress in the case of social workers. In this respect, it is worth stressing the importance of considering the potential of informal social support to reduce the negative consequences of burnout and thus addressing one of the more notable gaps in the literature, as outlined in preceding paragraphs.

Method

Participants and procedure

Two hundred social workers from public social services in Madrid were contacted by telephone to participate in our study, of whom 189 ultimately participated in our cross-sectional research (94.5 per cent response rate). Self-report questionnaires were distributed by mail to the social workers that voluntarily agreed to participate. The participants answered the questionnaires and

returned them by mail. To present the research, a letter was enclosed with each questionnaire that introduced the research team, the context and purpose of the research, and the structure of the questionnaire, and also guaranteed participant anonymity.

The sample was predominantly female (87.3 per cent, $n = 165$). The average age was 41.8 years, ranging from twenty-three to sixty years. The majority of the professionals were married or living with a partner (70.4 per cent, $n = 133$) and 51.9 per cent ($n = 98$) had children.

With respect to employment, the average duration of occupation as a social worker was eight years and more than half of participants (56.6 per cent, $n = 107$) had working experience of between sixteen and thirty years. Participants had spent an average of seven years in their current position. Approximately one-third of respondents (32.3 per cent, $n = 61$) had been in their current position for fifteen to thirty years, 32.8 per cent ($n = 62$) for six to fifteen years and, finally, 33.9 per cent ($n = 64$) for one to five years. Only 1 per cent ($n = 2$) had spent over thirty years in their current position.

Regarding agency size, the average was thirty-five workers per agency. Institutions with one to fifteen workers accounted for 34.4 per cent ($n = 65$) of the sample, with 23.3 per cent ($n = 44$) employing sixteen to thirty workers, 15.9 per cent ($n = 30$) employing thirty-one to sixty workers and 21.7 per cent ($n = 41$) with more than sixty workers. Finally, subjects reported an average of thirty-five clients per week, distributed in intervals from one to twenty-five clients (44.4 per cent, $n = 84$), from twenty-five to fifty clients (30.7 per cent, $n = 58$) and more than fifty clients (12.7 per cent, $n = 24$).

Finally, all participants were professionals from public social services. Of the participants, 138 (73 per cent) worked in the Social Services Network and fifty-one (27 per cent) worked in the Public Health System. Of the former, eighty-eight participants (63.9 per cent) performed their professional work in Primary Social Care and fifty (36.1 per cent) were employed in Specialized Social Care (elderly, mental health, education, children and family, etc.). This is representative of social work in Spain, where professionals principally work within the public system.

The study was approved by the 'Faculty Postgraduate Committee' (Faculty of Social Work at Complutense University of Madrid). In addition, all participants in the study provided verbal consent after being contacted by the research team.

Measures

A socio-demographic and job data questionnaire was used. It included workers' socio-demographic variables (i.e. gender, age, marital status and number of children), professional experience and experience in current position, and variables relating to the workplace including caseload (number of clients) and size of agency (number of employees).

Burnout was assessed with the Maslach Burnout Inventory–Human Service Survey (MBI–HSS) (Maslach and Jackson, 1986), using the Spanish version developed by Seisdedos (1997). The MBI is a twenty-two-item scale including three dimensions: Emotional Exhaustion (EE; nine items), Depersonalisation (DP; five items) and Personal Accomplishment (PA; eight items). EE describes the feeling of being emotionally overextended and exhausted, DP reflects an impersonal and unfeeling attitude towards professional services clients and PA describes feelings of success and competence regarding one's work, principally with relation to clients. Participants were asked to rate how often they felt the feelings described for each item on a seven-point Likert scale, ranging from 'never' (0) to 'every day' (6). The three-factor MBI structure has been replicated using different samples (Maslach and Jackson, 1981; Lee and Ashforth, 1996; Schaufeli *et al.*, 2001) and has been used with social worker samples (Kim and Ji, 2009; Hamama, 2012a, 2012b). The internal consistency of the MBI in our research was 0.848.

The twenty-eight-item version of Goldberg's General Health Questionnaire (Goldberg, 1978; Goldberg and Williams, 1988), adapted and validated into Spanish by Lobo *et al.* (1986), was used to assess psychological distress. This questionnaire is a screening instrument that estimates psychiatric morbidity and analyses the assessment a person makes of his/her own state of well-being, especially as regards certain emotional or psychological states that generate psychological distress. It consists of twenty-eight items divided into four seven-item scales: somatic symptoms (GHQA), anxiety/insomnia (GHQB), social dysfunction (GHQC) and severe depression (GHQD). Participants evaluate the occurrence of each item on a four-point response scale ranging from 'less than usual' (0) to 'much more than usual' (3). The factor structure of the GHQ-28 has been validated in various studies (Banks, 1983; Medina-Mora *et al.*, 1983). The internal consistency of the GHQ in our research was 0.939.

Finally, to analyse the social support networks that professionals have outside of work, we used an adaptation of the Social Resources Inventory (SRI) developed by Díaz Veiga (1987). It includes different social support dimensions: objective and structural factors (frequency of contact with networks), subjective factors (satisfaction with networks) and functional aspects (emotional, instrumental or both). These dimensions are assessed with relation to four contact areas: partner, children, wider family and friends. For each area of contact and satisfaction, scores range from 1 to 3. Montorio (1994) determined the internal consistency indices, finding values ranging from 0.35 to 0.86 depending on the sample. The internal consistency value in our research was 0.722.

Results

As shown in Table 1, in terms of the MBI dimensions, the average social worker scores are similar to the average scores for the normative sample

Table 1 Comparison of burnout scores of social workers with scores for the normative sample (Seisdedos, 1997)

Group	MBI subscales		
	EE	DP	PA
Spanish norms for MBI (<i>N</i> = 1,138)			
Mean	20.36	7.62	35.71
Standard deviation	11.30	5.01	8.0
Social workers sample (<i>N</i> = 189)			
Mean	26.16	7.51	36.94
Standard deviation	10.08	5.43	7.81

EE, Emotional Exhaustion; DP, Depersonalisation; PA, Personal Accomplishment.

Table 2 Incidence of low, moderate and high levels of burnout

	Low		Moderate		High	
	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%
EE	23	12.2	56	29.6	105	55.6
DP	50	26.5	75	39.7	58	30.7
PA	40	21.2	64	33.9	74	39.2

Note: the cut-off points for each MBI dimension are those established in the Spanish adaptation of the Manual (Seisdedos, 1997). EE—high: ≥ 25 , moderate: 24–15, low: ≤ 14 ; DP—high: ≥ 10 , moderate: 9–4, low ≤ 3 ; RP—high: ≥ 40 , moderate: 39–33, low: ≤ 32 . EE, Emotional Exhaustion; DP, Depersonalisation; PA, Personal Accomplishment.

(Seisdedos, 1997) for the DP and PA dimensions. However, there is a difference as regards the EE dimension, where the sample returned higher average scores. The sample thus had a high level of EE, moderate levels of DP and a PA higher than the sample for the Spanish adaptation of the MBI. In fact, as seen in Table 2, more than half of participants (55.6 per cent) reported high EE levels, 30.7 per cent showed high DP attitudes and 21.2 per cent of professionals reported feelings of low PA. While the majority of participants experienced positive feelings towards the work they were doing (PA, 39.2 per cent), according to Spanish norms, the sample was mainly characterised by its high EE level and moderate DP level (39.7 per cent).

As regards psychological distress, the average for social workers for the global GHQ-28 score is slightly higher than that indicated in the cut-off points. That is, as may be observed from Table 3, the total average obtained was 23.37 ± 12.01 , and thus the average was above the cut-off points established in the Spanish adaptation of the questionnaire (Lobo *et al.*, 1986). Although most of the professionals (56.6 per cent) did not present a possible case of psychological distress, 41.8 per cent did obtain scores above the cut-offs. The high percentages for scale C (social dysfunction) stand out.

As regards the organisational variables, PA is greater among those individuals attending to a higher number of users per week ($r = 0.352$; $p = 0.000$) and lesser among those social workers carrying out their professional work

Table 3 Descriptive statistics for GHQ-28

Descriptives	GHQA		GHQB		GHQC		GHQD		GHQ	
M	7.02		7.20		7.54		1.72		23.37	
SD	4.25		4.69		2.42		2.75		12.01	
Percentages	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%
Possible case	90	47.6	98	51.9	136	72.0	13	6.9	79	41.8
No case	97	51.3	90	47.6	52	27.5	176	93.1	107	56.6

GHQ, General Health Questionnaire; GHQA, somatic symptoms; GHQB, anxiety and insomnia; GHQC, social dysfunction; GHQD, severe depression; GHQ, global average score. Cut-off points—Global: ≥ 23 ; each subscale: ≥ 7 .

in institutions with a higher number of employees ($r = -0.171$; $p = 0.025$). The data also reveal correlations between the GHQ subscales and certain work variables. In this regard, the professional experience variable shows a significant positive correlation with the global score for GHQ-28 ($r = 0.157$; $p = 0.032$), with the severe depression variable ($r = 0.164$; $p = 0.024$) and with the anxiety and insomnia variable ($r = 0.163$; $p = 0.026$). In the same manner, the experience in current position variable correlates with the severe depression subscale ($r = 0.163$; $p = 0.025$). These results suggest that certain professional variables may influence psychological distress in social workers.

With respect to the association between burnout and psychological distress, Table 4 records the correlations for the study variables, with the following results standing out. The EE dimension correlates significantly and positively with each one of the GHQ subscales. These associations are repeated for the DP dimension exclusively with the anxiety and insomnia ($r = 0.321$; $p = 0.000$), severe depression ($r = 0.220$; $p = 0.003$) and global GHQ-28 score ($r = 0.233$; $p = 0.002$) subscales. The PA dimension is significantly negatively associated with all the GHQ-28 subscales, except somatic symptoms.

Considering the different social support dimensions analysed by SRI, significant negative associations were found for the EE dimension with the variables of satisfaction with support of extended family ($r = -0.293$; $p = 0.000$) and satisfaction with support of friends ($r = -0.179$; $p = 0.015$). Each and every one of the GHQ-28 subscales are significantly negatively associated with overall satisfaction with support, with satisfaction of professionals with the contact maintained with spouse or partner, with satisfaction with family contact and with satisfaction with friendships (see Table 4). Furthermore, the global support measure correlates with all the subscales measuring psychological distress, except for the severe depression subscale. There is also a statistically significant association between the frequency of partner contact measure and different GHQ-28 subscales (somatic symptoms: $r = -0.174$;

Table 4 Matrix of associations among main study variables

	EE	DP	PA	GHQA	GHQB	GHQC	GHQD	GHQ
GHQA	0.524**	0.115	-0.098					
GHQB	0.590**	0.321**	-0.178*					
GHQC	0.352**	0.118	-0.160*					
GHQD	0.406**	0.220*	-0.250**					
GHQ	0.573**	0.233*	-0.189*					
Number of users	-0.025	0.078	0.352**	-0.044	-0.037	-0.024	-0.036	-0.042
Number of workers	0.089	0.011	-0.171*	0.091	0.097	0.088	0.070	0.117
Professional experience	0.124	-0.083	-0.130	0.116	0.163*	0.101	0.164*	0.157*
Experience in current position	0.117	-0.024	0.016	0.129	0.120	0.097	0.163*	0.143
Overall support	-0.070	-0.088	0.004	-0.160*	-0.197**	-0.189**	-0.127	-0.191**
Satisfaction with overall support	-0.112	-0.080	-0.020	-0.221*	-0.265**	-0.259**	-0.181*	-0.274**
Overall contact frequency	-0.022	-0.093	0.026	-0.078	-0.111	-0.110	-0.064	-0.089
Satisfaction with partner support	-0.104	-0.023	0.083	-0.256**	-0.238**	-0.256**	-0.164*	-0.282**
Satisfaction with child support	0.059	-0.101	-0.077	0.018	-0.017	-0.050	0.023	-0.006
Satisfaction with family support	-0.293**	-0.104	-0.017	-0.195**	-0.343**	-0.343**	-0.302**	-0.294**
Satisfaction with friend support	-0.179*	0.024	-0.031	-0.248**	-0.266**	-0.228**	-0.197**	-0.267**
Frequency of partner contact	-0.069	-0.019	0.064	-0.174*	-0.152*	-0.194**	-0.136	-0.189**
Frequency of child contact	0.058	-0.116	-0.075	0.035	0.003	-0.024	0.053	0.020
Frequency of family contact	-0.071	-0.125	0.110	0.021	-0.050	0.031	-0.017	0.041
Frequency of friend contact	-0.057	0.049	0.090	-0.057	-0.078	0.050	-0.063	-0.025

EE, Emotional Exhaustion; DP, Depersonalisation; PA, Personal Accomplishment; GHQ, global score; GHQA, somatic symptoms; GHQB, anxiety and insomnia; GHQC, social dysfunction; GHQD, severe depression.

* $p \leq 0.05$; ** $p \leq 0.01$.

Table 5 Hierarchical linear regression models for psychological distress (GHQ)

Model		B	SE b	β	t	p	
1 ($p < 0.01$)	(Constant)	11.160	4.729		2.360	0.020	
	EE	0.703	0.088	0.562	7.975	0.000	
	DP	0.118	0.167	0.049	0.702	0.484	
	PA	-0.178	0.106	-0.109	-1.678	0.095	
2 ($p < 0.01$)	(Constant)	23.980	9.713		2.469	0.015	
	EE	0.547	0.086	0.437	6.393	0.000	
	DP	0.270	0.154	0.113	1.749	0.083	
	PA	-0.213	0.099	-0.131	-2.157	0.033	
	Frequency of partner contact	3.619	1.838	0.334	1.969	0.051	
	Satisfaction with partner support	-5.173	1.818	-0.475	-2.845	0.005	
	Frequency of child contact	13.713	3.892	1.635	3.523	0.001	
	Satisfaction with child support	-13.614	3.959	-1.603	-3.438	0.001	
	Frequency of family contact	3.729	2.067	0.111	1.804	0.073	
	Satisfaction with family support	-3.353	1.884	-0.115	-1.779	0.077	
	Frequency of friend contact	1.453	1.503	0.068	0.967	0.335	
	Satisfaction with friend support	-4.144	1.735	-0.171	-2.388	0.018	
	3 (n.s.)	(Constant)	23.222	10.130		2.292	0.023
		EE	0.529	0.085	0.423	6.188	0.000
DP		0.243	0.155	0.102	1.571	0.119	
PA		-0.176	0.104	-0.109	-1.697	0.092	
Frequency of partner contact		3.031	1.837	0.280	1.650	0.101	
Satisfaction with partner support		-4.453	1.830	-0.409	-2.433	0.016	
Frequency of child contact		14.042	3.897	1.674	3.604	0.000	
Satisfaction with child support		-14.372	3.956	-1.692	-3.633	0.000	
Frequency of family contact		3.252	2.051	0.097	1.586	0.115	
Satisfaction with family support		-3.724	1.873	-0.128	-1.988	0.049	
Frequency of friend contact		1.091	1.494	0.051	0.730	0.467	
Satisfaction with friend support		-4.348	1.733	-0.179	-2.509	0.013	
Professional experience		0.194	0.473	0.033	0.411	0.681	
Number of workers		0.011	0.005	0.133	2.174	0.031	
Number of users	-0.019	0.036	-0.034	-0.540	0.590		
Experience in current position	0.359	0.359	0.074	1.001	0.319		

EE, Emotional Exhaustion; DP, Depersonalisation; PA, Personal Accomplishment.

$p = 0.017$; anxiety and insomnia: $r = -0.152$; $p = 0.037$; social dysfunction: $r = -0.194$; $p = 0.008$; and overall score: $r = -0.189$; $p = 0.010$).

To understand the role played by burnout and informal social support in psychological distress, three theoretical models of increasing complexity were formulated and tested through a hierarchical regression analysis. The first model exclusively included the various burnout dimensions (EE, DP and PA) as independent variables. The second included the burnout dimensions and variables related to social support. The third and final model, in addition to the preceding variables, included the aforementioned work and organisational variables. Of these, the third model does not increase the explicatory capacity of the preceding ones ($F = 2.065$; $p = 0.089$).

As may be observed in Table 5, for model 1 (which explains 35.1 per cent of the GHQ-28 variance), only the EE burnout dimension shows a significant association with distress ($\beta = 0.562$; $p = 0.000$). In model 2, significant

associations appear between distress and the following variables: EE ($\beta = 0.437$; $p = 0.000$), PA ($\beta = -0.131$; $p = 0.033$), satisfaction with partner relationship ($\beta = -0.475$; $p = 0.005$), frequency and satisfaction of contact with children ($\beta = 1.635$; $p = 0.001$ and $\beta = -1.603$; $p = 0.001$, respectively), and finally, satisfaction with relationship maintained by professionals with close friends ($\beta = -0.171$; $p = 0.018$). This model explains 47.6 per cent of the GHQ variance.

Discussion

The participants in our study reported higher burnout levels than those found in previous research (Maslach *et al.*, 1996; Jenaro *et al.*, 2007; Lernihan and Sweeney, 2010). The sample was characterised by an elevated presence of emotional exhaustion, which was present for more than half of participants. This is consistent with numerous studies showing that, for social workers, emotional exhaustion is the most prevalent dimension (Bradley and Sutherland, 1995; Evans *et al.*, 2006; Acker, 2008). Though many variables influence the development of burnout, it should not be forgotten that one of the fundamental aspects of social work is the establishing of a highly emotionally charged relationship between professional and user. As recorded in various investigations since this phenomenon was first studied, those professions with heightened emotional demands, characterised by direct and continuous contact with persons in situations of need, are precisely those presenting the greatest risk of suffering burnout (Maslach, 1978; Soderfeldt *et al.*, 1995; Maslach and Leiter, 1997).

Although the proportion of social workers affected by psychiatric distress is lower than that reported in other studies (Caughey, 1996; Evans *et al.*, 2006), it remains consistent with the relevant literature that shows the high levels of psychological distress present among these professionals in comparison to other occupational groups and to the general population (Thompson *et al.*, 1996; Balloch *et al.*, 1998; Rossi *et al.*, 2012).

Our results show that 41.8 per cent of participants obtained scores above the cut-off points, especially with respect to social dysfunction (72 per cent), which, according to the Spanish adaptation of the questionnaire (Lobo *et al.*, 1986), indicates that these professionals present a possible psychiatric case on the basis of self-reporting levels of distress. However, as pointed out by Makowska *et al.* (2002) in their study of the validity of the GHQ, these findings must be interpreted cautiously due to the limitations of the measurement instrument. In particular, it is possible that estimates may overemphasise the incidence of disorders, leading to persons being erroneously classified as 'psychiatric cases' when, in reality, they are healthy. In any event, within the context of the present study, the GHQ does not serve a diagnostic purpose, and in fact the independent variables considered in the multivariate analyses reflect the presence of the symptoms identified in

the various instrument subscales, and not a diagnosis of a possible psychiatric case.

Nevertheless, the strong association found between burnout and psychological distress does render these levels of distress particularly important. Our results reinforce the findings of previous research (Bennet *et al.*, 1993; Lloyd *et al.*, 2002). Furthermore, it is the emotional exhaustion dimension that shows greater correlations with lack of health or well-being, which again indicates the fundamental role of emotions within professions such as social work, with managing emotions forming an integral part of daily professional life.

One of the fundamental aims of this research was to analyse the role played by informal social support in psychological distress, considering it together with burnout. Our results suggest that the association between informal social support and burnout is specific, with the key variable being satisfaction with social support. Additionally, the results suggest that informal social support is particularly important in those situations in which burnout is also a key factor in accounting for the psychological distress. In general terms, our results fit a model of direct effect of informal social support. In this regard, the results of the regression analysis undertaken suggest that an association exists between emotional exhaustion and the low personal accomplishment, on one hand, and psychological distress on the other. To this association, positive in statistical terms, one must add the opposing association between specific dimensions of social support (satisfaction with partner, friend and family contact) and psychological distress. Those social workers that suffer burnout would thus benefit from having access to an effective informal social network, which would provide support in functional terms. This benefit should not arise through sharing aspects of daily work in a manner that may compromise professional ethics by breaching client–professional confidentiality. Rather, we refer here to the potential buffering effect of informal sources of social support, forming part of a mutual assistance system based on reciprocity offered by both instrumental and, more importantly, emotional social support. This is particularly significant given the high levels of emotional exhaustion in our study. An effective system of informal social support would create a natural space for well-being separate from the distress caused by the social worker’s professional situation.

On this point, it is worth emphasising that, in our results, the quality of social support (Brown and Harris, 1978), in our case expressed as satisfaction with social support, is the variable associated with the reduction of psychological distress. This is a finding consistent with the previous research, which highlights the positive effect of informal social support from a subjective and functional perspective (Ogus, 1990; Barrón and Sánchez-Moreno, 2001; Yildirim, 2008).

As regards the structural dimensions of support, only frequency of contact with children shows a significant positive association with psychological distress. As indicated in other studies (Blanch and Aluja, 2012), a possible

explanation may lie in the dimension of gender. Our sample is predominantly female (a fact reflecting the realities of the profession in Spain), perhaps leading to the existence of difficulties in reconciling the family and professional lives that generate a double working day. In this regard, it is unsurprising that, faced with these balancing difficulties, there is an equivalent doubling in work overload, generating greater stress and psychological distress, particularly among women (Parasuraman and Simmers, 2001; O'Driscoll *et al.*, 2004; Juárez, 2007; Rubino *et al.*, 2013).

Regarding organisational variables, certain studies have shown that professional experience and current position decrease psychological distress (Furnham, 2001). After years of experience, social workers acquire a greater mastery of the activities, tasks and emotions associated with the job and develop strategies to cope with stress, which they modulate based on their experiences in previous situations. However, our results are contrary to previous findings in this respect. One possible explanation for this is that, despite the knowledge acquired through experience, constant and prolonged contact with the problems of clients and the institutional framework could cause the professional to feel progressively overwhelmed, increasing distress and feelings of burnout due to the emotional overload generated by many years of professional practice. For our sample, the effects of the Great Recession (during which time the field research for this study was carried out) may have exacerbated this process. There has been radical growth in inequality and an increasing proportion of the population have ever-greater socio-economic needs. Together with falling levels of resources available for social intervention, these factors have created a context in which it is the professionals with greater experience who may be better equipped to appreciate the significance of this growing inequality, experiencing higher levels of professional frustration, workplace stress and burnout.

In any case, it is noteworthy that organisational variables did not play an important role in our study. In fact, in the hierarchical regression analyses undertaken, the contribution of the variables considered (size of organisation, workload, experience in position) did not satisfy the statistical significance conditions for incorporation into the psychological distress explicatory model. These results are inconsistent with the previous literature on this issue (Pines *et al.*, 1981; Drory and Shamir, 1988; Burke and Richardson, 1996; Maslach and Leiter, 1997; Hamama, 2012a). A possible explanation may lie in the variables selected, which in the case of social workers may not be those of greatest importance in the development of burnout and psychological distress. Specifically, it appears necessary to determine the organisational variables that relate to the emotional exhaustion dimension, as this is the dimension of greatest importance in the explanation of burnout among professionals according to the results obtained.

In this respect, certain variables that may play a significant role in the development of burnout and psychological distress in social workers, which have not been analysed in depth in this study, are those related to the

interpersonal system of the organisation, principally as regards service users. It cannot be forgotten that social workers work with an oppressed population. From the perspective of anti-oppressive social work (Dominelli, 2002), ‘service users’ become an excluded social category within a social structure that exacerbates inequalities and social division. In this regard, it is necessary for the professional to confront their own prejudices and, further, to focus their intervention not merely on the person, but also on the exclusive and unequal system. Along these lines, resolute institutional support for *case advocacy* actions may assist in reducing burnout levels, helping the professional achieve a sense of agency and mastery in seeking to effect institutional and structural change with respect to oppressive situations. This is applicable both for depersonalisation—given the involvement with the needs of the groups and individuals on behalf of which case advocacy is implemented—and personal accomplishment, since case advocacy may contribute to improving the tools and strategies of social change that characterise social work intervention.

Conclusion

Our study demonstrates the great impact of the workplace environment on social workers, suggesting that this profession is associated with a high risk of suffering burnout and psychological distress. In this regard, this research makes its contribution within the framework of a scarcity of studies examining the relationship between burnout and psychological distress in Spain. But this contribution undoubtedly has certain limitations. First, it is necessary to design more complex research. Longitudinal studies and/or statistically representative samples would be of great use in understanding the development of burnout over the course of professional careers. It would also clearly be particularly useful to undertake research through the development of qualitative designs. This strategy would be particularly important in understanding the experience that professionals themselves have of burnout, thereby achieving a more detailed understanding of the mechanisms linking it with psychological distress in professionals. Second, our study did not include measures for formal and professional social support. Though the existing literature has clearly documented the association between this kind of support and burnout, future research could focus on the relationship between informal social support and professional social support, in addition to the processes by which such a relationship influences burnout levels experienced by social workers. The aim would be to determine the extent to which sources of support are complementary, additive or act as functional substitutes, among other possibilities, and to identify the impact of these dynamics in burnout. The results of this type of research may help to identify keys for developing policies aimed at reducing workplace stress and psychological distress.

Within the context of these limitations, the current research makes a contribution to knowledge of the incidence of burnout in Spain, a country in which previous research is scarce. Perhaps the most noteworthy element of the results obtained relates to the importance of informal social support. Given this importance, it would be worth designing prevention and intervention strategies concerning burnout among social workers taking the aforementioned trend into account. Taking part in informal social activities represents one possible approach to prevent burnout and psychological distress and offers an example of the aforementioned space for well-being (Yukelson, 1997). This strategy would be even more effective if complemented by effective social support within the workplace environment, such as peer-support groups (Schaufeli and Enzmann, 1998).

As our results suggest, these strategies would be particularly useful to reduce EE, the variable more closely related to psychological distress in the case of social workers. In future research, a joint consideration of the formal and informal dimensions of social support would permit a precise evaluation of each dimension's role and the specific patterns of their association with burnout and psychological distress.

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