MULTIDIMENSIONAL ANALYSIS OF BURNOUT SYNDROME IN SOCIAL WORKERS

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Abstract:

This study focuses on a comprehensive, multidimensional analysis of the burnout syndrome in social workers who are exposed to chronic stress and high emotional demands. The main objective is to identify and gain a deeper understanding of the specific factors contributing to emotional exhaustion, depersonalization, and reduced personal accomplishment in this profession. Based on quantitative research and the use of standardized psychometric tools (e.g., MBI), the work aims to uncover the relationships between workload, organizational support, supervision, personal coping

strategies, and the level of burnout. The results obtained will contribute to the theoretical understanding of the burnout syndrome within the context of helping professions and provide practical recommendations for interventions and preventive programs aimed at improving the mental health and sustaining the quality of social work.

Keywords: Burnout syndrome, social workers, emotional exhaustion, depersonalization, supervision, work stress, multidimensional analysis, helping professions.

Introduction

Social work, in the very essence of its mission, represents one of the most critical pillars of modern society, focusing on helping individuals, families, and communities in a state of social need, crisis, or disadvantage. It is a demanding profession, not only in terms of expertise and knowledge of legislation but, above all, in terms of psychological and emotional engagement. Social workers daily confront tragedies, traumas, systemic failures, and complex interpersonal problems, often serving on the front line. This continuous exposure to secondary trauma, coupled with ethical dilemmas, chronic administrative burden, and limited resources, creates a unique and exceptionally high-risk work environment.

From the perspective of occupational psychology and health, this environment is defined as highly conducive to the development of **burnout syndrome**. Burnout syndrome, originally conceptualized in the 1970s, transcends ordinary fatigue or exhaustion. It is a complex, multidimensional psychological state that typically manifests in three key dimensions:

- Emotional Exhaustion – The feeling that emotional resources are depleted, and the worker is no longer able to give more of themselves to clients.
- Depersonalization (Cynicism) – The development of a negative, indifferent, or cynical attitude towards clients and the work itself, leading to formal and impersonal task execution.
- Reduced Personal Accomplishment – A tendency to negatively evaluate one's own achievements and competence, leading to feelings of ineffectiveness and insufficient contribution.

It is precisely this multidimensionality that is crucial for understanding burnout among social workers. Burnout not only affects their individual well-being but also fatally influences the quality and ethics of their professional performance. Depersonalization can lead to a reduction in empathy and an objective, even

dehumanizing, approach to the most vulnerable clients, thereby undermining the very core of social work.

The objective of this analysis is therefore to examine in detail the theoretical models of burnout syndrome in the context of the specific demands of social work. It aims for a deeper understanding of how factors such as organizational culture, quality of supervision, perceived autonomy, emotional labor, and coping strategies interact with the worker's psychological resilience and contribute to the development of the individual dimensions of burnout. Such a complex, theoretical grasp of the topic is essential for creating a sustainable environment that protects not only the health and careers of social workers but ultimately ensures effective and humane social assistance for the entire society.

1. Theoretical definition of burnout syndrome

A central position in the theoretical foundation of the phenomenon was won by a psychologist who was one of the first to provide a rigorous, multidimensional definition of the problem. [1] According to her definition, burnout represents: "a syndrome of emotional exhaustion, depersonalization, and reduced personal accomplishment, which can occur among individuals who work with people in some capacity." This three-dimensional understanding—encompassing the failure of affective, interpersonal, and cognitive functions—has become the accepted theoretical matrix.

In general, burnout is formally defined and subjectively experienced as a state of physical, emotional, and mental exhaustion caused by long-term exposure to emotionally highly demanding situations. [2] This phenomenon, which can be defined in a broader context as a state of complete psychological and physical depletion primarily affecting individuals who have long faced a severe stressful situation, is characterized by the stressors significantly outweighing the salutary factors (salutogens). [3] Burnout is thus not synonymous with ordinary stress; it is the final stage of a pathological process. J. Křivohlavý mentions that burnout syndrome is the result of a process in which people who are deeply emotionally involved in something lose their original enthusiasm and motivation. [4] It is a paradoxical state that affects primarily those who have chosen to help others as their mission—individuals with high internal motivation, where the desire to help outweighs the low financial compensation and other disadvantages of the helping professions.

From a symptomatological perspective, burnout syndrome is defined as an

experience of exhaustion accompanied by a range of symptoms primarily in the psychological domain, and partially in the physical and social domains. [5] It is categorized as a specific emotional fatigue, a state of emotional depletion, manifesting as long-term sub-depressive mood and irritability. [6] The fact that burnout occurs especially in professions where the core of the work involves "working with people" confirms its interpersonal basis. Affected individuals show signs of emotional and cognitive wear and tear, exhaustion, often associated with an internal distance from work problems and a sharp decline in work performance. [7] The high-risk group includes particularly those workers who become overly immersed in their work, invest an unhealthy amount of energy, and strive for perfection in their execution, thereby exposing themselves to permanent psychological pressure. In this context, stress and unmanaged professional problems represent a relevant and accelerating factor in the development of burnout syndrome.

Dimensions of burnout syndrome

As indicated in the theoretical definition, the key step toward a rigorous understanding of burnout syndrome was its breakdown into components. Maslach and her colleagues [8] established a model that defines burnout through three interconnected yet distinct dimensions. [8] These dimensions form the structural framework through which the phenomenon is analysed, diagnosed, and addressed in intervention strategies.

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a) Emotional exhaustion

Emotional Exhaustion is considered the cardinal and most frequently cited component of burnout syndrome. It represents the feeling that an individual's emotional and energetic resources are completely depleted, and the worker is no longer able to dedicate emotional energy to their clients, colleagues, or work tasks. Subjectively, it manifests as feelings of overload, fatigue, and helplessness. For social workers, this dimension is accelerated by permanent exposure to client suffering, the necessity of managing complex emotions within interactions (emotional labor), and the long-term provision of psychological support without adequate emotional recuperation. Emotional exhaustion functions as the gateway to the development of the other two dimensions.

b) Depersonalization (cynicism)

Depersonalization (often replaced by the term Cynicism in newer terminology) represents a negative and detached response to chronic emotional overload. The worker creates an emotional distance from their clients and work, thus attempting to defend themselves against further emotional loss. Clinically, it manifests as indifference, loss of empathy, and a tendency to dehumanize clients, who are perceived more as "cases" or "sets of problems" than as human beings. In the context of social work, this dimension is ethically highly problematic because it reduces the quality of the professional relationship and violates the fundamental principles of helping behaviour—respect and care.

c) Reduced personal accomplishment

The final dimension reflects a tendency towards negative evaluation of one's own work achievements and competence. The individual experiences a drop in self-confidence, a loss of the meaning of work, and a conviction of their own ineffectiveness, despite objectively good performance in the past. Social workers who enter the profession with idealistic goals and high ambitions are particularly susceptible to frustration when they encounter systemic obstacles, bureaucratic restrictions, or when their efforts do not lead to an immediate and visible improvement in the client's situation. The feeling of reduced accomplishment leads to a loss of motivation and an unwillingness to invest further effort into work tasks.

Etiology of burnout in the context of social work

Understanding the emergence of burnout syndrome requires examining the specific work context of social workers, where several risk factors converge at the individual, interpersonal, and organizational levels. Work in the social sphere is inherently associated with high emotional dissonance. Workers often have to display care and empathy even when they are emotionally exhausted themselves or disagree with a client's decisions. Added to this is chronic overload—not only due to the high volume of work but primarily because of its emotional and cognitive complexity, requiring the resolution of unstructured and serious problems (e.g., domestic violence, child neglect). At the organizational level, the etiology of burnout is often linked to bureaucracy and resource scarcity. Excessive administrative burden, which distracts attention from direct client work, leads to frustration and feelings of ineffectiveness. Inadequate supervision, a lack of organizational support, and low salaries create the impression that the organization does not value the work social workers perform. This lack of perceived justice and transparency in compensation and task distribution is a strong predictor of cynicism and depersonalization. From an individual perspective, risk factors are tied to personal characteristics and coping styles. Workers with high idealism, a tendency towards perfectionism, and an unhealthy degree of immersion in client problems are more prone to rapid exhaustion. Their internal orientation towards helping and the satisfaction derived from it lead them to ignore their own boundaries and signs of overload, which accelerates the transition into the phase of emotional collapse and subsequent detachment from the profession. The etiology of burnout syndrome in social workers is therefore multifactorial; it represents a complex interaction among the extraordinary demands of the work environment, inadequate organizational structure, and personal vulnerability.

Symptomatology and clinical picture of burnout syndrome

The clinical manifestation of burnout syndrome is not merely a summary of surface symptoms, but reflects a deep structural psychodynamic crisis of the individual, determined by the interaction of chronic stress and the failure of key coping mechanisms. The symptomatology is multivariate, and its intensity and persistence correlate with the phase of the syndrome, leading to significant damage to psychological and psychosocial integrity. [9] Psychophysiological theory even identifies dynamic phases of burnout related to the dysregulation of the autonomic nervous system: tense burnout, which represents chronic hyperactivation of the sympathetic nervous system (an alarm state), and listless

burnout, indicating a state of parasympathetic overtraining (suppression and demotivation). [10] This imbalance is the substrate for a triad of key psychological and behavioural manifestations:

A. Emotional and cognitive exhaustion

Exhaustion is the central manifestation and reflects the collapse of the ego's energy system. It is not merely physical fatigue but a complete loss of emotional capacity for emotional labor (the ability to regulate and invest emotions in interactions).

- Affective manifestation – Dominance of dejection, hopelessness, and helplessness. Self-control disintegrates, manifesting as pathological irritability or uncontrollable affective outbursts (crying). From a psychological perspective, the key is the feeling of futility (*Learned Helplessness*), which in extreme cases accelerates suicidal ideation. [11]
- Cognitive manifestation – Reduction of cognitive functions: inability to concentrate, memory impairment, and mental fatigue that forces the affected individual to resign from responsibility. The cognitive plane is impaired by a loss of enthusiasm and the development of a global negative attitude toward the self, the work, and the environment. [12]

B. Alienation (cynicism and depersonalization)

Alienation is a defensive-apathetic reaction to unbearable emotional overload, where the ego instinctively minimizes the threat of further emotional loss.

- Interpersonal manifestation – The worker creates emotional distance, dehumanizes clients, and perceives them as objects rather than subjects of interaction. Cynicism sets in, functioning as a cognitive filter—empathy and compassion are reduced.
- Behavioural manifestation – Alienation escalates into scornful, sarcastic, or even aggressive behaviour toward colleagues and clients, which is a manifestation of displaced anger and frustration that cannot be vented otherwise.

C. Decline in professional competence

This dimension involves an impairment of professional identity and self-perception.

- Subjective incompetence – Although objective performance may still be acceptable, the affected individual loses faith in their own abilities, experiences a feeling of ineffectiveness, and professionally considers themselves incompetent. [13] This leads to negative self-reflection and a resignation of initiative.

The syndrome penetrates into the deeper layers of the psyche and somatic health:

Psychological and cognitive manifestations

- Affective disorders – Dominated by depression, chronic anxiety, and feelings of despair. Characteristic is frustration, which is escalated by egocentrism and a feeling of lack of recognition.
- Behavioural coping – The failure of healthy coping mechanisms leads to an escape into maladaptive strategies. This includes the rejection of advice and criticism (resistance to insight), and increased consumption of psychostimulant substances (alcohol, medication, coffee) as a dysfunctional attempt to manage chronic fatigue and anxiety.

Social and interpersonal manifestations

- Social retraction – A significant reduction in social contacts occurs, leading to social isolation and a deepening sense of loneliness and sadness. This retraction is an attempt to protect oneself from further interpersonal strain.

Somatic manifestations

Physical symptoms are the result of the long-term activation of the HPA (hypothalamic-pituitary-adrenal) stress axis. Besides chronic fatigue and sleep disturbances, this includes somatic pain (headaches, neck pain, abdominal pain) that lacks a clear organic cause. [14] These somatised symptoms are the bodily translation of unresolved psychological stress. A final psychological synthesis

indicates that the syndrome affects individuals with high internal demands—those who interpret failure as a personal defeat, are unable to rest effectively, and show an imbalance between giving and receiving. [15] Burnout is thus primarily a pathology of the professional relationship one has with the self and with the work.

Phased progression and evolutionary dynamics of burnout syndrome

The diagnostic definition of the syndrome (the combination of typical symptoms) encounters a challenging demarcation between normative adaptation and a pathological reaction, especially in the context of socially highly valued behaviour such as altruism and helping others. [16] Burnout is not an acute state but a long-term, evolutionary process that manifests in a sequence of psychological stages. Although a spectrum of models exists, from simple three-phase to the twelve-stage model, all illustrate the progressive erosion of professional identity and emotional resources.

Freudenberger's twelve-stage progression model

Psychologist Herbert Freudenberger described twelve stages that chronologically illustrate the transition from engagement to complete collapse. [17]

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Psychologist Herbert Freudenberger described twelve stages that chronologically illustrate the transition from engagement to complete collapse. [17] The process begins with high motivation and the need to prove competence (Stage 1), which quickly escalates into increased dedication (Stage 2). The critical point is the subtle neglect of one's own needs (Stage 3) and the subsequent suppression of internal conflicts (Stage 4). This self-destructive ignorance leads to a redefinition of values (Stage 5), where work goals dominate personal life. Gradually, the suppression of conflicts intensifies (Stage 6), and social withdrawal into passivity occurs (Stage 7), which is a harbinger of observable changes in behaviour (Stage 8). Psychological decompensation culminates in depersonalization (Stage 9)—a loss of the sense of one's own personality—and

internal emptiness (Stage 10), followed by fully developed depression (Stage 11). The final stage (Stage 12) is complete burnout, characterized by total physical, mental, and emotional exhaustion. It is necessary to emphasize that these stages overlap, and their boundaries are not clear-cut in clinical practice.

Table No. 1: Detection and psychological analysis of Freudenberger's twelve-stage progression model

Stage	Name	Psychological Analysis and Mechanisms
1.	The compulsion to prove oneself, ambition	High intrinsic motivation and idealism. The individual possesses an oversized self-concept, with work serving as the key means of self-validation. An idealistic drive is present, often in the context of altruistic narcissism, where helping others reinforces one's own self-worth.
2.	**Increased dedication**	Hyperactivity and overwork. The worker follows up on initial ambitions by investing disproportionate energy, leading to chronic over-identification with the professional role. They perceive the overload as a necessary price for achieving the ideal.
3.	**Subtle neglect of one's own needs**	Ego-syntonic negation. The individual begins to marginalize their own physiological and psychological needs (sleep, social contacts, relaxation). This behaviour is rationally justified by the imperatives of work, leading to a blurring of the professional vs. personal life boundary.
4.	**Suppression of conflicts and needs**	Defense and internalization of tension. Conflicts with colleagues, superiors, or clients are suppressed and negated to avoid threatening the idealistic image of the work. Internal emotional dissonance arises, increasing chronic tension.
5.	**Redefinition of values**	Radical cognitive restructuring. A shift in the hierarchy of values occurs. Everything unrelated to work (hobbies, family, friends) loses significance. The individual becomes one-dimensional, leading to social isolation and the limitation of compensatory mechanisms.

Stage	Name	Psychological Analysis and Mechanisms
6.	**Intensified denial of conflicts**	Escalation of Cynicism and Paranoia. The attempt to maintain the facade leads to an amplified defense through denial. The worker is frustrated, but instead of solving problems, they blame external circumstances. Interpersonal relationships are damaged; irritability and cynicism emerge.
7.	**Withdrawal into passivity**	Apathetic retraction. Social and emotional investment decreases. The worker withdraws into themselves, minimizing contacts, which is an escape from interpersonal strain. This passivity is a protective reaction against further energy loss.
8.	**Observable changes in behaviour**	Behavioural deviation. Emotional and cognitive impairments become apparent to others. This may include increased aggression, neglecting one's appearance, the onset of maladaptive coping (e.g., alcohol, excessive eating), or formal, bureaucratic execution of tasks without emotion.
9.	**Depersonalization (loss of sense of self)**	Psychological breakdown of identity. The individual loses consciousness of their self in the context of the profession and becomes a detached, mechanical actor. Clients are perceived as objects. In extreme cases, a feeling of unreality regarding the self and the surroundings sets in.
10.	**Inner emptiness**	Existential crisis and anhedonia. A feeling of emotional and cognitive void. Anhedonia—the loss of the ability to experience joy from any activity. A loss of meaning in life occurs, as the initial redefinition of values has failed.
11.	**Depression**	Clinical and affective illness. The inner emptiness transitions into a fully developed clinical state characterized by global dejection, hopelessness, and psychomotor retardation. The risk of suicidality is significantly increased at this stage.

Stage	Name	Psychological Analysis and Mechanisms
12.	**Complete burnout**	Collapse of the psychophysiological system. The terminal stage represents total collapse, complete physical, mental, and emotional exhaustion. The individual is incapable of professional or personal functioning and requires urgent therapeutic and often psychiatric intervention.

Source: Author's own processing

Psychometric and clinical methods for diagnosing burnout syndrome

Accurate and valid diagnosis of burnout syndrome is fundamental for adequate therapeutic and organizational intervention. The diagnostic process relies on a combination of standardized psychometric scales (quantitative detection) and qualitative clinical methods (understanding the context and subjective experience), as the syndrome is multidimensional and its boundary with ordinary overload is not strictly definable.

Quantitative diagnosis: Standardized psychometric tools

Psychometric tools form the basis for quantifying the three (or two) fundamental dimensions of burnout. Their advantages include objectivity, the possibility of comparison with normative data, and applicability in extensive studies. [19]

a) Maslach burnout inventory (MBI)

The MBI represents the "gold standard" in burnout measurement, rooted in the three-dimensional concept. [20] The instrument is divided into three subscales:

- Emotional exhaustion (EE) – Considered the core and most stable component of the syndrome. The MBI measures feelings of emotional overload and energy depletion. A higher score indicates a higher level of burnout.
- Depersonalization (DP) – Measures the interpersonal dimension, i.e., cynical

and detached reactions towards clients (or generally towards work in the MBI-GS). A higher score indicates a higher level of cynicism/depersonalization.

- Reduced Personal Accomplishment (PA) – Assesses the self-evaluation of competence. A lower score on this subscale (unlike EE and DP) indicates a higher level of burnout, i.e., feelings of ineffectiveness and lack of achievement. The original MBI-HSS (Human Services Survey) version was targeted at helping professions, while the MBI-GS (General Survey) extended validity to all types of occupations. Clinical diagnosis requires high scores on EE and DP and a low score on PA. Items are rated on a frequency scale (e.g., 0 = never, 6 = daily).

b) Oldenburg burnout inventory (OLBI)

The OLBI represents an alternative psychometric approach stemming from criticism of the MBI, particularly concerning the negative phrasing of all dimensions. The OLBI measures burnout as a two-dimensional syndrome: [21]

- Exhaustion – Encompasses physical, cognitive, and emotional exhaustion, thus being conceived more broadly than EE in the MBI.
- Disengagement – Assesses detachment and cynicism towards work.

A key feature of the OLBI is the balanced item phrasing (it includes both positive and negative statements), which helps to control for response bias. Responses are measured on a 4-point Likert scale.

c) Copenhagen burnout inventory (CBI)

The CBI is distinguished by its contextual focus and defines burnout primarily as fatigue or exhaustion. [22] It divides exhaustion into three specific subscales based on the causal attribution of fatigue:

Personal Burnout – A general feeling of fatigue and exhaustion without specific attribution.

- Work-Related Burnout – Attribution of fatigue specifically to the work context.
- Client-Related Burnout – Attribution of fatigue to interactions with clients, which is crucial for the helping professions.

The CBI thus allows for a more precise identification of the source of exhaustion, which is important for more targeted organizational intervention.

d) Burnout measure (BM)

The BM by Pines & Aronson focuses on measuring the level of physical, emotional, and mental exhaustion through 21 items (a shortened 10-item version—BMS—also exists) rated on a 7-point frequency scale. [23] Although it differs from the MBI in its dimensional structure, its goal is to quantify the feeling of wear and tear due to work.

Burnout Syndrome in the Context of Social Work

Work represents a key mechanism for satisfying not only biological and economic needs but is also an essential means of socialization, self-realization, and the development of cognitive schemas. [24]

Paradoxically, it is precisely in those professions that are focused on profoundly satisfying the social and emotional needs of others where the greatest risk of transformation from a source of fulfilment to a source of chronic psychological trauma accumulates.

Although the risk of burnout is *de facto* present in every work sphere, there is a set of professions that exhibit increased vulnerability to burnout syndrome. These include especially the helping and assisting professions, such as doctors, nurses, and, with high frequency, **social workers**.

The high prevalence of burnout in social work is multifactorial and is linked to the inherent demands of the professional role that exceed the adaptive capacities of the individual:

- **Chronic Demand for Unwavering Performance** – A key risk factor is the permanent pressure to achieve high, qualitatively unfluctuating performance, which is perceived as the standard, with minimal possibility for relief. This demand is associated with severe consequences for errors (which often directly affect the client's life) and simultaneously with a critical absence of positive feedback. [25]
- **Intense Personal Investment and Client Orientation** – Burnout occurs especially in positions where intense personal contact and a priority focus on satisfying complex and often unrealistic needs of others are necessary. [26]
- **Negative Balance of Output and Input** – In social work, the risk is accelerated by a long-term negative balance, where workers permanently give out more of themselves (emotional investment, time, energy) than they receive (financial compensation, recognition, visible positive results). [27]

Social work as a paradigmatic helping profession

Social work, with historical roots in early forms of charitable care and assistance to the poor at the beginning of the 20th century, [28] is currently establishing itself as a complex social science discipline and an area of practical activity. Its essential goal is the identification, explanation, mitigation, and resolution of social problems at the individual, group, and community levels. [29] The helping profession defines a group of occupations whose main component is professional assistance to other people. Social work differs from other professional fields primarily based on two critical factors:

1. The Human Relationship Factor

The fundamental distinguishing feature lies in the critical role of the human relationship between the helping professional and the client. Unlike other professions with frequent interpersonal contact (e.g., sales, management), helping professions presuppose establishing a trusting, professional relationship where high emphasis is placed on the emotional validity of the interaction. The helping profession represents a system where, on one side, there is the helping professional (social worker) and, on the other side, the client who receives the help. [30]

2. Involvement of personality in the work process

The execution of social work requires not only high professional competence (adequate education, knowledge, skills) but also the involvement of one's own personality in the work process. This necessitates personal maturity, flexibility, and ethical attitudes. [31] The helping worker is motivated by a willingness to serve others [32] and the principles of altruism—i.e., they are prepared to accept a threat to their own well-being for the benefit of the individual. [33]

Altruism as a psychological predictor of burnout

From a psychological perspective, a key phenomenon is explained: [34] the human need to give love and care. In the social worker, there is high motivation to create interpersonal relationships in which they are the primary giving partner, while the client is dependent on them. This dynamic can subconsciously

satisfy some individuals' need for requiredness (neediness) and unconditional acceptance.

Paradoxically, it is precisely this high altruistic imperative and the investment of one's own personality (where the worker constantly "gives") that makes the professional vulnerable. If the need for self-satisfaction (through recognition and success) is chronically unfulfilled in the context of the negative balance of output and input (as is the case in social work), the energy invested in the relationship is not reflected in a real feeling of fulfilment, which triggers the mechanisms of burnout.

Social work aims to strengthen the independence of clients and seek just socio-economic strategies, yet this constantly encounters systemic obstacles, making the frustration from the gap between the ideal and reality a chronic risk factor.

Behavioural, cognitive, and emotional case studies of burnout syndrome in social workers

Burnout syndrome transforms the psychological structure of the individual, which in the social work environment manifests as a set of profound behavioural, cognitive, and emotional changes that significantly disrupt the professional role and personal life. These changes are a relevant clinical indicator of burnout progression. [35]

A key pathognomonic sign is the onset of defence mechanisms that lead to alienation and loss of engagement towards clients:

Emotional distance and depersonalization – a social worker affected by burnout transitions into a state of disengagement and avoidance of clients. The client ceases to be viewed as a human being with complex needs and becomes merely an object (a case) that must be handled with the minimum possible investment. [36]

- Rigidity and loss of creativity – behaviour adheres rigidly to standard and established procedures. This creative inertia reflects a loss of the ability to approach the saturation of individual client needs flexibly and sensitively. [37]
- **Abuse of role and ethical failure** – In extreme, advanced phases, behaviour may take on toxic forms, manifesting as unmindful, arrogant, cynical, or even blaming conduct. These destructive tendencies can culminate in the intentional failure to provide necessary help, the denial of basic rights, and, in the worst case, physical or emotional abuse.

Burnout is accompanied by a profound change in the individual's cognitive and affective schemas, leading to a disruption of meaning and motivation:

- Sense of meaninglessness (existential frustration) – a worker in crisis feels that their efforts are futile, meaningless, and unending. The professional concept suffers because gratification is not attained, despite often above-average work investment. [38] The loss of meaning is also transferred to personal life, leading to anhedonia (the inability to experience pleasure) and a loss of ideals and enthusiasm. [39]
- Negativism and scepticism – the original enthusiasm is replaced by generalized negativism. The worker is sceptical about the effectiveness of the service and the future of clients. Reduced performance is a direct consequence of this apathy and indifference.
- Emotional lability and aggressiveness – following a sharp decline in physical and psychological energy, emotional lability sets in, manifesting as outbursts of anger or uncontrollable crying. [40] This frustration is often displaced onto the surroundings, leading to family breakdown and conflicts with colleagues.

The affliction of burnout syndrome has a profound impact on social integrity and psychological health:

- Social isolation and conflicts, where the individual withdraws into themselves, loses interest in meeting other people, and disrupts communication with colleagues. [41] The family becomes a burden with a transferred negative relationship, leading to an escalation of conflicts and social destruction.
- Comorbid psychological problems – burnout is often accompanied by the development of psychopathological states, primarily anxiety and depression, which are followed by psychosomatic difficulties (hypertension, insomnia).
- Maladaptive coping and refusal of help – the search for an escape from difficulties leads to the onset of maladaptive coping strategies, including the abuse of sedatives and psychostimulant drugs. [42] Clinically alarming is the state where the worker denies the state of burnout, refuses to accept the diagnosis, and trivializes seeking and accepting help. [43]
- Risk of suicidality – the absolute climax is total physical, emotional, and mental exhaustion and a feeling of meaninglessness in further life. [44] This existential crisis can lead to a propensity for suicidal thoughts and acts, which represents the most severe consequence of an unresolved syndrome. An individual without a meaning in life loses motivation to face adversity and resigns from any change. [45]

Supervision as an essential protective mechanism in burnout syndrome prevention

In the context of chronic stress and emotional burden to which the social worker is exposed (due to the client's position as an almost equal partner in the process of support and accompaniment), **supervision** represents an integral part of targeted primary and secondary prevention of burnout syndrome.

Supervision is defined as a structured interpersonal interaction, [46] whose main goal is to increase the professional competence of the supervised individual in effectively providing help. In social work, supervision focuses on the relationship with the client, communication, and the resolution of specific problem situations, aiming to reach the optimal approach for the given worker. [47]

The legal definition stipulates that supervision is carried out by a physical person with adequate accredited professional training (Act No. 448/2008 Coll., § 84, para. 8). [48]

Conclusion

The presented multidimensional analysis confirms that burnout syndrome is a highly risky phenomenon in social work, given its inherent emotional intensity, chronic burden, and interpersonal nature. Burnout is not merely ordinary fatigue but a complex psychological state that manifests in three mutually interconnected dimensions:

- Emotional Exhaustion (EE) – the key and entry gate of the syndrome, representing a feeling of absolute depletion of emotional resources.
- Depersonalization (cynicism) – leads to a negative, indifferent, and detached approach to clients, which is ethically highly problematic as it undermines the very core of the helping profession.
- Reduced Personal Accomplishment (PA) – manifested by a decline in self-confidence and a feeling of ineffectiveness, despite genuine effort.

The etiology of burnout in social workers is multifactorial and represents an unhealthy interaction between the environment and individual vulnerability. The key factors that accelerate burnout are organizational and systemic deficiencies: excessive administrative burden, lack of adequate supervision, and low perceived organizational and financial compensation, which leads to frustration and cynicism.

Individual predispositions, such as high idealism, perfectionism, and an exaggerated degree of immersion in clients' problems, also significantly contribute to rapid collapse, as they lead to the ignorance of one's own boundaries and signals of overload.

Based on the studied models (e.g., Freudenberger's progression model), it is evident that the syndrome has a phased, progressive character, starting with idealistic enthusiasm and ending with the total collapse of the psychophysiological system, often accompanied by depressive mood and social isolation. Understanding this process is essential for the implementation of targeted and effective preventative programs.

Recommendations for practice

Based on the identified etiological factors, the following recommendations are crucial for social work practice, focusing on both the organizational and individual levels:

1. Organizational and systemic measures (employer responsibility)

- **Optimization of workload and bureaucracy** – it is essential to radically reduce unproductive administrative burden that distracts social workers from direct client work and induces feelings of ineffectiveness and frustration.
- **Strengthening supervision and organizational support** – ensure regular, mandatory, and qualified supervision that serves as a space for emotional recuperation, processing secondary trauma, and reflecting on ethical dilemmas, not merely as an administrative tool.
- **Improving perceived justice** – increase salary compensation and ensure transparency in remuneration and task distribution. The feeling of low compensation and absence of justice is a strong predictor of cynicism (depersonalization).
- **Resource provision** – provide adequate material, personnel, and technological resources that reduce the feeling of helplessness among social workers when solving complex problems.

2. Individual and preventive measures (individual responsibility and training)

- **Psychoeducation and coping strategy training** – provide systematic training focused on developing healthy coping mechanisms and on setting and maintaining professional boundaries between the self and the client.
- **Early detection and prevention of idealism** – for workers with high idealism and perfectionism, who are more prone to ignoring their own needs, targeted prevention must be carried out to prevent their transition into the phase of emotional collapse (Freudenberger's Stage of Idealistic Enthusiasm).
- **Support for mental health and self-care** – encourage the balancing of work and personal life and compensatory mechanisms to prevent the redefinition of values where work dominates everything else (Freudenberger's Stage 5).
- **Utilization of diagnostic tools** – regularly conduct screening through standardized psychometric tools (e.g., MBI, OLBI, CBI) that can accurately quantify the level of emotional exhaustion, depersonalization, and reduced accomplishment. Early quantification allows for targeted and effective intervention.

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