Review Article

Burnout Among Social Workers: A Systematic Review of Drivers, Protective Factors, and Interventions Across Practice Settings

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Abstract

Background: Social worker burnout comprising exhaustion, cynicism, and reduced efficacy is a recognised occupational phenomenon with severe workforce consequences, including a projected shortage exceeding 195,000 US social workers by 2030. Methods: This systematic review synthesised 57 studies (six continents, 25 countries; all rated Low risk of bias) via PRISMA-guided narrative synthesis, integrating the Job Demands-Resources and Professional Quality of Life frameworks. Results: Caseload excess, secondary traumatic stress, and organisational stressors emerged as primary drivers, while social support, reflective supervision, meaning-making, and psychological capital buffered risk. COVID-19 amplified pre-existing structural vulnerability rather than creating novel distress. Mindfulness-based interventions showed clinically meaningful efficacy but faced structural ceiling effects in unreformed organisations. Findings also revealed context-dependent coping effectiveness, gaps between supervision provision and psychological safety, and a provisional burnout-turnover paradox warranting replication. Conclusion: This systematic review primarily aligns with SDG 3 (Good Health and Well-being) by examining the drivers, protective factors, and interventions associated with occupational burnout among social workers. It also contributes to SDG 8 (Decent Work and Economic Growth) by identifying strategies to promote healthier working environments and sustainable professional practice.

Keywords: Social worker burnout, Occupational stress, Secondary traumatic stress; Job Demands-Resources model, Professional Quality of Life, Organisational interventions, Workforce retention, Systematic review

1. Introduction

The WHO's ICD-11 recognises burnout as an occupational phenomenon arising from chronic, unmanaged workplace stress, characterised by exhaustion, cynicism or mental distance from one's job, and reduced professional efficacy {1}. Maslach et al.'s {2} model frames this as emotional exhaustion, depersonalisation, and reduced personal accomplishment. Given sustained exposure to trauma, crisis, and systemic adversity, social workers face elevated risk across all three dimensions {3}, alongside related constructs such as secondary traumatic stress (STS), compassion fatigue, and vicarious trauma {4, 5, 6}.

The workforce implications are substantial. Edwards and Wildeman [7] project a shortage of more than 195,000 social workers in the United States by 2030. This challenge is further compounded by the relatively short median tenure of child welfare professionals, reported at approximately 1.8 years, and annual turnover rates ranging from 14% to 26%. Giménez-Bertomeu et al.'s {8} meta-analysis of 24 studies (16,962 workers, seven countries) found pooled prevalence of 50% emotional exhaustion, 45% depersonalisation, and 39% reduced personal accomplishment, likely an underestimate, since it excluded STS, compassion fatigue, and vicarious trauma.

1.2 Theoretical Context

1.2.1 The Job Demands-Resources (JD-R) Model

The review's primary framework is the Job Demands-Resources (JD-R) model {9}, distinguishing job demands aspects of work requiring sustained effort and psychological cost from job resources, which help achieve goals, reduce demands, or foster growth. Sustained high demands drive a health-impairment process toward exhaustion; adequate resources drive a motivational process supporting engagement and efficacy, and can buffer demands' negative impact {9, 10}. Here, demands include workload, caseload, role conflict/ambiguity, emotional labour, and trauma exposure; resources include supervision, peer support, organisational justice, and role clarity, among others coded across the 57 included studies.

1.2.2 The Professional Quality of Life (ProQOL) Framework

Understanding the occupational demands of helping professions requires a framework that accounts for both general work-related stressors and the distinctive psychological consequences of trauma exposure. It is due to the reason that the JD-R model does not capture trauma-specific consequences of helping work, the Professional Quality of Life (ProQOL) framework {4} complements it. ProQOL frames helping-profession outcomes as a balance between Compassion Satisfaction positive feelings from helping others, linked to resilience and reduced

burnout/STS and Compassion Fatigue, which splits into Burnout (hopelessness and exhaustion from the work environment) and Secondary Traumatic Stress (a PTSD-like response to absorbing clients' trauma) {11}. Used in over 1,000 peer-reviewed studies, ProQOL's dual measurement captures how compassion satisfaction and fatigue coexist within the same practitioner. Together, JD-R and ProQOL offer non-redundant coverage: structural origins of burnout versus trauma-specific emotional consequences.

1.3 Prior Systematic Reviews and Evidence Gaps

Previous reviews have established important conceptual and theoretical foundations: Lizano {12} linked burnout to poorer worker wellbeing across 19 studies (1970–2014); Lizano and Mor Barak {13} showed longitudinally that emotional exhaustion predicted reduced job satisfaction; McFadden et al. {14} synthesised resilience themes across 28 child-protection studies; and Giménez-Bertomeu et al. {8} provided the first pooled burnout prevalence estimates for social services workers.

Despite these contributions, five gaps remain: concentrated in child welfare rather than the full range of practice settings (forensic, refugee, medical, hospice, humanitarian); protective factors, coping mechanisms, and interventions have received far less attention than risk factors; post-2020 evidence on COVID-19's impact on practitioner wellbeing remains unintegrated; no review has combined the JD-R and ProQOL frameworks; and the evidence base remains concentrated in Europe and North America, underrepresenting low- and middle-income countries {8}.

1.4 Rationale and Research Objectives

This review addresses these gaps through a larger evidence base (57 studies, 25 countries, six continents) that integrates protective factors and interventions alongside risk factors, incorporates COVID-19-era literature, applies the integrated JD-R–ProQOL framework, and spans the full range of social work practice settings.

Primary Research Question:

This paper addresses the primary research question: What does the literature reveal about the drivers, protective factors, and organisational responses to burnout among professional social workers?

This is operationalised through four secondary research questions:

RQ1 — Burnout Drivers: What factors contribute to burnout, secondary traumatic stress, and compassion fatigue among social workers?

RQ2 — Protective Resources and Coping: What protective factors and coping strategies help reduce burnout and support wellbeing among social workers?

RQ3 — Organisational Interventions: How effective are organisational and training-based interventions in reducing burnout among social workers?

RQ4 — Theoretical Integration: How well do the JD-R and ProQOL frameworks explain the burnout and wellbeing patterns found in this review, and where do they extend or challenge the models?

RQ1 is addressed in Section 3.3, RQ2 in Sections 3.4 and 3.5, RQ3 in Section 3.6, and RQ4 in Section 4.1.

This systematic review primarily aligns with SDG 3 (Good Health and Well-being) by examining the drivers, protective factors, and interventions associated with occupational burnout among social workers. It also contributes to SDG 8 (Decent Work and Economic Growth) by identifying strategies to promote healthier working environments and sustainable professional practice.

2. Methods

This review followed PRISMA 2020 guidelines {15} and used qualitative narrative synthesis, as heterogeneity in design, outcome measures, instruments, and populations across the 57 included studies precluded meta-analysis. The protocol was prospectively registered on OSF (Registration ID: x8n5s; https://osf.io/x8n5s), as the appropriate PROSPERO category for reviews of risk factors and aetiology was unavailable at the time.

2.1 Database Search

Six databases and search engines were searched: PubMed, SpringerLink, Taylor & Francis Online, Wiley Online Library, Google Scholar, and Google Scholar Labs the latter two included to capture grey literature and preprints. A Boolean strategy combined three concept blocks distress indicators, the social work population, and coping/resilience mechanisms applied to titles, abstracts, and keywords, with truncation for word variants:

("Burnout" OR "emotional exhaustion" OR "compassion fatigue" OR "occupational stress") AND ("Social worker" OR "social work") AND ("Coping mechanism*" OR "coping strateg*" OR "resilience")

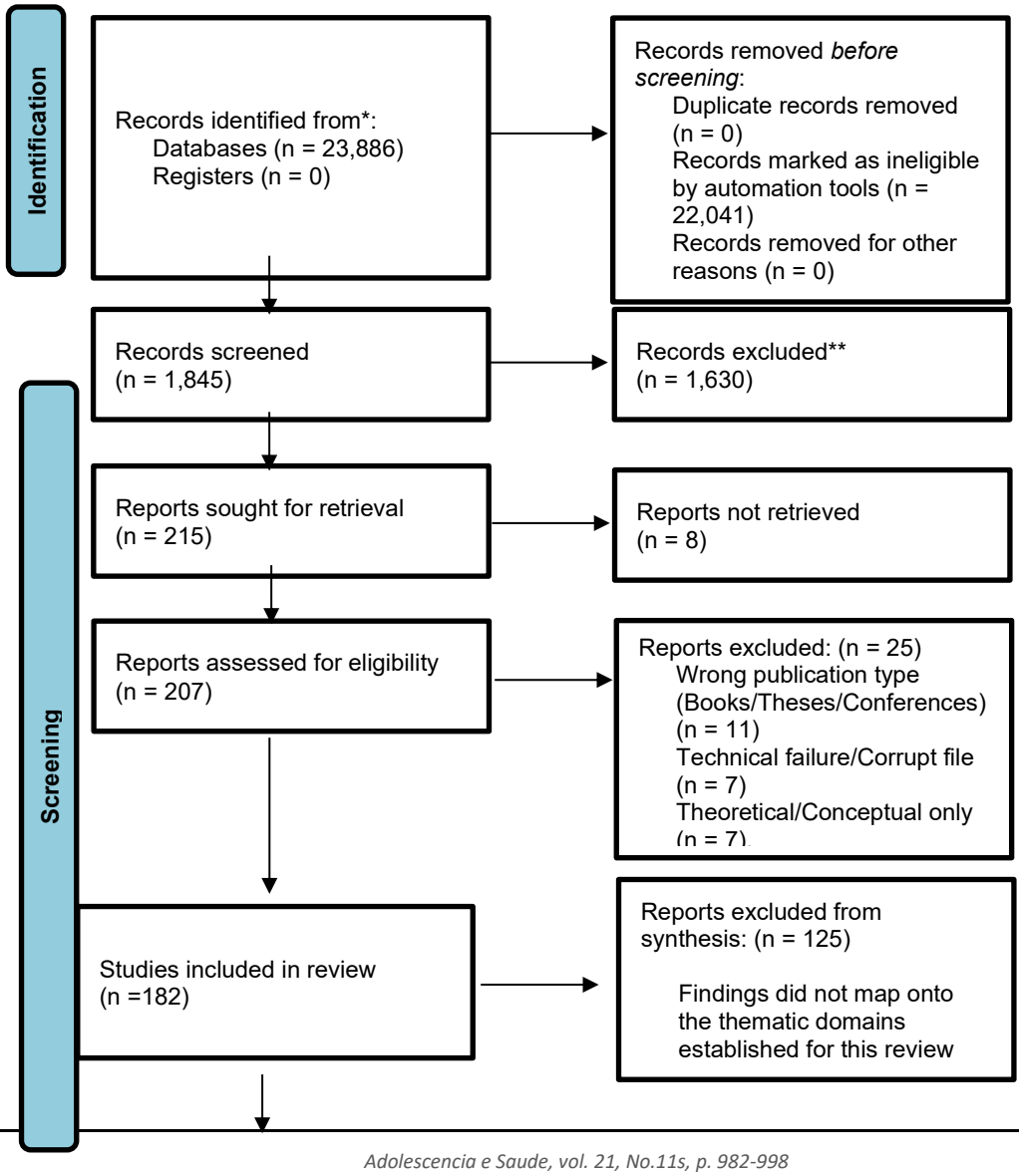
The string was adapted to each database's syntax preserving its core logic. Search dates, exact strings, and record counts per source were logged; the temporal scope was unrestricted, from earliest available records through 2026.

2.2 Eligibility Criteria

Eligible studies focused primarily on professional social workers (clinical, case management, child protection, community, medical, mental health, forensic, and refugee/humanitarian roles, plus allied roles where social work was the primary identity) and reported primary empirical data — quantitative, qualitative, or mixed-methods — addressing at least one of: risk factors for occupational distress (burnout, compassion fatigue, secondary traumatic stress, vicarious trauma); coping or resilience strategies; or protective organisational, interpersonal, or individual factors. Studies had to be peer-reviewed, English-language, and full-text, with no restriction on publication year. Excluded were book chapters, theses, and conference proceedings; theoretical/conceptual papers, editorials, letters, and secondary analyses without primary data; studies where social work data could not be disaggregated from broader human-service or healthcare-worker samples; studies unrelated to burnout/distress constructs; and reports unobtainable due to persistent paywalls (despite institutional and inter-library loan attempts) or file corruption.

2.3 Screening

The search returned 23,886 records; automated filters (language, year, document type) removed 22,041, leaving 1,845 for title/abstract screening. This stage excluded 1,630 records against the population, phenomenon, or design criteria, leaving 215 reports sought in full text eight were unobtainable due to paywalls. Of the 207 retrieved, 25 were excluded at full-text review (wrong publication type, n = 11; corrupted files, n = 7; theoretical papers without primary data, n = 7 exceeding the four anticipated in the registered protocol, since some proved conceptual only on full-text review), leaving 182 studies eligible for inclusion and quality appraisal. Of these, 125 were subsequently excluded from narrative synthesis because their findings did not map onto the thematic domains established for this review, yielding a final synthesised sample of 57 studies (Figure 1). Data were extracted using a piloted, standardised form capturing study characteristics, burnout instruments, JD-R-coded predictors/resources, ProQOL-coded outcomes, and theme assignment; coding uncertainties were resolved by re-review or author contact.



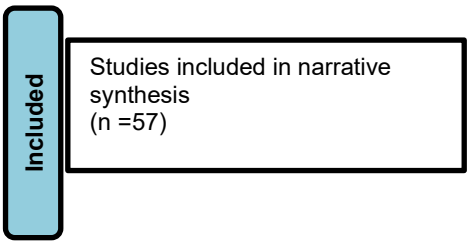


Figure 1: PRISMA 2020 flow diagram of study identification, screening, and inclusion

2.4 Quality Appraisal

Methodological quality was appraised with design-appropriate tools Joanna Briggs Institute (JBI) checklists for quantitative observational studies {16} and qualitative studies {17}, and the Mixed Methods Appraisal Tool {18}. Garza et al. {19}, a quantitative secondary-data joint-modelling study, was appraised using the JBI Analytical Cross-Sectional Studies Checklist. Each study received an overall bias rating (Low/Moderate/Borderline/High).

2.5 Synthesis

Given the heterogeneity across studies, findings were synthesised narratively through a structured five-stage process: (1) sorting studies into ten a priori themes (Burnout Drivers, Protective Resources, Professional Well-Being, Coping Strategies, Organisational Interventions, Barriers to Well-Being, Burnout Moderators, Burnout Mediators, Workforce Retention, and Policy Issues); (2) coding all variables by JD-R category (job demand, job resource, or personal resource) and ProQOL outcome (burnout, STS, compassion satisfaction, or compassion fatigue); (3) synthesising findings within each theme, noting convergence, contradictions, and cross-cutting patterns; (4) examining variation by study design and risk-of-bias rating; and (5) mapping the strength and consistency of evidence for each driver, factor, and intervention, distinguishing conclusions from multiple Low-risk studies versus single or higher-risk sources.

3. Results

3.1 Overview of Included Studies

This review synthesised evidence from 57 empirical studies examining burnout, secondary traumatic stress (STS), compassion fatigue, vicarious trauma, and related well-being constructs among social workers. The literature spans 1993–2026, concentrated post-2019, reflecting accelerated scholarly attention following the COVID-19 pandemic.

3.1.1 Study Design

Quantitative designs were most common (n = 43, 75.5%), spanning cross-sectional surveys, regression, structural equation models, and longitudinal/survival analyses. Mixed-methods designs followed (n = 10, 17.5%), combining approaches mainly to evaluate interventions and explore practitioner experience alongside quantitative measurement. Qualitative designs (n = 4, 7.0 %) used interviews, focus groups, and thematic or phenomenological analysis.

3.1.2 Geographic Distribution

Included studies originated across six continents and 25 countries. North America produced the largest share (n = 19, 33.3%), led by the United States, followed by Europe (n = 16, 28.1%) and Asia (n = 13, 22.8%). Oceania accounted for five studies (8.7%), followed by Africa with three studies (5.3%) and South America with one study (1.8%). The evidence base remains weighted toward high-income, Anglophone, Western contexts, a pattern addressed in the Discussion.

3.1.3 Practice Settings

Studies were drawn from six practice settings: general practice was most represented (n = 19, 33.3%), followed by child welfare (n = 13, 22.8%), which as Section 3.3 elaborates consistently showed the most elevated burnout profiles. NGO/community organisations contributed eight studies (14.0%), followed by other/specialised settings (n = 7, 12.4%), medical/hospital-based social work (n = 6, 10.5%, including hospice, palliative care, oncology, and acute care), and mental health/psychiatric settings (n = 4, 7.0%).

3.1.4 Burnout Measurement

The instruments employed across the studies demonstrated considerable variation. The Maslach Burnout Inventory (MBI) and its variants (MBI-HSS and abbreviated form) were most frequently used, followed by the Professional Quality of Life Scale (ProQOL), which captures burnout, STS, and compassion satisfaction in one framework. The Secondary Traumatic Stress Scale (STSS) and Copenhagen Burnout Inventory (CBI) also appeared across several quantitative studies. At least 10 of the 57 studies used no standardised instrument; this includes the four qualitative studies, which explored burnout thematically without psychometric measurement. This heterogeneity constrains cross-study comparison of prevalence estimates, addressed further in the Discussion.

3.1.5 Quality Appraisal and Risk of Bias

All 57 studies retained for narrative synthesis underwent quality appraisal using design-appropriate JBI tools (quantitative/qualitative) and the MMAT (mixed-methods). The final evidence base was methodologically robust: all 57 studies (100%) were rated Low risk of bias, with no studies rated Moderate, Borderline, or High. Quality was consistently low risk across study designs: all 43 quantitative studies, all 10 mixed-methods studies, and all 4 qualitative studies were rated Low risk of bias.

Table 1: Summary Characteristics of Included Studies (N = 57)

Characteristic	Category	N (%)
Study Design	Quantitative	43 (75.5%)
	Qualitative	4 (7.0%)
	Mixed Methods	10 (17.5%)
Geographic Region	North America	19 (33.3%)
	Europe	16 (28.1%)
	Asia	13 (22.8%)
	Oceania	5 (8.7%)
	Africa	3 (5.3%)
	South America	1 (1.8%)
Practice Setting	General Practice	19 (33.3%)
	Child Welfare	13 (22.8%)
	Mental Health	4 (7.0%)
	Medical / Hospital	6 (10.5%)
	NGO / Community	8 (14.0%)
	Other / Specialised	7 (12.4%)
Risk of Bias (JBI)	Low	57 (100%)
	Moderate	0 (0.0%)
	High	0 (0.0%)

Note. Percentages based on N = 57.

3.2 Thematic Organisation of the Evidence

Thematic coding of the 57 studies generated ten overarching themes. Burnout Drivers was the most prevalent, present in 27 studies (47.4%), followed by Protective Resources in 22 (38.6%), Professional Well-Being in 13 (22.8%), and Coping Strategies in 13 (22.8%). Burnout Moderators featured in seven (12.4%), while Organisational Interventions and Workforce Retention each featured in six (10.5%), Mediators in four (7.0%), Barriers to well-being in three (5.3%), and Policy Issues in one (1.8%). Most studies were coded to multiple themes.

3.3 Burnout Drivers: Antecedents of Occupational Exhaustion (RQ1)

3.3.1 Workload, Caseload, and Administrative Demands

Excessive caseloads and administrative workloads are the most pervasively replicated structural antecedents of burnout, corroborated across quantitative, qualitative, and mixed-methods designs globally. Disney & Purser {20} studying US caseloads, found burnout increased with client violence incidents ($B = 0.14$, $p < .001$) and higher

working hours (B = 0.02, p < .05). Pazer {21}, in German municipal social workers, found administrative workload correlated strongly with emotional exhaustion (r = 0.687, p < .01) and inversely with professional resilience (r = -0.468, p < .01), reflecting the demand-resource dynamic. McGrath et al. {22}, in Australian rural/remote rehabilitation social work, reported the meaning of burnout which substantially exceeded Australian healthcare-worker reference norms (M = 29.7 vs. 21.1–26.6, p < .05 to p < .001); caseload volume correlated positively with burnout (rho = 0.583, p < .001) and organisational culture negatively (rho = -0.443, p < .05). Snorradóttir et al. {23}, studying Icelandic social service workers, found 43.9% met criteria for exhaustion disorder, with job stress the strongest predictor (Exp(B) = 5.77, p < .001) and job satisfaction protective (Exp(B) = 0.36, p = .002). This evidence implicates structural workload conditions, not individual capacity, as burnout's primary driver.

3.3.2 Secondary Traumatic Stress, Trauma Exposure, and Emotional Demands

Chronic exposure to client trauma is the second dominant driver of occupational distress, with STS often mediating broader burnout outcomes. Twis et al. {24}, studying case managers at a homelessness services centre, found nearly the entire sample reported at least one STS symptom in the preceding week, with 75% reporting high or severe STS (M = 50.63, SD = 9.83). Lev et al. {25}, in Israeli social workers, found ethical conflict frequency (β = .324, p < .001) and client violence exposure (β = .115, p < .01) predicted STS, while resilience was protective (β = -.291, p < .001).

The different components of empathy demonstrate varying effects. Thomas {26} found personal distress a reactive, self-focused empathic response predicted higher burnout (β = .348, p < .001) and compassion fatigue (β = .297, p = .001) among clinical social workers, while empathic concern, perspective-taking, and fantasy did not. Yi et al. {27}, in Korean medical social workers, corroborated this: personal distress predicted both burnout (β = .387, p < .01) and STS (β = .502, p < .001), while empathic concern predicted compassion satisfaction (β = .393, p < .001); longer employment duration also predicted higher STS, contradicting the assumption that junior workers face disproportionate risk.

Emotional demands further interact with psychological vulnerability: Icekson et al. {28} found childhood maltreatment history predicted attachment anxiety (β = 0.27, p < .01), which in turn predicted burnout (β = 0.16, p < .001), while Altınoğlu-Dikmeer et al. {29}, studying practitioners with refugee populations in Turkey, found traumatic stress was predicted by fatigue (β = 0.47, p < .001), helpless coping (β = 0.25, p < .001), and years working with refugees (β = 0.17, p < .01).

3.3.3 Organisational and Systemic Stressors

Structural and organisational conditions are significant burnout antecedents, with replicated effects for role conflict, role ambiguity, professional stigma, and client-perpetrated violence. Stanley et al. {30}, in UK social workers, found role ambiguity predicted perceived stress (t = 2.49, p = .01) and role conflict predicted lower job satisfaction (t = -3.33, p = .001), partially mediated by workplace support (b = -.15, p < .001). Zhang et al. {31}, in a Chinese sample, found role conflict (β = 0.262, p < .001) and role ambiguity (β = 0.162, p < .001) predicted depressive symptoms, while job autonomy was protective (β = -0.058, p < .001).

Professional stigma by association is a further stressor: Brener et al. {32} found it correlated with poorer workplace wellbeing (r = -0.21, p = .001), higher burnout (r = 0.26, p < .001), and greater turnover intention (r = 0.18, p = .006) among Australian social workers. Client-perpetrated violence is another documented hazard — Alfandari et al. {33} found client physical aggression predicted somatic symptoms (B = 0.38, p < .01) and PTSS (B = 0.30, p < .01), while team trust was inversely associated with both (B = -0.06 and -0.07, p < .01); Jiang & Jiang {34} found violence exposure predicted turnover intention via compassion fatigue (b = 0.128, 95% CI [0.085, 0.176]).

Qualitative evidence frames burnout not as individual pathology but as a rational response to neoliberal managerial frameworks: across Australian, British, Norwegian, and Chilean studies, bureaucratic targets, administrative burden, and organisational blame cultures were repeatedly identified as primary drivers of chronic distress {35, 36, 37}. Mänttäri-van der Kuip {36}, in Finnish social workers, found nearly 11% experienced severe reactive moral distress, took more sick leave (16.74 vs. 6.79 days, p = .026), and were far more likely to intend to leave (42.4% vs. 17.2%).

3.3.4 The COVID-19 Pandemic as a Structural Amplifier

A subset of studies, concentrated in 2020–2026, documents COVID-19 as a structural amplifier of pre-existing

burnout risk. Wilke et al. {38}, in a four-wave longitudinal study of early-career Florida child welfare workers, found self-reported good-or-better mental health declined from 97.2% to 80.8% over 18 months (Cochran's Q = 97.17, p < .001), and psychological distress nearly doubled (M = 3.20 to 6.57, F = 957.48, p < .001). Cogan et al. {39}, in health and social care workers during the pandemic, found COVID-19-related stress (β = 0.157) and pre-existing burnout (β = 0.584) were the strongest predictors, together with pandemic risk perception accounting for 54.6% of variance in acute stress (all p < .05), with 49.3% meeting clinical threshold for acute stress disorder.

Qualitative evidence from Australia, the UK, Israel, and South Africa converges: pandemic-enforced remote delivery collapsed the boundary between trauma exposure and practitioners' domestic environments, intensifying vicarious traumatization, a burden that was gendered, with female practitioners disproportionately affected by remote delivery, caregiving, and home-schooling {40, 41, 42, 43}. Griffiths et al. {44}, using heart rate variability as an objective stress marker, found readings remained below healthy norms across a four-month window (31.10–34.40 ms vs. normative 38–43 ms), with physiological relaxation declining over the period (F(3,48) = 2.884, p = .045).

3.4 Protective Resources: Buffers Against Burnout (RQ2)

3.4.1 Social Support, Supervision, and Team Cohesion

Social support is the most consistently identified, methodologically robust protective factor, buffering burnout across all six geographic regions and practice settings. Yusta-Tirado et al. {45}, in dementia-care social workers, found social support negatively predicted emotional exhaustion (β = -.30, p = .001) and depersonalisation (β = -.23, p = .001), and positively predicted personal accomplishment (β = .32, p = .001). Quinn et al. {46}, in US hospice/palliative care social workers, found a positive supervisory relationship reduced STS (b = -4.88, p < .01), while caseload size increased it (b = 0.13, p = .02). Senreich et al. {47} found feeling valued as a professional was the strongest predictor of lower workplace stress (b = -.35, p < .001) and higher compassion satisfaction (b = .285, p < .001).

Supervision's protective function depends on relational quality and delivery modality. Pelon {48}, in hospice social workers, found those supervised primarily via email/telephone reported higher compassion fatigue (M = 54.74) than those receiving face-to-face individual (M = 47.81) or group supervision (M = 47.25; p < .05), corroborated qualitatively by evidence that supervisors who assessed wellbeing, modelled self-care, and created psychologically safe spaces produced better outcomes. Alfandari et al. {33} similarly found team trust negatively predicted somatic symptoms and PTSS following client aggression (B = -0.06 and -0.07, p < .01), underscoring team-level relational safety as a proximal buffer.

3.4.2 Meaning-Making, Purpose, and Professional Identity

Deriving meaning from practice is an emotional resource across studies and settings. Singer et al. {49}, in US social workers, found higher purpose in life predicted lower vicarious trauma (b = -.306, p < .001), lower STS (b = -.353, p < .001), and lower burnout (b = -.398, p < .001). Desrumaux et al. {50}, in a French sample, found resilience (r = .57, p < .001), interpersonal justice (r = .41, p < .001), and supervisor support (r = .40, p < .001) each correlated strongly with well-being, with coworker support mediated by meaning-making.

Mandell et al. {51}, studying child welfare workers, found 11.4% (n = 24) simultaneously exhibited high emotional exhaustion and high job satisfaction, the 'Sailing' profile, sustaining engagement through active meaning-cultivation despite chronic demand. This challenges deficit-focused models assuming exhaustion and satisfaction are mutually exclusive, and speaks to the ProQOL framework's split between compassion satisfaction and fatigue.

3.4.3 Resilience, Self-Compassion, and Psychological Capital

Individual resilience is protective across settings, though its independent effect is often modest. Hindman et al. {52}, in child welfare caseworkers, found all three burnout domains predicted lower retention intent (R^2 = .31–.41, p < .001); resilience significantly moderated this relationship, though the interaction accounted for only 2.5% of unique variance. Masson {53}, in South African forensic social workers, found vicarious trauma correlated negatively with resilience (r = -0.443, p < .01). Stanley & Sebastine {54} found occupational stress and resilience interacted to predict compassion fatigue (β = .31, p < .01), while resilience independently predicted compassion satisfaction (β = .47, p < .001).

Self-compassion is an empirically robust, cross-culturally supported protective resource. Moryosef & Taubman-Ben-Ari {55} found self-compassion negatively predicted secondary traumatisation (β = -0.287, p < .001) and

moderated the exposure-trauma relationship (β = -1.211, p < .01), while deliberate rumination increased risk (β = 0.328, p < .001). Lianekhammy et al. {56} found financial strain negatively predicted self-compassion, particularly self-kindness (β = -.36, p < .001) indicating economic precarity constrains access to psychological resources. Ho & Chan {57}, studying Hong Kong social workers longitudinally, found T1 Psychological Capital predicted more rational problem-solving and less avoidance coping at T2 (γ = 0.14 and -0.14, p ≤ .03), establishing temporal precedence for psychological capital as a determinant of subsequent coping.

3.4.4 Organisational Culture and Structural Protections

Trauma-informed care (TIC) organisational culture is a structural protective factor. Keesler {58} found TIC culture positively predicted compassion satisfaction (β = 0.42, p < .001) and negatively predicted burnout (β = -0.61, p < .001) and STS (β = -0.18, p < .01), explaining 40.5% of variance in burnout. Clark et al. {59} found psychological safety (β = -0.954, p = .024) and workplace connectedness (β = -1.060, p = .017) independently predicted lower STS among 429 social workers, supporting organisational culture, not individual resources, as key to translating structural demands into sustained burnout.

3.5 Coping Strategies: Individual Responses to Occupational Distress (RQ2)

3.5.1 Problem-Focused and Active Coping

Problem-focused coping — active planning, informational support-seeking, positive reframing, direct problem-solving is the most consistently protective coping modality. Yago-Alonso et al. {60}, in forensic/penitentiary social intervention professionals, found coping strategies collectively explained 60% of variance in STS: problem-solving and problem avoidance reduced STS (B = -0.135, p < .01 for both), while dysfunctional strategies, social withdrawal (B = 0.378, p < .001) and wishful thinking (B = 0.361, p < .001) increased it. Tamiolaki et al. {61}, in Greek social workers who had experienced traumatic events, found resilience was positively predicted by positive reframing (β = 0.24, p = .008) and planning (β = 0.29, p = .002), while self-blame was inversely associated (β = -0.43, p = .001).

Acker {62} demonstrated design-level complexity: emotion-focused coping strongly predicted emotional exhaustion (R^2 change = .12, p < .001) and depersonalisation (R^2 change = .16, p < .001), while problem-focused coping also predicted emotional exhaustion (R^2 = .05, p < .001) suggesting coping's adaptiveness varies with context, stressor type, and regulatory capacity.

3.5.2 Maladaptive and Avoidant Coping

Avoidant coping, behavioural disengagement, denial, social withdrawal, consistently predicts escalation rather than reduction of STS symptoms. Mashego et al. {63}, in South African forensic social workers, found behavioural disengagement correlated strongly with STS intrusion, avoidance, and arousal (r = 0.67–0.79, p < .001). Tamiolaki et al. {61} found denial strongly predicted STS (β = 0.44, p = .001) and was a completely ineffective prevention strategy among Greek social workers.

Counterintuitively, Mashego et al. {63} also found venting and humour, typically adaptive in general-population coping literature, functioned as maladaptive STS amplifiers in forensic social work, with venting correlating with heightened STS avoidance (r = 0.58, p < .001). Akinsulure-Smith et al. {64}, in New York refugee resettlement workers, similarly found a coping factor comprising substance use, humour, and venting predicted STS (β = .38, p < .001) and emotional exhaustion a divergence from non-helping-professional coping evidence discussed further in Section 4.5.

3.5.3 Mindfulness and Acceptance-Based Strategies

Mindfulness-based coping is the most extensively studied individual strategy, with replicated efficacy evidence across controlled and quasi-experimental designs. Pillay et al. {43}, in a quasi-experimental study of South African trauma counsellors, found mindfulness training reduced burnout (F = 12.61, p < .001), STS (F = 10.66, p < .001), and vicarious trauma (F = 38.22, p < .001), sustained at three-month follow-up. Crowder & Sears {65}, using a randomised waitlist-control design evaluating Mindfulness-Based Stress Reduction, found perceived stress differences between groups widened at one week (p = .02, d = 1.39); within the intervention group at 26 weeks, ProQOL burnout decreased and compassion satisfaction increased (both p ≤ .03, d ≥ .99).

Maddock {66, 67} established specific mechanisms: attention regulation directly reduced perceived stress (β = -.26) and increased personal accomplishment (β = .82, both p < .05), while acceptance and non-aversion indirectly reduced emotional exhaustion via reduced work-related worry, mechanistic findings extending beyond efficacy

to show how mindfulness works.

3.6 Organisational Interventions: Systemic Approaches to Burnout Prevention (RQ3)

3.6.1 Supervision-Based and Reflective Practice Interventions

Clinical/reflective supervision is the most commonly studied organisational intervention, with evidence across child welfare, mental health, forensic, hospice, and general practice settings indicating that relational quality and delivery format, not structural provision determines supervisory value ({48, 68} meta-analytically). Cohen & Gagin {69}, evaluating a seniority-differentiated skills training programme for hospital social workers, found reductions in depersonalisation (29.75%, $p = .04$) and increases in personal accomplishment (12.39%, $p = .03$) across senior and junior cohorts, with emotional exhaustion decreasing only in the junior cohort, alongside a rise in within-group peer support ($p = .04$).

3.6.2 Training and Resilience Programmes

Training-based interventions show measurable effects on burnout, particularly depersonalisation and personal accomplishment. Clark et al. {70} evaluated the Resilience Alliance programme: 96.8% of participants attended at least one session and 83.6% completed it (≥9 of 12 sessions); skill acquisition was the primary motivation for completers, while competing work demands was the most common barrier reflecting a paradox: the conditions necessitating intervention constrain access to it. Põder & Merkuljeva {71}, using difference-in-differences estimation, found a treatment effect on engagement ($p < .05$) but not self-efficacy.

Reeves et al. {72}, using eye-tracking during simulated child neglect assessments, found social workers showed higher disgust responses than health visitors (20% vs. 3%, $p < .05$), who showed higher sadness instead patterns largely invisible to practitioners, suggesting simulation-based training may build affective self-awareness that conventional supervision cannot easily address.

3.6.3 Trauma-Informed Organisational Structures

Evidence for trauma-informed care as an organisational intervention is consistent in direction though variable in design quality. Keesler {58} provided the strongest quantitative evidence, with TIC culture explaining 40.5% of burnout variance among direct support professionals. Baker et al. {73}, evaluating multidisciplinary reflective rounds in a hospital setting, found 98% of participants would recommend the programme and 85% rated rounds as good to exceptional. Qualitative studies from Middle East and European contexts document workers' calls for structural protections, enforceable caseload limits, mandatory in-person supervision, and organisational cultures prioritising relational process over proceduralism as preconditions for individual-level interventions to succeed {36, 37}.

3.7 Burnout and Workforce Retention: Organisational Consequences

Burnout is associated with reduced retention intention across studies spanning North America, Europe, Asia, and Oceania. Hindman et al. {52} found all three burnout domains, work-related, client-related, personal, negatively predicted retention intent among child welfare caseworkers, work burnout showing the largest effect ($R^2 = .410$, $p < .001$). Brener et al. {32} found stigma-associated burnout correlated with greater turnover intention ($r = 0.18$, $p = .006$). Parveen et al. {74}, in a three-wave cross-lagged study of Norwegian child welfare workers, found bidirectional relationships: threat/violence exposure at T1 predicted intention to leave at T2 ($\beta = 0.13$, $p < .01$), while intention to leave at T2 predicted subsequent violence exposure at T3 ($\beta = 0.18$, $p = .001$), consistent with disengaged workers perceiving workplace conditions more negatively.

A notable finding comes from Garza et al.'s {19} secondary-data joint modelling study of 1,740 child welfare professionals: job satisfaction reduced both departure hazard (HR = 0.509, $p < .001$) and burnout ($\beta = -0.19$, $p < .001$), while the association between burnout and departure risk was marginally significant and negative ($\alpha = -0.81$, $p = .074$), suggesting a possible 'burnout-turnover paradox' where higher burnout may be associated with reduced departure risk. Although the study was appraised as low risk of bias (JBI: 8/8), this finding remains a hypothesis-generating observation warranting prospective investigation and should not be overgeneralised given its marginal statistical significance ($p = .074$).

4. Discussion

4.1 Principal Findings and Theoretical Contribution (RQ4)

This review of 57 studies, all rated Low risk of bias, offers an integrated, theoretically grounded account of social worker burnout. The evidence shows burnout is multidetermined and ecologically embedded, shaped by

structural demands, organisational conditions, relational dynamics, and individual psychological characteristics. No single factor functions independently in shaping the observed outcomes. Burnout emerges through accumulating, reinforcing processes in which chronic demands exceed available resources across ecological levels.

The findings support and extend the Job Demands-Resources (JD-R) model {9}. The most recurrent drivers: caseload excess {20, 21}, secondary traumatic stress {24, 26}, and organisational stressors {30, 36}, map onto the JD-R demand domain, while the most reliable protective factors , social support {45}, reflective supervision {48, 69}, meaning-making {49}, and psychological capital {57}, correspond to the resource domain. JD-R's core prediction, that resources buffer demands, receives strong support.

The Professional Quality of Life (ProQOL) framework {4} complements JD-R by explaining findings that resist simple demand-resource mapping. Mandell et al. {51} found co-occurring high emotional exhaustion and high job satisfaction in 11.4% of a child welfare sample, irreconcilable with a simple depletion model, but predicted by ProQOL's separation of compassion satisfaction and compassion fatigue as components that may co-exist rather than sit on one continuum. These merits dedicated longitudinal investigation.

4.2 Positioning Within the Existing Literature

This review extends prior syntheses. Lizano {12} and Lizano and Mor Barak {13}, synthesising 19 – 55 studies mainly in child welfare, linked workload, role conflict, and limited organisational support to burnout and turnover. Giménez-Bertomeu et al. {8}, in the first MBI-specific meta-analysis of social services burnout (24 studies, 16,962 participants), established pooled prevalence of 50% emotional exhaustion, 45% depersonalisation, and 39% reduced personal accomplishment. This review extends that base through greater scope (57 studies, 25 countries), explicit treatment of COVID-19 literature, a dual JD-R/ProQOL framework, and a stronger quality profile. It also surfaces contradictions coping context-dependence, the supervision-safety gap, and the provisional burnout-turnover paradox that more limited reviews were not positioned to identify.

4.3 The Structural Versus Individual Intervention Debate

The evidence resists a simple either-or resolution. Individual-level interventions, particularly mindfulness-based programmes, show genuine efficacy: Pillay et al. {43} documented sustained effects at three months (η^2 = .18–.40), and Crowder & Sears {65} found sustained ProQOL improvements at 26 weeks (d = 1.6 for compassion satisfaction). These are not trivial effects.

However, individual interventions face structural ceiling effects in unreformed organisations. Clark et al. {59} found the most common barrier to resilience-programme completion was competing work demands, the very condition the programme aimed to buffer. Qualitative evidence from European and Middle Eastern settings shows practitioners rejecting not self-care itself, but organisational framing that treats it as a substitute for structural reform {36, 37}. We therefore propose a sequencing principle: structural reforms to caseload, supervision, and boundary protection are prerequisites, not optional accompaniments, to individual-level intervention.

4.4 The COVID-19 Pandemic: Crisis, Innovation, and Enduring Consequences

Pandemic-focused literature complicates a simple deterioration narrative. Wilke et al.'s {38} longitudinal data showing psychological distress nearly doubling within 18 months of employment entry, before the pandemic, establishes that workforce vulnerability predated COVID-19. The pandemic instead amplified pre-existing structural vulnerability: Cogan et al. {39} found burnout at pandemic onset was the strongest predictor of acute stress (β = 0.584), outweighing pandemic-specific stressors.

The evidence also shows crisis conditions catalysed innovations, peer mutual-support networks, flexible working, digital service delivery, that practitioner found genuinely valuable. This paradox, acute harm alongside adaptive innovation, implies innovations generated under pressure should be deliberately institutionalised rather than allowed to erode as urgency subsides.

4.5 Critical Contradictions and Theoretically Significant Divergences

Three contradictions merit explicit attention. First, coping strategy effectiveness is context-dependent. Venting and humour functioned as maladaptive STS amplifiers among forensic social workers {63, 64} contradicting their

status as adaptive resources in general psychological literature. This cannot be resolved by a simple adaptive/maladaptive dichotomy; effectiveness instead depends on the specific stressor, team culture, and the practitioner's regulatory capacity at the time. Generic coping recommendations uncalibrated to context are theoretically inadequate and potentially counterproductive in high-acuity settings.

Second, supervision is not a universally protective resource in practice. Many clinicians working with high-trauma populations, including child sexual abuse survivors {75}, did not experience formal supervision as a psychologically safe processing space, inconsistent with the field's near-universal endorsement of supervision. This does not contradict supervision's established efficacy {46, 48, 69}, but reveals a gap between structural provision and its actual protective function. Access to supervision is an inadequate proxy for its protective value; psychological safety and explicit permission to process trauma are necessary for it to work.

Third, Garza et al. {19} identified a provisional, marginally significant negative association between burnout severity and departure risk ($\alpha = -0.81$, $p = 0.074$) that, if replicated, would challenge a foundational assumption of turnover theory. This finding should be treated as hypothesis-generating pending replication. If this pattern is replicated, professional entrenchment, characterised by financial dependency, limited alternative employment opportunities, and substantial investment in occupational identity, may help explain why highly burned-out practitioners remain in their professions rather than opting to leave. Garza et al. {19} proposed professional identity entrapment and exit barrier theory: for many practitioners, work constituted a core aspect of selfhood such that withdrawal was experienced as existential loss rather than occupational transition. This remained a hypothesis warranting prospective investigation, not an established finding.

4.6 Variation across Practice settings

Burnout profiles also varied by practice setting. Child welfare services generated the most consistently elevated burnout profiles, driven by severe case content, high caseloads, legal accountability, and organisational blame cultures {38, 52, 73}. Mental health social workers were next most at-risk, particularly under high psychiatric acuity and thin community infrastructure. Medical and hospice social workers showed high compassion fatigue driven by mortality exposure {48, 76}, while general practice social workers showed the most heterogeneous profiles.

4.7 Implications for Practice, Policy, and Research

4.7.1 Practice Implications

The evidence supports mindfulness-based practice as a first-line self-care strategy, given demonstrated efficacy across multiple controlled designs {48, 65, 66, 67}. Attention-regulation and acceptance mechanisms suggest brief, mechanism-focused training may work as well as comprehensive MBSR in resource-constrained settings. Practitioners in forensic and high-trauma-exposure s
ettings should be guided to distinguish coping strategies by context rather than apply generic frameworks.

4.7.2 Supervision and Organisational Implications

Supervision should shift from administratively oriented to relationally grounded, with face-to-face contact maintained wherever feasible given the documented disadvantage of email/telephone-only supervision {48}. Organisations should implement trauma-informed cultures structurally, enforceable caseload standards, mandatory in-person supervision, psychological safety infrastructure as preconditions for, not alternatives to, individual wellbeing programmes {58, 59}. Cohen & Gagin's {69} evidence on seniority-differentiated training suggests career-stage-tailored interventions outperform one-size-fits-all development.

4.7.3 Policy and Research Implications

Burnout prevention should move from voluntary organisational programmes toward enforceable labour law and occupational health protections; persistent 15%–26% annual turnover in child welfare, despite decades of research, suggests voluntary compliance is structurally insufficient. Four key priorities emerge from these findings. First, adopt the MBI-HSS and ProQOL as minimum common metrics, since instrument heterogeneity across the 57 studies is the most significant obstacle to synthesis. Second, prioritise funding for LMIC burnout research. Third, directly and prospectively replicate the Garza et al. {19} burnout-turnover paradox before it informs policy. Fourth, systematically investigate coping context-sensitivity across settings and stressor types, particularly forensic and refugee services. First, the MBI-HSS and ProQOL should be adopted as minimum common measurement standards, given that substantial heterogeneity in instruments across the 57 studies represents a major barrier to meaningful synthesis. Second, greater research funding should be directed towards investigating burnout in low- and middle-income countries (LMICs), where evidence remains comparatively

limited. Third, the burnout–turnover paradox identified by Garza et al. [19] should be replicated through direct, prospective studies before its implications are incorporated into policy and practice. Fourth, future research should systematically examine the context-dependent nature of coping strategies across diverse settings and types of occupational stressors, with particular attention to forensic and refugee-service contexts.

4.8 Limitations of this Review

The study is subject to several limitations apply. Despite the strong quality profile, heterogeneity in burnout definitions, instruments, and samples across 57 studies precluded meta-analytic pooling, constraining conclusions about effect magnitude. Geographic concentration in North America, Europe, and Oceania 61.4% of the evidence base in North America and Europe alone limits global generalisability, particularly for LMIC contexts, where caseload burden, compensation, infrastructure, and political violence exposure may differ substantially. This is an equity issue as much as a methodological one: the included African and South/Southeast Asian studies point to burnout drivers of greater structural severity alongside distinctive protective resources such as collectivist community support and spiritual coping {29, 61}, suggesting this synthesis may underestimate driver severity and overestimate protective-resource accessibility outside the dominant regions. The review is restricted to English-language publications, potentially excluding Spanish, Chinese, Norwegian, Icelandic, and German-language scholarship. All 57 included studies were rated Low risk of bias following quality appraisal. The review spans overlapping but conceptually distinct constructs burnout, compassion fatigue, STS, and vicarious trauma, introducing heterogeneity that narrative synthesis cannot fully resolve. Finally, publication bias may have inflated representation of positive intervention findings relative to null or negative results.

5. Conclusion

This review yields three conclusions for the field's response to burnout. First, the evidence base all 57 included studies rated Low risk of biaS is now robust enough to move from prevalence documentation to confidently prescribing evidence-based interventions: mindfulness-based programmes, relational supervision, trauma-informed organisational cultures, and peer support infrastructure each have sufficient evidence to warrant routine implementation rather than continued piloting. Second, the structural-individual debate resolves into a sequencing imperative: structural reform is a precondition for individual intervention effectiveness, not an alternative individual coping alone cannot sustain wellbeing where organisational demands exceed human regulatory capacity. Third, burnout is a social justice issue: when social workers disengage or leave, the consequences extend beyond careers to the vulnerable people who depend on them. Building a sustainable workforce is therefore a societal imperative, achievable given political will and adequate resources.

Declarations

Ethical approval

Not applicable. This review synthesised publicly available, peer-reviewed literature and did not involve human participants, primary data collection, or access to personal data.

Consent to participate

Not applicable. No human participants were involved in this study.

Consent to publish

Not applicable. This manuscript contains no individual person's data. All sources cited are publicly available peer-reviewed publications.

Competing interests

The authors declare no competing interests.

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Clinical trial number

Not applicable.

Data availability

No datasets were generated or analysed during the current study. The review synthesised findings from 57 peer-reviewed studies identified through systematic database searches. All included studies are cited in the reference

list. The review protocol is publicly accessible via the Open Science Framework (OSF) at https://osf.io/x8n5s.

Author contributions

R.H. conceptualised the study, developed the review protocol, conducted the database searches, performed title and abstract screening, full-text eligibility assessment, data extraction, quality appraisal, narrative synthesis, and drafted the manuscript. P.B. guided the review process, verified the studies selected for inclusion, and contributed to data extraction and synthesis. All authors reviewed and approved the final manuscript.

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