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“Noble Suffering”: Social Suffering Theory Applied to the Experiences of Early-Career Stage Social Workers in the Midwestern United States

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Abstract

There are a wide array of psychological and emotional occupational harms prevalent amongst the caring professions. Conceptually these phenomena have coalesced under terms like moral distress and injury, compassion fatigue, and burnout. While these terms have a rich body of literature developing their definitional constructs, discussion is still fluid on the boundaries amongst and between them when focused on the caring professions to include physicians, nurses, psychologists, psychiatrists, and social workers. This study draws from semi-structured phenomenological interviews conducted with early-career social workers possessing less than five years of professional experience independent of their academic preparation. This study finds that the early-career experiences of social workers including their academic phase are saturated by a social system of cyclical burnout well beyond the syndromic understanding of the term.

Keywords: graduate students, social workers, field placements, compassion fatigue, burnout, moral distress and injury, social suffering theory

Dedication

This thesis is dedicated to those who care for us and particularly the social workers for whom I am blessed to call friend.

Acknowledgments

I would like to thank my Thesis Director, Jason Silverstein Ph.D., for his encouragement and guidance throughout the thesis process. I would also like to sincerely thank my Research Advisor Richard Martin Ph.D., for his sound advice in shaping the proposal that led to this project. From inception to fruition, thank you both for the thoughtful feedback and insightful collaboration.

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Chapter I.

Introduction

Among the direct-care mental health professions, the training of social workers is unique in the speed at which students are introduced to the act of caring, the shear topical breadth of the discipline, and low prerequisite thresholds to entry if any exist at all. The potential career paths available to someone with a Master of Social Work (MSW) degree might just as easily be a human resources administrator at a commercial organization as they could be a therapist working in clinical settings. In fact, a social worker providing psychological counseling may simply possess a bachelor's degree which stands in stark contrast to their mental health professional counterparts, however this study focuses on the experiences of those social workers with graduate degrees. Where a psychiatrist is a medical doctor with a formal residency, prior to specializing in psychiatry, social workers often have focused graduate degree experiences of two or so years during which they are immediately aligned to field placements in a variety of settings, often prior to the beginning of academic coursework.

Generally, students enter field placements as student-practitioners applying theory learned in the classroom for real clients and patients. As social work students, they are not independent practitioners, rather they are meant to receive close supervision at the field placement site to ensure quality of care for the client with oversight provided by the university. "Close supervision" in this case is a relative term where supervision may be implemented in a variety of styles between an experienced social worker(s) and the student-practitioner with an overarching goal of assisting the student in providing

"competent, appropriate, and ethical" care (National Association of Social Workers 2013, 6). In practice this may be a period of shadowing where the student follows the senior social worker as they conduct their duties or the opposite where the student-practitioner is shadowed. For some settings, supervision may take place periodically, such as a weekly check-in, as the senior social worker reviews the notes and recordings of the student-practitioner to provide guidance on quality of care as well as support the student's skill acquisition and refinement methodological implementation.

Settings for field placements can range from hospitals, community outreach centers, non-profits, addiction centers, and mental and behavioral health facilities. Each one represents a complex professional environment coupled with the unique challenges of caring for the people these organizations serve. Student-practitioners must navigate this while managing an aggressive course load (for two-year programs specifically) while often working an additional job to provide for themselves.

As found in this study, students often bounce between social work domains (e.g. community versus family practice) as they discover their vocational placement across the field. A student may enter the MSW program expecting to focus on individual therapy and through field placement and classroom experiences find that they derive greater satisfaction from working with a different client population altogether such as family counseling. Of particular interest to this research are those social workers who pursue pathways that lead to direct-care disciplines within the mental and behavioral health field typically occurring in hospital, addiction centers, private practices, and mental and behavioral health facilities.

Post graduation requirements to enter practice vary from state to state in the United States. In Ohio, where this research occurs, a social work student would need to, at a minimum, sit for a state licensure exam to obtain their Licensed Social Worker (LSW) license to practice. In the social worker community these licenses are both a credential that is obtained as well as a professional identity. Meaning, one gets their LSW license and would then refer to themselves and others who possess the same credential as *an* LSW. Following the attainment of the LSW license, additional supervision would be required for those social workers who intend to build their own practice as they would need an independent license to do so.

Once enough supervised hours are accrued, the LSW would sit for another exam to obtain their "I" or independent license making them an LISW. Should the social worker decide to provide supervision for others, either as a service or as part of their business development, they would need to obtain an additional license, the LISW-S which only requires time to obtain in Ohio. No further testing or training is required to supervise student-practitioners or fellow LSWs seeking their LISW. According to study participants this policy of supervisory credentialing without verification is potentially problematic as so much of a social work student's preparedness relies on the quality of their supervisors. The field allows for additional credentialing in the form of certifications for specializations such as trauma work or substance abuse, but at least in Ohio, there are no forcing factors beyond the drive of the individual and perhaps the policy of the workplace, though this research detected no such occurrences of institutional policy enforcement.

The Suffering of Giving Care

It is within the dynamic and complicated settings of direct-care that early-career social workers may encounter the increasingly discussed topics surrounding the psycho-emotional suffering and injury of the caring professions for the first time. The concept of psycho-emotional suffering and injury in this sense departs from its definitional root origin and is used within this research more broadly to encompass the emotional and psychological occupational harms that healthcare professionals experience from the act of giving care. Under certain circumstances this phenomenon may transcend the psychological and emotional self and extend to impact the moral and spiritual selves of the caregiver. These phenomena are myriad and are represented in the literature by the terms compassion fatigue, burnout, moral distress and injury, and secondary/vicarious trauma amongst others.

While these terms legitimately exist with valuable distinctions amongst them, the apparent overlap and interconnectedness between them may be blurred by writing them as a comma-separated list. Additionally, many of these phenomena persist in a conceptual state, in the academic sense, as empirical measures are being validated and definitional constraints are debated. These terms are reviewed in greater detail in Chapter 2. Given that there is no parent term to encapsulate them all currently, where this research labels "psycho-emotional suffering and injury" what is really being referred to are the collective harms that are experienced by the caring professions resulting from their practice, meaning direct interactions with their patients/clients as members of a care team within a care system.

Various forms of suffering related to the psycho-emotional suffering and injury of the caring professions are distinguished as being embodied phenomena (Maslach et al. 2001) among caregiving professionals that can lead to coercive paradigms challenging the psychological, emotional, moral and/or spiritual self of the caregiver (Austin et al. 2005). The consequences of these harms may result in suboptimal care for patients, negative internalized symptoms experienced by the practitioner resulting in practitioners questioning whether they should remain in the practice of healing in general. From onset, practitioners can become susceptible to numerous symptoms including loss of empathy, negative self-perception, anger, depression, diminished professional performance, cognitive and behavioral changes, and depersonalization.

The occurrences of these phenomena are significant, with The Atlantic (Yong 2021) reporting that 35-45% of nurses and physicians in the United States were actively experiencing burnout prior to the outbreak of the COVID-19 pandemic. Once the pandemic took effect, the added pressures of a politicized global health crisis combined with inadequate support and resources drove hundreds of thousands of healthcare professionals out of the practice altogether. For those frontline healthcare workers who remained, a significant majority, 52.7-87.8% according to one study (Norman et al. 2021), suffer from formal moral distress and test positively for posttraumatic stress disorder (PTSD) criteria.

Morally injurious experiences have been investigated along tightly defined branches under the terms of moral distress, moral injury, moral stress, moral residue, compassion fatigue, secondary traumatic stress, and burnout amongst others. Conceptually, there are two main arguments shaping the understanding of moral distress

and injury as either primarily external – meaning resulting from systems and organizations (Epstein & Hurst 2017), or internal – for example a deficit in one's own resilience or an unreasonable/irrational expectation of one's own abilities or capacity (Carse & Rushton 2017). A portion of the literature works to bridge concepts by linking compassion fatigue and burnout as moral injury types (Forster 2009) or further specifying taxonomies of moral distress and injury with an approach using inclusive and exclusive criterion as means to give the still evolving concept a more concrete shape (Campbell et al. 2016; Fourie 2017). While the body of literature is robust by many measures, the boundaries of these various injuries remain blurry as the conceptual distinctions remain in flux and are compounded by a still fluid demarcation of *who* can experience *what*.

Despite the semantic churn over the definitional nature of these phenomena, interventions are actively being developed and studied at the same time. Due to the urgent, near epidemic level of prevalence, most of these interventions are implemented in response to occurring distress/injury and are not targeting onset conditions which have largely been left to the academy to mitigate (Kopacz et al. 2015). The isolation of onset conditions is particularly difficult to operationalize within a scientific model as the symptomology expression of these phenomena is particular to the individual who experiences them which is further impacted by the specific environment system(s) in which they practice couple with a variability of patient populations weaving together a tapestry of social systems. Given the status of etiological understanding, the direction of research has been reasonable up to date as the methods and measures to empirically know causation are still being developed (Coetzee & Laschinger 2018).

Topics such as the role of apology (Govier 2002), evidence-based posttraumatic stress interventions (Barrett & Stewart 2021), compassion satisfaction (Craig & Sprang 2010), and moral courage (Keinemans & Kane 2013) have been explored, though much of the literature focuses on populations treating trauma victims and other extreme circumstances. While these are important conditions to study, what can be lost is the nuance of a metaphorical war of attrition taking place where the effects of long-term exposure can chip away over time culminating in a similar effect. Some conceptual work does exist for this kind of analysis such as the *Crescendo Effect* model developed by Epstein and Hamric (2009) with analogous patterns observed across syndromes.

The literature has not directly engaged with illness as an active component of moral distress and injury outside of secondary/vicarious traumatic stress. Illness in this sense broadly refers to the suffering of the patient be that a behavioral disorder such as borderline personality disorder (BPD) or a medical condition as routine as a broken bone. Therefore, while it may be casually obvious how the suffering of a trauma survivor may be transmitted vicariously to the one who provides psychological care, other forms of transmission resulting from accompaniment largely remain unaccounted for.

Though, if it is assumed that caring professionals are indeed caring people, a critical reading of stigma related literature can be argued to demonstrate the capacity for illness itself to play an active role in the patient/healer relationship beyond trauma material as illness begins to manifest as a third personality that impacts the perceived effectiveness of the care provider. In other words, the symptomology of the illness itself can be powerful enough to manifest distress and injury within the practitioner in the same capacity as other well-established factors, particularly regarding mental and behavioral

disorders. As will be expanded upon in Chapter 2, stigma then can be mislabeled trauma and/or rational coping strategies when confronted with serious mental illness.

While the literature does well to account for many caring professions to include nurses, physicians, psychologists, bioethicist, and social workers; social workers and psychiatrists are underrepresented in the findings which may explain the lack of attention toward the role of mental illness itself. Similarly, it is not obvious how the role of experience influences the occurrence and embodiment of psycho-emotional suffering and injury, or how early-career exposure shapes the coping styles and perceptions of healthcare workers, or how the academy has begun preparing students for encountering these phenomena in the field. What can be detected in the research to date is at least a quantitative correlation between years of experience and frequency of occurrence for compassion fatigue and its inverse, compassion satisfaction (Craig & Sprang 2010). However, other factors such as personal history can easily upset the validity of these findings.

Social Suffering Theory

This research explores the psycho-emotional suffering and injury of healthcare workers by approaching the subject from an orientation grounded in the theory of social suffering (Kleinman 2010) which develops a four-dimensional framework which is itself informed by a multi-disciplinary approach. Social suffering theory posits human suffering as a social issue and invites an assessment that views instances of suffering as conditions that operate under the influence of forces beyond acute symptoms and attempts to attribute their causation to the myriad of systems that shape our daily lives. Typically, social suffering theory would be organized around the patient population, but

this research uses the framework reflectively bringing the caregiver into focus. By combining historical, anthropological, and biosocial medicine disciplines, social suffering theory emphasizes the roles of political, economic, institutional, and interpersonal relationships to develop a deeper understanding of illness and suffering at both the individual and collective level (see Figure 1 for an example of how social suffering theory may regard an emerging health issue). Given this framework, social suffering theory arguably seeks a deeper etiological understanding of how an illness manifests with limited restrictions for a multi-factor explanation embracing many patrial explanations.

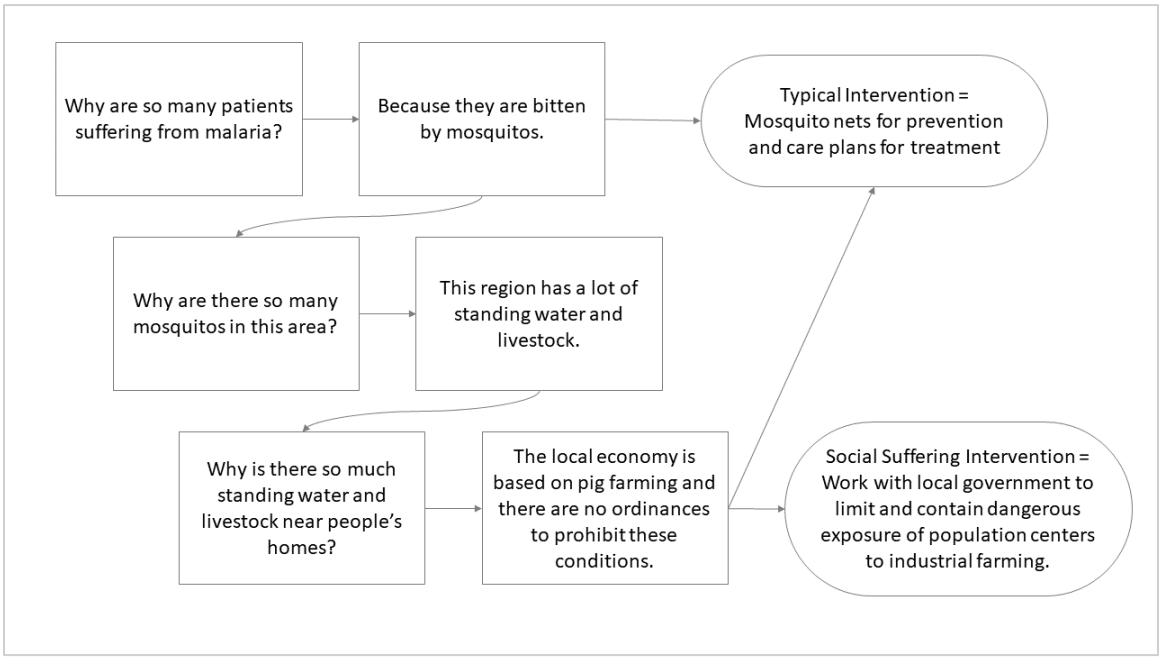

Figure 1. Social Suffering Rationale

Simplified example of how social suffering theory would investigate and intervene in an emerging health crisis.

Using such a framework opens further possibilities to examine existing thought through a new lens that accommodates a complicated multi-faceted view centering the humanity of both the patient and the practitioner. By applying social suffering theory, this research seeks to recast the psycho-emotional suffering and injury of healthcare workers as forms of social suffering. Kleinman's (2010) framework outlines four dimensions through which suffering occurs thereby broadening the inquiry by inviting the social scientist to trace causality beyond acute symptoms and their direct inputs towards a holistic understanding of the environmental systems in which they occur.

The theory of social suffering is further benefitted by clear integrations with Galtung's (1990) construction of cultural, structural, and direct violence, and Merton's (1936) work on the unintended consequences of purposeful action all of which speak directly to the problem of moral distress and injury though their voices are not directly invoked thus far in the literature. Regarding Merton's work we will see in the findings that while the healthcare worker community may be aware of the occupational risks of psycho-emotional suffering and injury, appropriately communicating those risks beyond the theoretical may not be implemented in an optimal way. Instead, the intention of preparing students is experienced as performative action, diluting the importance of mitigating such prevalent risks. Similarly, Galtung's formulation of violence and how it operates in a multi-channel social system is reflected in the way that social suffering theory's framework arranges sources of suffering. Meaning that sources of suffering may operate under such normalized guises that the affected populations no longer detect them as factors.

We can conceive of social suffering theory as creating an aster plot or radar graph where the four dimensions of causality are not single destinations of explanation but rather combine as a composed view of a multi-variable understanding of the environment that catalyzes and self-reinforces perpetual risks and realizations of suffering. The nature of this framework to allow for the "both and" offers a compassionate conceptual baseline to interrogate the current direction of the literature. As is observed in Galtung's construction of violence, so too can we see social suffering operating in multiple contexts which impact the individual/s all at once. More importantly regarding the model outlined in Galtung's work, we can observe the reinforcement of systems of suffering with motivations or rationalizations grounded in any one or several prepended socio domains which in turn may blind us to the broader powers that have been normalized in society.

A Phenomenological Study of Social Workers

The purpose of this research is to apply social suffering theory's framework to the conceptual discussion of healthcare worker psycho-emotional suffering and injury with the objective of assessing these phenomena as forms of social suffering. This study complements this analysis with phenomenological data from practicing social workers who can speak directly to their field placement and early-career professional experiences as it relates to the factors known to contribute to distress and injury.

Research Objectives

This research aims to answer: 1) are there benefits to analyzing forms of caregiver psycho-emotional suffering and injury as forms of social suffering within a holistic theoretical framework, 2) how might we expand social suffering theory to better include

fiduciary relationships, such as those between a therapist and their patients/clients given the para-social nature of those relationships, and 3) how do early-career social workers make meaning of their relationship to illness, their patients, and the systems in which they practice.

Methodology

To explore these questions, this research applied a qualitative phenomenological design to develop narratives of the lived experience from early-career social workers. Semi-structured interviews were used as the primary source of data with participants being given the opportunity to provide additional written information following the interview. Interviews were audio-recorded and the codified using Moustaka's (1994) transcendental protocol to develop themes across the interviews for analysis.

Chapter II.

A Taxonomy of Direct-Care Suffering

This chapter will begin by breaking down the commonly used terms that are found in the literature related to psycho-emotional suffering and injury, highlighting definitional distinctions between the concepts where consensus has been found. These synthesized descriptions are drawn from a total of twenty-five peer reviewed studies and articles. Aside from general keyword queries and peer reviewed source filtering, the following resources were filtered for applicability in regard to study population belonging to healthcare worker professions. Sources include literature reviews, auto/ethnographies, empirical research projects, and conceptual academic construction. As a general note, where the literature does integrate these concepts, it often tends towards relational association as a linear system versus seriously investigating a comorbidity perspective which is understandable given the ongoing development of high-validity empirical measures.

Burnout

Burnout is often referenced with the conception articulated by Maslach (1982, p.3) as “a syndrome of emotional exhaustion, depersonalization, and reduced personal accomplishment”, and “exhaustion, cynicism, and inefficacy” (Maslach et al. 2001, 399). Its usage across the literature has functioned as both analogue and synonym for compassion fatigue as well as secondary traumatic stress, however confusion with the

latter has been somewhat improved with the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association 2013), also commonly referred to as the DSM-V, which formalizes secondary traumatic stress within the formulation of post-traumatic stress disorder (PTSD) criteria. While these symptoms may sound physical, emotional, or competency-based, burnout is an embodied psychological phenomenon that refers to the lessening of one's emotional or physical capacity, a coping style of depersonalized detachment, and/or a negative change in one's ability to perform professionally with a defined set of symptoms or features setting it apart as a syndrome.

Formal burnout is distinctive from compassion fatigue and secondary traumatic stress by several key characteristics. Burnout results from a "process" (Farrell & Turpin 2003; Conrad & Kellar-Guenther 2006) which is to say the burnout occurs from long-term exposure to job stress (e.g., excessive caseloads) and does not manifest in reaction to a single pronounced event. Burnout is also not limited to the caring professions though its prevalence is significant with one study reporting 39% of social workers sampled as experiencing current burnout and a reported lifetime occurrences rate of 75% (Siebert 2006). Newer research demonstrates the consistency and post-pandemic increase of the issue with a reported 49% of all U.S. healthcare workers experiencing burnout with social workers reporting at a higher rate of 59.8% (Prasad et al. 2021). Another distinguishing factor unique to burnout is its resistance to intervention which may require the individual to change roles or seek out an entirely different career (Figley 2002, 1436) whereas compassion fatigue does respond positively to intervention.

Current literature has been progressing burnout from concept to construct as a defined psychological syndrome. Current debate tends to center on the limitation of the

set of features which compose burnout syndrome (exhaustion, cynicism or depersonalization, and reduced personal achievement) and whether or not there is empirical evidence to support a sequence to the order of which feature emerges first as the primary symptom (Edu-Valsania et al. 2022). However, burnout, as the literature currently situates it, tends to emerge from within the individual in response to their external world therefore it is measured in the domains of personal history, age, experience, or gender.

By doing so the literature leaves out the environment system in which it occurs, meaning the myriad of systems that include not only variables such as caseload but the transmission of burnout amongst peers in a social context. To put it another way, consider the behavioral theory of development where external stimuli (which includes the people we surround ourselves with) in part teaches us appropriate responses to input via the modeling acceptable behavioral. In a field saturated with burnt-out individuals, what is the effect of a person's training phase occurring under the direction of those suffering from burnout?

Compassion Fatigue

Figley (1995) first developed the concept of compassion fatigue during his studies of secondary traumatic stress as a way of describing the cost borne by those in the helping professions. Compassion fatigue then is a cognitive-emotional response experienced within the care giving practitioner expressed as feelings "of helplessness, loneliness, anxiety, and depression" (Conrad & Gunether 2006), which may alter typical reactions to the practitioner's social and professional worlds. Such behavioral shifts resulting from professional caring are one significant differentiating factor between

compassion fatigue and burnout. By way of example, suppose a hypothetical trauma therapist has been working with female survivors for a long period. The practitioner's exposure to their patients' narratives overtime may illicit a shift in their attitude towards the offending sex to such a point that seeing clients of the offending sex puts the therapist in a state a projection where compassion can no longer be extended to male clients as they have now been universally cast in a cognitive association with violence generally, regardless of the material the male client brings to the session.

While compassion fatigue, burnout, and secondary stress often appear together and function in varying degrees as interchangeable terms, there are significant differences that should be recognized. Conceptually, compassion fatigue is a result of a buildup of compassion stress (Figley 2002) similar to how burnout is the result of a "process". This suggests that compassion fatigue should be preventable by appropriately resourcing practitioners with the means to reduce the accumulated amount of compassion stress they carry with them. Compassion stress, however, is different from the burnout process because of its origin coming directly from the engagement of compassion whereas burnout is distinguished by its origin of general job stress. Perhaps this difference of origin is why compassion fatigue is largely considered recoverable whereas burnout is not.

Figley's conception of a bivariate model (compassion stress and fatigue) also demonstrates why compassion fatigue is markedly different from secondary traumatic stress (Forster 2009). Secondary traumatic stress, as we will see later in this chapter, can be the result of a single event whereas compassion fatigue occurs in response to prolonged exposure because of a crescendo effect of compassion stress build up (see

Figure 2). Note that this is a similar pattern to what we see in the discussion of moral distress and injury further in this chapter. Figley (2002) outlines this pattern as a sequence: first, the practitioner experiences compassion stress – the emotional response manifested directly from the act of caring; secondly the stress is embodied as a lingering residue, or a kind of emotional debt; lastly, should the accumulated debt go unmitigated and be allowed to build to some internal threshold within the practitioner, it transforms into compassion fatigue. Of course this simplified explanation does not account for the influence of compassion fatigue on the limit of one's compassion stress threshold which is likely a non-linear variable.

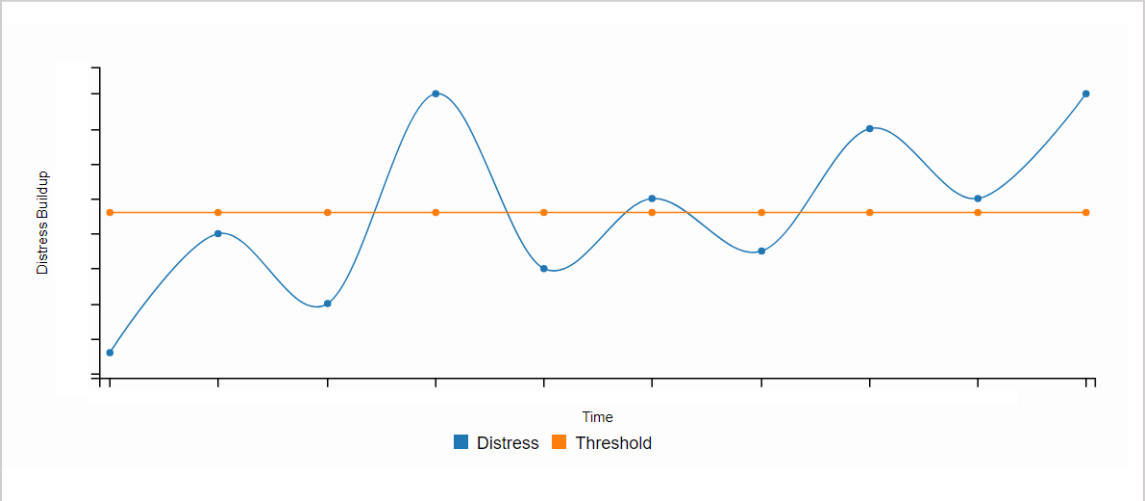

Figure 2. General Model of Distress Accumulation

General model for compounding distress/stress cycles present in phenomena such compassion fatigue and moral distress. The model presupposes that an individual's psychological or cognitive/behavioral endurance is static for illustrative purposes only.

The concept of compassion fatigue has not stabilized to the same extent as burnout while the scientific method struggles to empirically engage with such profoundly human notions such as empathy and compassion though neuroscience has made meaningful progress in this area (Coetzee & Laschiner 2018). While the theoretical models have developed in richness to convincingly convey the processes that culminates in the condition of compassion fatigue, true etiological understanding of how the cognitive and emotional self are affected remains an area for further inquiry.

Moral Distress & Injury

The concept of moral distress is credited to Andrew Jameton (1984), who first developed the term to describe a particular type of "cost to caring" amongst nurses. Jameton's initial terming of moral distress included three components: firstly, an awareness of a moral conflict or what the literature emphasizes as an explicit conscious "knowing" of a morally correct thing to do, secondly an institutional constraint that prohibits the individual from exercising what they "know" to be the correct moral action, and lastly failing to put into action the moral action. In the failure to enact the moral action, the individual suffers a harm to their moral self as moral distress, or as Jameton would later clarify as "initial distress" (2013), resulting in feelings of "frustration, anger, guilt, anxiety, withdrawal, and self-blame" (Epstein & Hamric 2009).

At the time, Jameton was attempting to codify a particular moral issue facing nurses in contrast to another oft discussed issue, the moral dilemma, which is shared in commonality with social workers (Austin et al. 2005). The major distinction between the two is that moral distress is experienced when there is a morally right thing to do but a morally wrong action occurs whereas a moral dilemma is notable for a conflict between

multiple morally correct options. In the former, an outside force negatively influences the ability of the individual to put into action the morally aligned conviction, while in the latter perhaps one choice may prove to have been better than the other with hindsight, but in the moment the struggle is amongst several morally affirmed choices.

As the field took an interest in moral distress, Jameton (2013) went on to expand his meaning of the term and its nature. For Jameton, moral distress is not a unique feature of nursing, rather it can manifest in any field that deals with moral action and inaction therefore other professions may rightfully assert the suffering of moral distress making the term "moral distress" a more universal phenomenon. Therefore, there has been significant research conducted amongst such groups as warfighters and police officers. Furthermore, he went on to reframe the term into something that functions more like a framework with the introduction of "initial distress" and "reactive distress" to better reflect the operation of moral distress in the field.

In this revised understanding, an individual suffers initial distress at the precise moment of personal moral betrayal. After the situation in which the moral harm is initially experienced, reactive distress, or what is now commonly referred to as "moral residue" (Campbel et al. 2016, Epstein & Hamric 2009, Manttari-van der Kuip 2016, Weinberg 2009) transforms the initial distress carried by the carer and is described by Jameton (1993) as the distress that one experiences in response to the initial distress in moments of reflection or rumination. By way of example, the initial stress may manifest as frustration or anger directed towards the constraint which then is internalized as shame or guilt for the failure to act in alignment with one's own moral conviction. In this way we see an operational similarity to the way in which compassion fatigue functions which

may explain the causal association between compassion fatigue and moral distress as inputs to one another (Weinberg 2009). However, to be clear, compassion fatigue and moral distress have a profound difference. Where compassion fatigue extracts an emotional "cost of caring" moral distress is a compromise of one's own moral integrity.

Moral injury on the other hand can be thought of as a sub-component of moral distress while simultaneously as an entirely distinct affliction in its own rite. It is described as psychological trauma in response to individual or prolonged exposure to perceived moral compromises of oneself leading to feelings of guilt and/or existential crisis (Mewborn 2023, Jinkerson 2016). The symptomology of moral injury so closely conforms to the clinical criteria for PTSD diagnosis that it is considered a possible cause of PTSD in addition to causal causation of burnout and compassion fatigue. Because of this linkage, intervention research has focused on applying similar evidence-based interventions as would be applied to a patient suffering from PTSD.

Much of the discussion surrounding moral distress and injury in recent literature revolves around what degree of rigidness for the concept's components is appropriate. Compelling arguments have been made for relaxing the feature of "knowing" to include emergency scenarios where decisions are made without adequate time to do much beyond instinctual reactions (Campbell et al. 2016). Others have argued for the validity of moral distress as a positive harm whereby it functions as evidence of a morally engaged agent, though the counter is best argued by Epstein, Gingell, and Hamric (2009) who state:

> "The problem is that the presence of moral distress indicates a lack of meaningful ethical discussion that includes all perspectives and all relevant stakeholders…therefore, [moral distress] cannot be viewed as a healthy phenomenon precisely because of this lack of, or exclusion from, ethical discussion. It is the violation of one's core values and obligations that makes moral distress such a powerfully negative phenomenon."

The body of literature contributing to our understanding of moral distress and injury is robust, however most of the historic research has occurred amongst warfighter populations. Little literature exists specific to social workers and the field has only recently seemed to engage with the concept (Weinberg 2009, Reamer 2022). Where literature does exist in relation to social workers it tends to be focused on bringing conceptual awareness to the field as something that affects the client whereas amongst nurses it is regarded as a phenomenon that also happens to healthcare workers. Given that from an organization's hierarchical context, nurses and social workers may easily find themselves in the same power differential, meaning subject to similar institutional constraints by virtue of professional authority, it begs the question if moral distress and injury has a place to be regarded by social workers as a form of suffering that not only impacts their clients, but their community of practitioners as well.

Secondary Traumatic Stress and Vicarious Trauma

The terms secondary traumatic stress and vicarious trauma often appear in the literature interchangeably (Newell & Gordon 2010, 57) when discussing stress disorders amongst healthcare workers. These terms are not formal diagnoses but instead comprise some of the inclusive criteria for reaching a posttraumatic stress disorder diagnosis (American Psychiatric Association 2013, 271). However, the meaning of "witnessing" another's trauma has been unclear since at least the DSM-IV (1994). In response, the International Classification of Diseases (ICD-11) (2021), developed the construct of complex post-traumatic stress disorder (CPTSD) to accommodate prolonged exposure more clearly for trauma exposure circumstances. However, in the U.S., the DSM-V is the

authoritative reference regarding mental and behavioral disorders and as it stands currently, the DSM does not recognize CPTSD as a sub-type of PTSD.

Outside of diagnosis, the keywords of "secondary" and "vicarious" locate the relationship of the sufferer to the traumatic "material" (Forster 2009), a phrasing which obscures the relational component of caring for trauma patients. In a counseling setting, the entanglement between client and practitioner cannot be underscored enough, and even when expanded upon is likely to be difficult to grasp the true impact of this relationship type without firsthand experience of how truly profound a strong therapeutic alliance is experienced. Not all styles of therapy insist upon this degree of alliance though many do place a moral basis on the act accompaniment where compassion, solidarity, and equity are reciprocally exchanged between patient and practitioner.

For social workers and other mental and behavioral healthcare workers practicing therapy or counseling, material exposure occurs through dialogical work with the patient/client as the practitioner accompanies the sufferer along their healing journey and is exposed to the "material" in the form of the patient's narrative. This close accompaniment may lead to the caregiver embodying the trauma of their patient resulting in changes to the practitioner's own behavioral patterns. In some cases, these behavioral changes trickle further out into the social network of therapists, for example, influencing parenting decisions as found among psychologists caring for victims of sexual trauma (Padmanabhanunni and Nondumiso 2022).

Due to the nature of social work, the populations that social workers engage with have higher rates of trauma history and therefore social workers have a higher rate of trauma exposure when compared to the other helping professions. According to Bride

(2007), the rates amongst social workers of embodied secondary/vicarious stress are significant. Most social workers who responded to the survey show at least some conditions of secondary stress and posttraumatic stress disorder with a minority fully satisfying the conditions for a posttraumatic stress disorder diagnosis. However, Bride's study is constrained by a medicalized analysis that uses strictly DMS-V criteria for detecting occupational distress and it is difficult to understand how this stress impacts the life of a social worker beyond self-reported frequency. The degree of harm does not necessarily equate to occurrence alone just as it is impossible to comparatively evaluate one's subjective experience of pain to another's. Despite this limitation, the findings are telling with the top three symptoms being intrusive thoughts, avoidance of the client, and irritability.

A common consequence of secondary/vicarious stress is compassion fatigue and/or burnout, but these terms are in no way limited to caring for trauma patient populations. As a result of enduring prolonged periods of duress, caregivers exist in a state of genuine suffering that is not implied through a colloquial understanding. The risks include clinical depression, secondary/vicarious and general trauma disorders, and suicide (Kelly 2020). While much emphasis has been given to the prolonged occupational exposure to trauma material, secondary traumatic stress can be experienced either through intensity of a single event or accumulation of less intense exposure.

Research has been conducted which focuses on the prevalence of secondary traumatic stress amongst social workers (Bride 2007, Gil et al. 2015, Meldrum 2002) however the risks of exposure during the academic phase of preparation has been largely unexplored up until recently (Rogers & Sylvia 2022). Given that secondary traumatic

stress can both be the result of a process or single occurrence, what are the real-world risks facing student-practitioners and early-career social workers and are there intentional steps taken to mitigate or prepare students of potential harm?

Stigma as Evidence of Received Harm

If we compare the emotional and psychological experiences of mental health professionals who work with complex mental health illnesses with those suffering from compassion fatigue or secondary traumatic stress – the language used to describe the internalized emotions and self-perceptions are nearly the same. Feelings of overwhelm, burnout, failure, withdrawal, and inadequacy can manifest as the result of powerful therapeutic relationships between therapist and client when treating challenging illnesses such as borderline personality disorder (BPD) (Sansone & Sansone 2013).

The therapeutic relationship between therapist and client when treating BPD is of such inter-personal intensity that the DSM-V frequently makes equivalencies between therapists and lovers in terms of emotional intimacy with the client (American Psychiatric Association 2013, 663-666). The impact on the therapist is so great, they begin to exercise the very same coping styles they are treating in their patients (Sansone and Sansone 2013; Bride 2007). Namely avoidance of *the* client or any client with a BPD diagnosis as a way of insulating themselves from the emotional abuse often experienced while treating BPD. A mirroring effect can be observed in these testimonies and appears to be a clear indication of proximal social suffering, yet it remains named as “stigma”. Stigma necessitates an educational intervention such as anti-stigma training (Knaak et al. 2015; Mottaghi et al. 2020) measured in terms of competency, whereas proximal

suffering requires validation of legitimate suffering coupled with psychological and emotional care.

It must be acknowledged that stigma manifests in more than one way. This argument for regarding stigma as a consequence of care giving is limited to stigma that is derived from one's own experience. With regard to mental health professionals, the stakes can be profoundly high and the "cost of caring" equally high. Disengagement by practitioners towards the more intense mental illnesses and disorders could be viewed compassionately when accounting for the severity of an illness's symptomology as this is a sign of proximal suffering and/or trauma.

In the case of BPD one of the pronounced features is the act of self-harm or suicidality. The chronic nature of this self-destructive behavior must be underscored regarding BPD where rates of occurrence have been reported with as many as 75% of BPD cases resulting in a suicide attempt with 10% of cases resulting in suicide completion (Goodman et al. 2017). Therefore, to give a BPD diagnosis to a client, or accept a new patient with that diagnosis is to acknowledge a voluntary entrance into a therapeutic relationship in which the therapist will likely accompany their client through potentially violent if not lethal territory.

Stigma can also be "taught" to others and in these instances stigma interventions would be appropriate and do not fall under the argument that stigma is mislabeled trauma or compassion fatigue. In the context of social workers, supervision is one of the main training vectors therefore should a supervising social worker train their student-practitioners based on traumatized experience, stigma may be transmitted to the student without the critical contextualized experience, meaning negative stigmatizing behavior

unjustly compounds harms onto the client. Played out over time in a care team environment, stigmatizing of certain patient populations, or the oft referenced “difficult patient” may become normalized to such an extent that the harms it elicits become invisible to those charged with that care of the stigmatized.

Synthesis of Psycho-Emotional Harms

Carrying forward the language of stigma related internalized harms (e.g. anxiety, withdrawal, depersonalization, inadequacy, and depression) we can observe that in the literature to date there is significant overlap between the psycho-emotional injuries borne by the caring professions. Not only does the symptomology of these phenomena overlap but there is a case being made as to their interconnectedness whereby causal connections create a complex mesh of contribution and exacerbation towards and between each (see Table 1 for a summary of shared symptomology).

Therefore, this research approaches these phenomena from a social systems perspective where they may be assessed holistically whereas by taking individualized syndrome orientations pushes the assessment towards a medicalizing approach where comorbidity is possible but losses the visibility of concurrency. With a conditional exception to burnout, all of these phenomena have a social component, yet even burnout may be argued as bureaucratic neglect by way of inadequate resourcing and staffing. With regards to compassion fatigue and secondary traumatic stress, it is the social connection of empathetic care which intertwines the practitioner and patient, with moral distress and injury we see the presence of the bureaucratic and institutional authority spilling out via power differentials amongst professional positions.

Table 1 - Symptomology Comparison of Psycho-Emotional Injuries

	Burnout	Compassion Fatigue	Moral Injury & Distress	Secondary Traumatic Stress
Anger		X	X	X
Anxiety		X	X	X
Avoidance				X
Changes to Belief or Behavior		X		X
Cynicism	X	X		
Depersonalization		X	X	
Excessive Rumination		X		X
Exhaustion	X	X	X	X
Frustration			X	
Guilt		X	X	X
Helplessness		X		
Hopelessness	X			X
Irritability	X	X		X
Isolation				X
Lack of Empathy		X		
Powerlessness	X		X	X
Reduced Performance	X			X
Sadness		X	X	X
Sleep Issues	X	X	X	X
Withdrawal	X		X	X

Chapter III.

Method

This study is a qualitative phenomenology which was conducted using semi-structured interviews that occurred both in-person as well as over web-conferencing software, namely Google Meet. In total, 5 participants participated in the research solicited through a network of social workers in the Cleveland, Ohio area. Participant interviews lasted between 1 and 2 hours loosely following an interview outline designed to guide the conversation that focused on their academic and professional experiences. Interview data was analyzed to support answering: 1) are there benefits to analyzing forms of psycho-emotional suffering and injury as forms of social suffering within a holistic theoretical framework, 2) how might we expand social suffering theory to better include fiduciary relationships, such as those between a therapist and their patients/clients given the para-social nature of those relationships, and 3) how do early-career social workers make meaning of their relationship to illness, their patients, and the systems in which they practice.

Participants

Participants who met the study's inclusion criteria (i.e., professional social worker with less than 5 years' experience, MSW graduate, practicing in the Midwest) were asked to participate in a 60-90 interview session. Those who expressed an interest were given a consent package prior to the interview being scheduled and the use of audio-recording was approved. The consent form also made clear that the interviews were to be free of identifying information to protect the participants' privacy. Audio formats of the

interviews were stored on a multi-factor encrypted hard drive until the transcripts had been extracted and initial analysis performed.

Participants who provided consent were then scheduled for an interview using whichever format (in-person or remote) made them feel most comfortable. The interview flow followed a linear time-based format with the initial focus placed on each participant's motivations to enter the social work profession via a MSW path, comparative field placement experience in alignment with academic preparation, and closing on current professional narratives. Questions were intentionally posed as open-ended with unstructured follow up questions based on participant dialog.

Among the study's participants, the total of workplace sites included 11 field placement sites and 5 professional settings totaling 16 workplace sites. The breadth of social work represented by the participants included experience with community organizing, direct one-on-one therapy, group therapy, counseling, and clinical work. The environments the participants drew experience from included hospital emergency rooms, psychiatric wards, private practices, non-profits, state programs, and university settings. The domains of social work across all participants included community, individual, family, LGBTQIA+, youth, children, emerging adults, substance abuse, and mental and behavioral health generally.

Procedure

The intention of using a semi-structured interview style approach was to have each session accommodate the unique experiences of the participant and remain flexible to inquiry about areas that were significant to them. For those participants who provided consent, all interviews began with a general inquiry as to the motivations or inspiration

for choosing a career in social work with follow up questions regarding the evolution of those motivations. The interview guide was designed to anchor questions in relation to field placement to give participants a concrete association with time when discussing academic preparation. This structure created an organic flow up to the present where the interview switched from a student-practitioner context to one of professional experience. All participants were given an open opportunity to add anything they felt was of significance for their experience in social work or to ask any clarifying questions.

Data Analysis

Once all the interviews had taken place, the study applied Moustakas (1994) transcendental phenomenology procedures which begin with an initial listening of the recordings to bracket out, or set aside, the subjective experiences of the researcher to better listen to subsequent sessions from a place of openness. Additional listening sessions then began to focus on marking significant statements and notional quotes from each interview to begin the development of themes, or broad categories that integrate the otherwise separate narratives. Once themes began to appear, additional listening sessions were used to mark out textural descriptions that clarify *what* was being experienced. The later rounds of listening sessions focused on structural descriptions of *how* the themes' circumstances came to be, or to put it in other words, the inputs that made those circumstances possible.

The above systematic listening procedures were documented using a practice known as affinity mapping taken from design thinking practices. Affinity mapping is taking knowledge in the mind and transforming it into a visual construct which facilitates the grouping of, and interplay between data points. This can be done simply with physical

sticky notes and a sharpie marker or via a digit proxy using software such as Miro. The use of sticky notes, whether physical or digital, in this practice is intentional to encourage a lowly-committed state of mind where ideas can rapidly be iterated on, and notes rearranged into groups as concepts are evaluated for validity.

Figure 3. Affinity Mapping in Progress

As each interview was listened to individually, “stacks” of single-line statements were assembled with a color designated for each speaker. An arbitrary stack was selected and placed on a “board”. As subsequent stacks were added to the board, like-items were grouped together creating a “theme” which was then captioned by the researcher to summarize the overall topic that related the notes. Additional linkages were added with each listening phase as the priority of the listener shifted from notional statements to descriptive context, and then finally structural synopsis. It may be important to note that the priority of seeking textural and structural descriptions was not mutually exclusive during each listening phase and most listening phases beyond the initial session included the creation at all three levels as concepts were refined. By assigning each participant a unique color, the resulting visual map clarified areas of widespread commonality from individual experience or sentiment.

Chapter IV.

Findings

The following chapter highlights social factors detected during the interviews and documents those themes within the social suffering theory framework's socio domains of the political, economic, institutional or bureaucratic, and interpersonal. These findings later informed the construction of experiential thematic analysis which is expanded on in Chapter V – Discussion.

Socio-Political Analysis

Two socio-political forces were detected during the interviews that complicate or potentially drive the social suffering of social workers in Ohio. The first was the effect of state legislation regarding social policy which was represented in discussions involving anti-trans/queer legislation. The second was the variability of state licensure policy and how it impacts the volume of work a social worker must do to make a livable wage which touches on a crossover with socio-economic forces at play.

Local Laws and Social Work Policy

Perhaps most obviously related to the notion of external constraints from moral distress and injury, what happens if we extend external constraints up beyond the organization and situate political activity as part of the consideration for the influence of external constraints? This consideration was highlighted most comprehensively amongst those participants who provided care for members of the LGBTQIA+ community and the increase of anti-trans/queer legislation unique to Ohio. As described by queer therapist,

Celestia Hellbrede LSW (2023) when discussing the introduction of eight pieces of legislation criminalizing queer identities, "[it] is difficult not to feel stuck as a social worker in the current political environment. My client's fears in behavioral health sessions are often my own."

Hellbrede's statement hints at the enmeshment common between practitioners and their clients in therapeutic settings. The practitioner may not only be caring for a person affected by legislation but may, at the same time, be a member of the affected population themselves. This was emblematic of nearly all participants whose scope of practice closely aligned to their personal history or that of a family member. We can logically extend this to states where issues such as reproductive rights are besieged with legislation seeking to criminalize abortion even in cases of incest and rape and other social policy issues. Law then can be viewed as an external constraint that forces a social worker to be a mandatory reporter in said cases which could be a morally abhorrent position to be in. Law in this case has the capacity to not only dismiss the genuine suffering of people through criminalization, but weaponize it against them through the very agents who exist to protect them which is then internalized within the social worker as existential crisis when the political and personal worlds collapse together in the therapy office.

One facet when considering the role of local laws that is unique to social work, and is also highlighted in Hellbrede's article, is an inherent ethical obligation of social workers to actively resist and champion against powers that unjustly discriminate against communities which is codified in the National Association of Social Workers Code of Ethics (2021) whereas other healthcare professions may not be implicitly called to be activists/practitioners. Perhaps this is why "Ohio hates social workers. I've talked with

[my professor] about this and Ohio doesn't believe that social workers should be clinical workers. They believe that [social workers] should just be part of DCFS (Department of Children and Family Services), they shouldn't be therapists" (private practice social worker).

Licensure Standards and Burnout

From the literature previously discussed in Chapter 2, we know that excessive caseload is a driver of the burnout process. For states in the U.S. like Ohio, licensure standards unintentionally, or perhaps intentionally, reinforce this process by forcing early-career social workers to take on excessive caseloads if they wish to derive a livable wage from their profession, specifically when that professional concentration is as a private practice therapist. This is because Ohio discourages social workers from working for themselves regardless of whether they are receiving supervision, forcing most to obtain employment in private practice from existing practices. In such arrangements, the early-career social worker must split their pay in common distributions of 50/50 with the business or more favorably to the LSW, 60/40 for billable hours that are reimbursed by insurance. Meaning that the obligatory labor of note keeping is unpaid. By virtue, early-career social workers are financially coerced into seeing higher client volumes regardless of their emotional or psychological capacity to do so.

Understanding that burnout is a process, forced excessive workloads does not necessarily yield rapid burnout amongst early-career social workers but most certainly lays the foundation for potentially early-onset burnout when it could otherwise be mitigated. Therefore, as future research gives more attention to early-career experiences, this study finds that accounting for licensure standards should be considered as a key

variable for study validity. Situated in Ohio, this primarily affects those working in private practice in terms of policy mandates, but similar pressures were found to occur from the institutional side in hospital settings where administrators push for increasing profits and "growing the business" (private practice social worker) without providing adequate resources both in terms of staff and material.

Socio-Economic Analysis

In response to the political forces producing an environment that encourages overwork, participants in this study all necessitated additional forms of support to begin their careers. For nearly all participants this was represented as holding multiple jobs. For some participants it is multiple jobs in different social work practices and for others it is working outside of social work to derive a "real income" (private practice social worker) making social work more of an act of service that provides a little extra money.

For those participants in private practice, when asked about the estimated volume of work it would take to achieve a livable wage from their preferred job site, the estimate was an approximate 25-30 clients per week. While on the surface this looks like 25-30 hour-long sessions, meaning a 25 to 30-hour workweek, it equates to a higher workload than may be obvious. As mentioned, note keeping is a critical activity both for medical insurance and for liability protection. For each session, administrative overhead is tacked on and for these participants that labor is unpaid. This volume of work does not easily represent additional requirements such as researching referrals for higher levels of care or resources such as abuse centers or food programs. Therefore, without accounting for the nature of the work (the emotional and psychological costs of caring), early-career social workers begin their careers needing to work more than the "typical" 40-hour workweek.

Interestingly, the economic forces are not only enacted from outside parties. As one participant (private practice social worker) termed it, there is a communal expectation of "noble suffering". Which is to say, there is a sort of stigma that may be cast upon a social worker who is making decent money in the field as some feel that "true social work" is to suffer with the suffering. A Dorothy Day lifestyle of voluntary poverty and solidarity as it were. Of course, the intent of social work is not to mire people in suffering but liberate them from it so where this notion of voluntary suffering comes from is mysterious and in some ways validates the critique that causality of a portion of psycho-emotional suffering of professional carers is self-induced martyrdom. The only valuative judgement that was observed in this study, however, was the deliberate exploitation of a social work degree by fellow classmates as a means to bypass the time and cost expense of a PhD in psychology with the intent of not adhering to the social work ethics mandate.

Institutional Analysis

Several institutional factors were detected as contributing to the social suffering of social workers in the forms of performative academic preparation, and power differentials and resourcing once on the jobsite.

Do as I Say Not as I Do

For the participants in this study, the academic coverage of occupational risks was purely theoretical. As students, they were aware of the concepts of burnout, compassion fatigue, and secondary traumatic stress, but no one felt there was any integrative education on what to do about these risks beyond understanding the definitional concept.

None of this study's participants had an understanding of moral injury and distress as a phenomenon that impacts the helping professions. Instead, participants observed their professors as discussing ideas of self-care with a sad irony. Bear in mind, for these participants their coursework load would periodically rise to 9 courses a semester (a mix of standard courses and intensives), a field placement, and a job leaving absolutely no time for self-care. Additionally, there was no capacity to keep up with the coursework either. Students had to cherry-pick which courses would get more attention over others out of the sheer necessity to pass their classes which in turn diminished the perceived quality of their academic training.

While students knew that their chosen occupation has inherent risks, at no point in time were the coping mechanisms modeled for them. The perception was that the school passed that responsibility off to the field placement supervisor. In fact, participants routinely reported notions about field placements as "where the real learning happens" (private practice social worker) and that the academic schedule was chronically uncoordinated with the demands of their field placements.

> "I was patching up girls who are slitting their wrists and cleaning blood off the floor...and then would go to my classes and we're going to emotionally regulate and talk about breathing exercises. The disconnect was so strong. The coursework I'm doing isn't enough to back what I'm doing in the field" (clinical social worker).

At the same time, they were acutely aware of the ethical implications of performing the actions of social work without adequate preparation.

"I was not prepared" (clinical social worker).

"I felt really ill-equipped to be in counseling sessions with people" (hospital social worker).

"I was scared shitless" (private practice social worker).

"We're all drowning" (private practice social worker).

If there is one field that should be acutely sensitive to an individual's emotional and psychological capacity, on paper social work should be at the top of the list. However, with each interview, the sad irony of how under resourced these student-practitioners were, was jarring to observe as an outsider.

Organizational Authority

Like nurses, social workers' occupational authority sits in a precarious hierarchy where they can be regarded as subject matter experts, but final care decisions are held by the attending physician. Often when a social worker's expertise is needed in a clinical setting they will "spend more time with the patient" (hospital social worker) than the physician, which is a sentiment seen frequently in nursing literature when discussing moral distress and injury. Because of the closeness to the patient, the assisting profession, in this case social work, feels a sense of knowing that exceeds that of who has authority, be it administrator or physician, so when moments of disagreement occur, we see the operation of "knowing" what is best in potential conflict with direction from others.

There is a certain professional kinship between nurses and social workers in this regard as both professions call for more time spent with the patient but with reduced authority over their care. It invites a questioning of why social work does not regard moral distress and injury as a thing that happens to them when the concept is so incorporated in nursing literature. Participants reported feeling professionally "less than" their colleagues and that "not a lot of listening happens" (hospital social worker). Encouragingly, where conflict over patient care was discussed at length, positive feelings were noted when physicians argued, meaning there was legitimate discussion, for a

different treatment plan as it demonstrated a degree of engagement and concern with the patient's best outcomes in mind and where agreement was not shared at least there was a sense of a true care team as "the physician was invested in the patient's best interest" (hospital social worker).

Care team dynamics appear to be heavily influenced by the context in which they operate. For the hospital social worker, they work in both an emergency room as well as an inpatient ward. The emergency room setting is one of near constant overwhelm with caseloads that encourage if not force expediency as the objective of care within an emergency room is to get the patient stabilized, and in a position to manage their own care. In an inpatient setting the focus of care shifts from triage to genuine care and the team functions accordingly. In the care environment there are daily meetings across the teams and the care given to patients is far more coordinated. In complete contrast to an emergency room setting there is a significant sense of "camaraderie and respect" (hospital social worker).

"It's notable because there are so many settings where because there was less money invested, less school required, [social workers] are less-than somehow" (hospital social worker).

Over Reliance on Passion

A consistent theme across the interviews was the acknowledgement of an industry wide reliance on the good intentions of social workers as some form of stopgap to mitigate compassion fatigue, burnout, and secondary trauma. Early-career social workers reported consistently that training, once on the jobsite, is not provided to any meaningful

extent as the employer and seniors leads expect the new LSWs to "have learned everything in school" (clinical social worker).

"I definitely do not feel supported (referring to resources) and do not feel like I was given adequate training to be administering suicidality scales [for example]" (hospital social worker).

Depending on the setting, time is not always afforded to the continued development of professional skills once the professional phase of the career begins. This is less of an issue for social workers working in private practice as therapists. In a private practice setting, supervision is scheduled in both one-on-one and group formats and tends to be considered something of a compensatory benefit given that most LSWs desire to obtain an independent license. However, hospital settings appear to be significantly different. Supervision is more ad hoc, unscheduled, and occurs informally as the social worker makes their rounds "in between assessments and in passing throughout the workday" (hospital social worker). This leaves the social worker feeling isolated and unsure of their expertise even in instances where they are the only mental and behavioral health expert in the care team.

> "Does this person need to be hospitalized? Do they need their rights taken away because they are not sound of mind or they're probably going to hurt themselves or others? It's a really big decision and to know that that time (care team discussion and supervision) isn't there, feels like at least we're failing people and at most that there's harm taking place" (hospital social worker).

Dialogue amongst care team members is critical and is underscored consistently within nursing literature regarding moral distress and injury. It is not that nurses and social workers have the authority to direct such profound steps in care, but social workers are the ones responsible for making these recommendations to the attending physician

who has ultimate authority over the patient's care. Such a role carries an understandably significant ethical burden which expresses itself in the absence of collaboration and peer-to-peer consultation.

Both academically and professionally, the institutions that shape the development of a social worker overly rely on their willingness to identify and execute on observed shortcomings even though there is no experiential basis to expect this depth of awareness, or perhaps more accurately, what to do about it in practical steps.

> "I think the reason why people leave this field or why people get burnt out in this field is there's so much reliance on 'this person's a good person and they have the right intentions' so we're just going to throw them in blind" (private practice social worker).

Some participants were able to identify areas where they felt additional attention was needed, or as one participant put it, "I didn't feel like I was necessarily prepared for what I wanted to go into" (hospital social worker). This social worker went on to independently seek out an additional field placement during their MSW program to reach a place where they felt better equipped for the demands of being in an inpatient social work role. Others accidentally discovered preparatory weaknesses by happenstance in an elective, while others observed it retrospectively after graduation.

Proximal Suffering Analysis

Proximal suffering or as referred in social suffering theory as interpersonal describes how the experience of the individual sufferer of an illness radiates their suffering out through their social network typically in reference to the non-technical caregiving of a family member(s). Here I update the term as "proximal suffering" to clarify that mere proximity to the suffering of another is enough social connection

regardless of the nature of the relationship. For social workers and other mental health professionals their relationship to the client/patient is fiduciary as medicine has moved further away from the emphasis of care in care-giving professions in favor of technical, optimized, quantitative outcomes. Yet compassion fatigue and secondary traumatic stress are clearly the result of the social connection between practitioner and client as evident in the emotional components ascribed to each syndrome.

Participants in this study, while exposed to proximal suffering, were at least at this point in time, able to healthily compartmentalize away the encounters as a result of illness creating a sort of conceptual barrier between themselves and the episode. “This behavior isn’t you, this is your anxiety” (clinical social worker).

More significant harm was experienced by the social work students because of the actions taken by professionals at their field placements rather than from clients. However, some of the descriptions registered severe intensity within the context of a student-practitioner’s training experience. One such example was a participant who was working in the role as a school counselor and was being psychologically and emotionally abused by a client who required a higher level of care. This occurred as part of a university program that provides the student body with limited access to therapy services. If the circumstances are severe enough, the student/client would be referred out to the appropriate level of care they required. In this case, a slow but consistent pattern emerged that required the supervisor’s supervisor to step in and redirect the student/client to another source of care. However, this intervention was latent and “should have been caught earlier” (private practice social worker). As a social work student, they were in a learning/practice mode, so it was difficult to assert that this is a patient who needs a

higher level of care, in contrast to the question they committed to – "what do I need to be doing differently for my client".

The most outrageous example drawn from the interviews was an episode where a knife was pulled on one of the study participants working in a clinical youth program. While being threatened with a knife appeared traumatizing to codify, the social worker reported being generally unfazed by the isolated incident itself understanding the behavior to be attributed to the child's attachment issues. The actual "trauma" (clinical social worker) was articulated as a failing of the organization and the supervisor - the professional abandonment of those who are supposed to be there to protect the social work student. Prior to the incident this social worker had attempted to escalate the patient's needs for several weeks without action from the organization. What was most disturbing in this instance was what happened after the fact. The social worker promptly put in notice to leave the organization after the incident but agreed to return to work the next day to assist in a limited fashion with another client. Upon arriving, she was greeted by her supervisor who had brought the offending client to the social worker's car at which point it became clear that the supervisor had weaponized the client's behavior and openly faulted the client with "driving away" (clinical social worker) the social work student.

This confrontation forced the social work student to correct the supervisor's narrative to the patient. The social work student then had to sit and watch as all trust evaporated from the patient as they broke down upon realizing the manipulation of the supervisor.

Chapter V.

Discussion

This chapter expands on the findings of the research and develops themes drawn from the interview data. While not representative of all topics discussed, these sections had widely shared experience with enough detail provided to support theoretical assertions. Quoted sentiments throughout this chapter are notional quotes drawn from the interviews.

Socialis Laborator, Cura te Ipsum

The phrase, physician heal thyself, takes on new meaning when notionally applied to social workers. In the case of this project's participants, it is represented as care extended to proxies of the social worker themselves or that of a close personal connection.

"What drew me to social work specifically was my experience with mental health whether it be with psychiatrists or inpatient, wanting to be a positive impact in that world whereas I had been exposed to both negative and positive impacts." (hospital social worker)

"I wanted to be a social worker for my mom, to be the one providing care in the way I wish she had gotten." (clinical social worker)

Even those social workers who did not initially know what population groups they wanted to work with found themselves working with individuals whose experiences closely aligned with their own. This degree of closeness to the client/patient raises the stakes as far as the material that is shared inside a therapy session. Speaking back to

estimations of client volume (25-30 sessions per week) to provide a livable wage, the exception to that was one of clients with general symptoms. Estimated emotional capacity is far lower regarding clients whose history so closely mirrors that of the social worker, as in, approximately one third that volume would quickly exhaust the social worker. This draw on one's capacity is heightened as the significance of the issue increases which is to say that the more foundational the therapeutic topic, the more capacity it takes from the social worker.

> "The concept of leaving work at the door at the end of the day and being able to have boundaries doesn't exist because our identities are so tied into the work that we do. Essentially, we are working with the youth we once were." (private practice and youth social worker).

In a way there is a phenomenon of vicarious care taking place where, given the right client session, the social worker is able to enact a deeply compassionate level of care as an LSW in a way that they were disempowered to do previously in life for the self or simply never received.

The mirroring of oneself between practitioner and client/patient also impacts other workplace stressors as was described about behavior of peers in the job place. As someone (hospital social worker) with a history of suffering from mental illness, overhearing co-workers mock and joke at the expense of "difficult patients" is deeply hurtful. It is understood as coping through humor for some in a quasi-rational sense, but for others it is clear transmission of stigma to less experienced colleagues who participate in these inappropriate discussions. It is a demonstration of a complete lack of acuity for the suffering of others. Regardless, it extracts an emotional toll from the social worker personally beyond the scope of work itself and outside the categories of typical

workplace variables. Feelings of shame and guilt were expressed about not having the capacity to speak up on every occasion.

Underneath the hurt caused by the apathetic and callous discussions, is the root of a vocational calling profoundly intertwined in the social worker's own emotional reaction to challenging patients who are experiencing crisis. Their personal history extends a genuine empathy to the patient and by extension their family, and even the surrounding care team exposing a "new level of empathy" (hospital social worker) for the people who care and their fallibility when confronted with a kind of suffering that "they don't fully understand".

Putting the Cart Before the Social Worker

Surprisingly field placements occur before school begins, at least this was the case for the participants in this research. What makes this significant is the fact that a student in a MSW program does not equate to related academic preparation during undergrad. Meaning, someone may be accepted into the program and be coming from a disparate discipline such as computer science with minimal to no academic training in relevant domains. Placement recommendations and student preparedness can appear wildly out of touch with one another as was the case with one study participant (private practice social worker) who began their MSW program without a background in related fields and one of their first field placement recommendations was hospice care. It appears that at least in the case of this top-ten social work school, prerequisites have been traded for ease of access at the expense of a trial by fire program with the risk of psychologically traumatizing students.

By entering field placements prior to the academic schedule starting, this creates a disservice to the student-practitioner in two forms. Firstly, given that no instruction has been given, the students' selection of field placement site may not be altogether optimal for their professional desires. Without theoretical experience, students coming from non-psychology backgrounds may "waste time" (private practice social worker) in a field placement that offers little in the way of practical experience. Secondly, it creates a seemingly brittle reliance on the strict management, on behalf of the field placement site and supervisors, to be appropriately tasking the student. This alignment to field placement site is intended to be overseen and guided by a university advisor, however, to reiterate, for students with no relevant experience the decision to immediately enter a workplace seems premature.

This pattern of jumping the shark continues as schooling lags practical needs regarding field placements. Like many master's programs, participants reported a curriculum that begins with general orientation courses that speak to the wide breadth of social work before the schedule allows for more specialized coursework.

> "They didn't even teach us what we need to learn to actually practice, they taught us theories. The reasons why we do these things, and why we teach these things, and why we practice the way we practice, but they weren't like 'this is how you actually practice'. We're like, this is not going to help us with our work in the real world" (private practice social worker).

This leads to student-practitioners feeling perpetually "unprepared" (all study participants) or having a sense of "disconnection" (private practice social worker) between school and the work performed at the field placement site. Valuative statements were common amongst the study's participants about the quality of education since the material was seen as "I've already been doing this" (clinical and private practice social workers) cultivating a feeling of dismissal as if to say the lessons were a day late and a

dollar short. It appears that from a program design perspective, both students and field placement sites would have been better served by delaying the alignment to work site at least until the first term had been completed.

The COVID crisis was also a subject that encumbered the field placement election for the study's participants as the global pandemic occurred at the beginning of their academic phases. For good or ill, COVID locked out many possible field placement postings as hospitals and other clinical settings rightfully needed to restrict people physically to minimize the spread of the virus. This left university advisors in an unprepared predicament resulting in many of the participants needing to find their own field placements without the guidance of their advisor. To put it bluntly in the words of several participants, "it was shit show" (clinical and private practice social workers). Further, not all field placement sites were able to protect the health and safety of students in instances where in-person care was still a necessity thereby compounding the cognitive load of working a job, providing care to high priority individuals, and attending classes while be under the constant duress of risk of infection.

All these factors serve to undermine the academic experience which is a critical component of the system that is built to train social work students. The university is fully reliant on the field placement site to translate theory into applied theory, whereas the field placement is reliant on the school to be providing timely theoretical awareness. With safety restrictions in effect during the pandemic this left students being aligned to sub-optimal field placements which "was a bust all around" (hospital social worker). Perhaps this constraint was less significant for certain areas of social work, but for students whose

desire was to work directly with patients/clients, the result was a significant loss of one of the most "valuable" (hospital social worker) facets of the MSW program.

The system is clearly highly sensitive to disruption and while we can be generous that no one was prepared for the challenges of a global pandemic such as COVID occurring, the ethics of taking students' tuition and putting them into broken and sub-optimal learning circumstances not only harms the student in terms of overall educational quality but also begs the question as to what standard of quality was given to the clients of the field placement sites and consequently extrapolated further to future clients/patients.

"Burnout is Cycle"

The heading of this section is attributed to one of the study's participants working in clinical settings who first articulated the cyclical nature of burnout.

In a field saturated with burnt-out individuals, what is the effect of a person's training phase occurring under the direction of those suffering from burnout? This was a question not originally accounted for when this research began but became evident as the interviews unfolded. The replication and intrenchment of burnout amongst the social worker participants' narratives was profound to the ear of an outsider and normalized as status quo for those within these care systems. In perhaps the most social worker assessment possible, it was primarily accounted for as the toll burnout takes on the client which is where the exacerbation of the issue truly takes a new shape.

Burnt-out care is sub-optimal care. Sub-optimal care creates resistance within the client to therapeutic intervention and develops into deep social issues of mistrust and anxiety when forging new therapeutic relationships. Therefore, future care givers must

overcome not only the challenges of suffering that the client is dealing with, but the debt of poor care that was provided by others. This in turn takes more capacity from the social worker to overcome and increases the otherwise "normal" level of exhaustion expediting the burnout process. Layering in the consequences of working alongside burnt-out fellows, the care systems appear to be in a state of homeostatic burnout. Far beyond a syndrome, burnout is a self-reinforcing systematized cycle.

The entire experience of someone entering a MSW program through to professional job posting is comprehensively shaped by burnout. The coursework delivery from the university appears to be a two-year intensive coupled with a series of field placements that are desynchronized from theoretical attainment. As students, they are burnt out academically which carries negligible impact since the majority of the first year's material is evaluated as "meaningless" (hospital social worker), "impractical" (private practice social worker), and "useless" (clinical social worker) in the context of field work. Each participant had experience with "bad supervisors" during their field placements, which the university wholesale relies on for theory integration. As a result, cultural fit over scope of practice has become the de facto criteria when looking for jobs for this study's participants.

Burnout then is as much an issue that each study participant faces as it is also simply the way things are. "We're all busy" (hospital social worker) is normed to such a degree that the wrongness of being overworked becomes invisible and is instead viewed as inevitable or existential to the caring professions.

Chapter VI.

Conclusion

This research sought to examine the psycho-emotional forms of suffering and injury experienced by the caring professions through a lens that was informed by the framework of social suffering theory. In doing so, the understanding of the complexities that influence one's internalization of the stressors to which they are subjected professionally was broadened to a scope which was unanticipated. Due to the emphasis on systems and social connections required by social suffering theory, syndromes transformed into ecologies that affect communities of practitioners rather than a perspective of an individual's subjective experience in response to an environment system. The volume of forces at play surrounding the discussion of issues such as burnout, compassion fatigue, secondary traumatic stress, and moral distress and injury moves much further outwards when assessed as forms of social suffering than they otherwise might by taking a medicalizing approach.

Specific to the early-career stage of social workers, this study found three foundational conditions that have potentially profound influences to take into consideration for future research.

1. Law and Politics be they federal or local. Social policy and political climate directly impact social work generally and may cause an omnipresent cloud of duress for those practitioners who are members of the communities they champion.
2. Licensing policies and how they affect caseload in terms of the financial security of the practitioner. Case volume may be driven from poor staffing or employers

intentionally overworking employees but arguably unscrupulous pay structures of licensed professionals that strip them of nearly half their pay coerce self-driven overwork.

3. Program structure during graduate studies for translating theory to praxis. The relevance of curriculum in timely response to the demands of real-time fieldwork is difficult for a field as broad as social work and is therefore a key point of interest for the period when professional experience in years is low.

The psycho-emotional suffering and injury of social workers occurs within a network of overlapping systems moving in and out of flux with one another. There is most certainly causality which can be attributed to the interplay amongst these phenomena however the pursuit of a procedural explanation as the field seeks to integrate them forgoes the reality of a systems-within-systems perspective. At the heart of these phenomena is a social-being existing simultaneously in myriad systems all of which draw upon the psychological and emotional endurance of the care giver, throttled in intensity from moment to moment. Using a holistic framework such as social suffering theory affords the advantage of allowing for broad abstractions of variables that influence the development of the syndromes which are focused upon here.

While this study is limited by the number of participants and small geographic area, these limitations are infused in the underlying argument. The relationship between a carer and their patient/client and the surrounding systems are rife with complexities and spontaneous input that do not fit a universalizing assertion. Rather that the friction towards universalization is itself the universalizing feature of psycho-emotional suffering and injury phenomena. For each case - distinct, temporal, mini-worlds inform the

experience of caregiving which cascade through time and culminate in a web of associative life-experience which augments future psychological and emotional responses.

The principal limitation of this study design was its one-time engagement with study participants. With funding and additional resources, the narratives of early-career experiences, and by virtue the emergence of psycho-emotional suffering and injury phenomena, would have been benefitted by capturing participant perspectives as they unfolded over time. A participant may be able to retrospectively assign value and judgement now, however had they been engaged when these events were unfolding, participants might have reported different internalized feelings and evaluations. Likewise, given that phenomenology is sensitive to the subjectivity of the researcher, the consultation and collaboration of a research team would only strengthen and enrich the findings.

Future research efforts seeking to etiologically integrate psycho-emotional suffering and injury phenomena by implementing a study design that accounts for the above limitations would greatly advance the understanding of how these phenomena manifest and better inform methods of prevention. Using holistic multi-domain frameworks such as social suffering theory could help explain the apparent interplay and causal association the literature currently makes amongst burnout, compassion fatigue, moral distress and injury, and secondary traumatic stress, as well as expand on insights of early-career experience in general. Findings have direct application at the micro (e.g. care team), meso (e.g. hospital), and macro (e.g. national healthcare policy) levels and have implications for the other caring professions.

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