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Resilient Coping and Burnout in Healthcare Social Workers during the First Wave of the COVID-19 Pandemic in Portugal and Spain

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Abstract

Healthcare social workers faced a demanding professional challenge during the COVID-19 pandemic, which had multidimensional repercussions. Studies with health professionals concerning Burnout and resilience strategies have been considered relevant and gained special attention for their position in the response to the pandemic. Here we highlight the risks of Burnout and the potential protection of coping strategies in a profession that mediates the social dimension of health and disease. We aimed to understand their impact on social workers who worked in the health field in Portugal and Spain during the first wave, analyzing the levels of resilience and burnout. 336 social workers from Portugal (n = 252) and Spain (n = 84) participated. Despite the high perception of multidimensional stressors (at a personal, relational, professional, and organizational level), burnout risks were moderate to low. The predisposition to burnout due to depersonalization was residual (1.8%), but that due to low personal accomplishment (18.8%) and emotional exhaustion (21.4%) were higher; however, the majority did not show any risk of Burnout. The levels of resilience demonstrated facing the COVID-19 Pandemic were low (47%) or moderate (29.8%), with 23.2% at high levels. The aggregation of Burnout and coping strategies into three risk profiles reveals differences in the perception of fear of implications in working with patients, the impact felt at work, and the support felt at the health unit. Support and resilience strategies that favor the psychosocial and professional well-being of healthcare social workers must be promoted, especially in emergencies.

Keywords: Social Work. Burnout. Resilience. Pandemic. Occupational risk.

INTRODUCTION

The COVID-19 pandemic brought important challenges to society, health systems, and healthcare professionals. Since the beginning of the public health crisis, health professionals have received special attention for their key position in the response to the pandemic. In this context, the work of social workers in the healthcare field presents enormous margins of uncertainty and various stressors, as well as adaptive needs that are worth knowing.

In addressing the disruptive and challenging impact of the COVID-19 pandemic on professionals, studies on Burnout with samples of health professionals have been highlighted in recent literature[1,2,3,4]. Burnout

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is seen in this study as a state of exhaustion resulting from involvement in a specific emotionally demanding work situation[3], such as that triggered by COVID-19. It is also important to address the ability to deal with stressors, enhancing positive adjustments and overcoming adverse situations[5] through the approach to resilient coping mechanisms in a context of significant adversity[1,6].

The impact on the mental health of health professionals and their relationship with work during previous pandemics, such as the flu and SARS in 2003, has been reported in the literature[7]. Studies with health professionals who worked during the COVID-19 pandemic showed the negative impact that stress, anxiety, and Burnout have had on their quality of life[1,4,8]. The uncertain context and action in the emergency are associated with the feeling of insecurity in the work environment[3]. The uncertainties of professionals are in the individual and professional sphere, but they extend into other relational systems. Working with people who are suspected or infected with COVID-19 reinforces concerns and exerts pressure[1,9] to which personal factors are added (fear of being infected or isolated, or fear of having an infected family member), social factors (social stigma against health professionals) and exhaustion[3]. Manifestations of anxiety are also mentioned regarding the lack of personal protective equipment and the risk of infection for oneself and one's family members[9,10].

A study of healthcare professionals in Portugal concluded that, during the COVID-19 pandemic, more than half showed signs of burnout, stress, and anxiety, with a particular emotional and physical impact attributed to the exposure of professionals to "unprecedented demands", such as mortality, rationing of personal protective equipment, pressure, fear of contagion, and ethical dilemmas[2]. However, at the same time, about 80% consider themselves capable of dealing with difficult and potentially stressful situations[2]. In Spain, a study with hospital professionals demonstrated anxiety, and particularly highlighted suicidal thoughts and behavior in 8.4% of professionals[11]. Social workers who are at the forefront of the public health crisis resulting from the pandemic, especially those working in the healthcare field, would have been exposed to the same type of stressors as the other professional groups that intervene in the health system.

In the social worker profession, Burnout has become an everyday term to address stress and work-related overloading[12]; however, factors of personal, professional, and social exhaustion can interact and overlap[13,14]. The exhaustion of a social worker is not limited to the professional environment during a global pandemic[15], it is added to the social crisis and uncertainty, making it essential to diversify and use creative strategies to deal with the situation and to work[13].

It is, therefore, relevant to know the coping strategies and resilience of Social Work professionals. Coping refers to the adaptation to a situation at a given time and resilience refers to a dynamic process over time[5]. One study with social workers during the pandemic highlighted the mediating role of emotional coping between work demands and psychological distress[16].

Studies on Burnout with social workers prior to the pandemic reveal the relevance of Burnout among this professional group, despite having different prevalences, while highlighting emotional exhaustion, working and career conditions, workloads, as well as external factors[17,18,19], and indicating peer recognition as a protective factor[19].

Social workers at the international level faced similar challenges during the pandemic[20,21]; however, social workers in different countries, namely in Portugal and

Spain, have been dealing with fluctuations and worsening of the pandemic with different intensities and impacts, as evidenced by the literature that COVID-19 itself may constitute a risk factor for stress among health professionals[22].

Thus, the aim of the study was to understand the impact of COVID-19 on social workers working in the healthcare field, analyzing their levels of resilience and burnout. We hypothesize that social workers present risks related to Burnout associated with protective levels resilient coping in the context of the challenges posed by the Pandemic.

METHODS

Procedure

The study is part of an Iberian transnational investigation called "Emergency Plan for Healthcare Social Work in the COVID-19 Pandemic". Data collection was performed through an online questionnaire through Google Drive between 4/5/2020 and 2/6/2020. The disease caused by the Coronavirus, COVID-19, was declared a global pandemic by the World Health Organization on March 11, 2020. The survey period corresponds to the "first wave" in both countries.

The sampling was non-probabilistic, using the social workers of the health system as strategic informants who disseminated the survey through the snowball technique, via e-mail or private message, to potential participants who matched the sample selection criteria. Respondents were informed about the objectives and conditions of participation in the research, and agreed to participate voluntarily, allowing the data to be used for research purposes (informed consent).

Participants

A total of 336 social workers working in the health system in Portugal (n = 252) and Spain (n = 84) participated in the study. The majority were women (93.6%) aged between 22 and 67 years old. Participants had worked on average as social workers for 19.4 years, and for 13.3 years in the health care unit. Most had a bachelor's degree (55.7%), followed by those with postgraduate studies (20.8%) or master's degree (20.8%) (Table 1).

Participants integrate health units in different regions of Portugal and Spain. Respondents in Portugal mainly came from the regions of Lisbon and Vale do Tejo (n = 102; 40.8%), the Northern region (n = 63; 25.2%), and the Middle region (n = 43; 17.2%), but also some were from Alentejo, Algarve, and Autonomous Regions (n < 14). Those from Spain are mainly from Catalonia (n = 38; 45.2%) and the Community of Madrid (n = 25; 29.8%), but also from other Communities (n < 8).

Table 1- Sociodemographic and professional characteristics of the participants by country – (Portugal and Spain, 2020).

	Portugal n = 252		Spain n= 84		Total n = 336	
	A (SD)	Min-Max	A (SD)	Min-Max	M (SD)	Min-Max
Age	45.2 (8.9)	22 - 65	47.3 (9.2)	23 - 67	45.7 (8.9)	22 - 67
Years of professional practice as a social worker	18.9 (8.8)	1 - 41	20.6 (9.8)	0 - 34	19.4 (9.1)	0 - 41
Years of professional practice in the current health unit	13.3 (8.9)	0 - 40	13.3 (9.9)	0 - 34	13.3 (9.1)	0 - 40
	n	%	n	%		
Academic education						
Graduation	145	57.5	42	50.0	187	55.7
Postgraduate studies	55	21.8	15	17.9	70	20.8
Master's degree	46	18.3	24	28.6	70	20.8
Doctorate	6	2.4	3	3.6	9	2.7
Sex						
Female	239	94.8	72	85.7	311	92.6
Male	13	5.2	12	14.3	25	7.4
Health Care Unit where he/she works						
Primary care	65	25.8	34	40.5	99	29.5
Hospital care[a]	106	42.1	27	32.1	133	39.6
Specialized care[b]	18	7.1	19	22.6	37	11.0
Other care levels / Other units[c]	63	25.0	4	4.8	67	19.9

Notes:

a) General hospitals of different levels (in Portugal: Group I, II and III)
b) Specialized hospitals (in the areas of pediatrics, oncology, mental health, rehabilitation, etc.) and community centers specialized in mental health.
c) Integrated Continuing Care, Palliative Care, Central and Regional Health Administration Services, Private Health Units, and other units.

Source: Own elaboration.

Instruments

Maslach Burnout Inventory- Human Services Survey (MBI-HSS). The Maslach Burnout Inventory is the most used instrument to assess the Burnout syndrome[23,24]. The Human Services Survey version was used to assess Burnout in professionals working in social and health services, by implementing the Portuguese version[25] and the Spanish version[26]. The MBI-HSS is a self-assessment scale, in which the subject assesses how often he/she perceives feelings related to work expressed in 22 statements, presenting a Likert-type response scale with 7 points, from "0 - Never/ Not once" to "6 - Always/Everyday"[23,24,25]. The scale has three dimensions: emotional exhaustion (EE), depersonalization (D), and personal accomplishment (PA). The interpretation of scores results from the interaction between dimensions, not having a unique Burnout score[23]. The EE dimension has 9 items (1, 2, 3, 6, 8, 13, 14, 16, 20; ranging from 0 to 54 points), D has 5 items (5, 10, 11, 15, 22; ranging from 0 to 30 points) and PA has 8 items (4, 7, 9, 12, 17, 18, 19, 21; ranging from 0 to 48 points). The higher the score obtained in the emotional exhaustion and depersonalization subscales and the lower the score obtained in the personal achievement subscale, the higher the level of Burnout in the professional[23,25].

The literature points out the use of cut-off

points and the use of percentiles to classify groups of workers as misleading[27,28] because the cut-off points used in the studies are divergent from each other, making their comparability and external validity difficult[28]. However, reading the MBI-HSS results is complex and lacks reference points that allow comparisons between classifications. In the absence of MBI-HSS cutoff points validated for the Portuguese population, in the present study, we followed the guidance of Shirom[29] based on the frequency of feelings towards work as predisposition indicators for Burnout: in the EE and D dimensions, the mean values ≥3 (regularly/a few times a month); in the PA dimension, mean values are considered <3. After evaluating the internal consistency of the MBI-HSS dimensions, EE and PA had good levels of internal consistency (α = 0.897 and α = 0.861, respectively), whereas D had a lower coefficient (α = 0.604) , which is the dimension with the smallest number of items.

Brief Resilient Coping Scale (BRCS). The BRCS was proposed by Sinclair and Wallston[5], and Portuguese[30] and Spanish[31] adaptations were used. The scale is one-dimensional and self-filled, consisting of four questions that assess resilience as a coping strategy, viewed as a capacity to deal with stress adaptively. It features a 5-point Likert-type frequency response scale, from "1-Almost Never" to "5-Almost Always". The total score ranges from 4 to 20, with the following scores indicating three levels of resilient coping: low ≤ 13; medium 14-16; high ≥ 17[5]. Participants were asked to respond to the scale thinking about their daily work during the COVID-19 Pandemic, thus, the interpretation was carried out in this context. In evaluating the internal consistency of the BRSC in the sample of the present study, we obtained a Cronbach's Alpha of 0.762, a value higher than that recorded in other studies[5,30].

Analysis

Quantitative, descriptive, and inferential analyses were performed using the IBM SPSS Statistics 21 software. Tests were performed to verify the assumptions for using parametric tests. The Kolmogorov-Smirnov test was used, in addition to the calculation of z for asymmetry and kurtosis, verifying the normality of the distribution of variables, following Kim's parameters[32] for samples larger than 300 subjects. We opted for One-way ANOVA to assess differences between means. The K-Means Cluster was also used to aggregate the study's central variables, maximizing the differences between clusters.

RESULTS

The average results of the scores obtained in the dimensions of the MBI-HSS point to moderate levels of Burnout associated with EE, low levels associated with depersonalization, and high levels of Burnout associated with low PA of social workers.

Only 1.8% of the participants had feelings compatible with depersonalization, 18.8% had feelings towards PA predisposing to Burnout, and 21.4% had feelings of emotional exhaustion associated with Burnout. Coping levels presented before the COVID-19 pandemic are low (47%) for most participants, followed by moderate levels (29.8%), with 23.2% of the sample showing high levels of resilient coping (Table 2).

The dimensions assessed by the MBI-HSS correlated with resilient coping. PA is strongly and directly proportionally correlated with coping (r = 0.510, p < 0.01), whereas EE and D have small and inversely proportional correlations with coping (r = -0.120, p < 0 .05;

r = -0.178, p < 0.01, respectively). Statistically significant correlations led to exploring the aggregation between variables. Aggregating the variables through the K-Means Cluster with a three-cluster solution (after testing other solutions) identified three profiles of social workers in the face of the Pandemic: 1) a profile with a low Burnout level associated with EE and D and a moderate level associated with PA with a moderate level of coping (Cluster 1), which was the most prevalent (44%); 2) a profile with a high risk of Burnout associated with low PA and a low level of Burnout associated with EE and D, with a low level of coping (Cluster 2); 3) a profile with greater predisposition to Burnout due to high levels of EE and low levels of PA, despite moderate levels of D and coping (Cluster 3) (Table 2).

The one-way ANOVA test did not indicate differences between groups, as well as the Games-Howell Post-Hoc tests, for different levels of health care. However, social workers in primary care perceive higher levels of EE while those in other areas of care have lower levels of EE. The results for D were similar between social workers in different care settings, while those working in other areas of care reported the lowest levels and those working in specialized care with the highest levels. As for PA, social workers from general hospital care and other areas of care stand out, with those from primary care and specialized care obtaining the lowest scores, although there are no statistically significant differences between the groups (Table 3).

Social workers who worked in health services dedicated to patients with COVID-19 showed higher levels of D and PA compared to those who did not work directly with these patients ($p < 0.05$), with no differences between groups concerning EE. Regarding resilient coping, the ANOVA test did not indicate differences between the means according to social workers who work in different types of health units or according to whether or not they worked in a unit dedicated to COVID-19 ($p > 0.05$) (Table 3). The effect size assessed by Eta^2 was small in all cases.

We also assessed the correlation between the MBI-HSS and BRCS scores, age, and years in the profession. Resilient coping, EE and D are not significantly correlated with age or years of professional practice. PA, on the other hand, has an inversely proportional correlation with age ($r = -0.117$, $p < 0.05$) and with years of professional practice ($r = -0.145$, $p < 0.01$) in the health unit where the professional is currently working. Despite being small correlations, these data imply that the higher the age and years of professional practice in the health unit, the lower the PA score tends to be.

The study identified a set of multidimensional stressors associated with the Pandemic. After evaluating the level of fear of personal, family, interpersonal, or professional implications for working directly with patients with COVID-19, we found moderate to high levels of fear, with the greatest fear of having implications at the family level (M = 3.71). The level of impact of the public health emergency perceived in different dimensions is also between moderate and high impact, with higher levels being upon the unit, on the multidisciplinary team, on the relationship with the sick person and with the family and informal network ($M < 4.02 > 3.90$).

Regarding the level of difficulties perceived in relation to the intervention, the more relevant difficulty is in terms of intervention with the sick person, their family, and informal network, as well as in finding timely/alternative answers, or in ensuring discharge or continuity of care ($M < 4.01 > 3.93$). The highest level of support felt at the health unit was associated with the Social Work team (M = 3.62), while the lowest level of support was

attributed to the administration of the health unit (M = 2.93) (Table 4).

The D is not statistically significantly correlated with the levels of fear, impact, difficulty in the intervention, or perceived support ($p > 0.005$). EE increases proportionally with higher levels of fear of implications, impact, and difficulty in intervention processes, despite the small correlations. With the highest level of perceived support, the self-evaluated exhaustion tends to decrease ($p > 0.01$). PA is positively correlated with fear of implications, impact, and level of support ($p > 0.01$), with small correlations (< 0.3) with the first two variables and a moderate correlation (> 0.3) with the level of support perceived in the health unit. Resilient coping presents small and directly proportional correlations with the perceived multidimensional impact and with the level of perceived support ($p < 0.01$) (Table 5).

As previously mentioned, we identified three profiles (clusters) of social workers regarding coping and Burnout (profile 1 - low to moderate risk of Burnout and moderate level of coping; profile 2 - low risk of Burnout by EE and D and high risk associated with PA, and low level of coping; profile 3 - high to moderate risk of Burnout and moderate level of coping). When analyzing the differences between the means of the four stressors (composite variables) according to the three profiles, after evaluating the homogeneity of the variables using the Levene Test ($p < 0.05$), we found very strong evidence of the existence of differences ($p < 0.001$) for levels of fear, multidimensional impact, and level of perceived support in the health unit, with a moderately sized effect through the Eta^2 values (> 0.06). No differences were found in the level of difficulty associated with the intervention ($p > 0.05$) (Table 6).

The results of the a posteriori tests show very strong evidence of differences in the averages of fear of implications of working with COVID+ patients between profiles 1 and 2 and between profiles 2 and 3 ($p < 0.001$), but no differences between profiles 1 and 3. Regarding the impact of the pandemic, we found strong evidence of differences between profiles 1 and 2, and 1 and 3 ($p < 0.01$), and very strong differences between profiles 2 and 3 ($p < 0.001$). As for the level of perceived support, there was very strong evidence of differences between profiles 1 and 2 ($p < 0.001$), strong evidence for profiles 1 and 3 ($p < 0.01$), and no differences between profiles 2 and 3 ($p > 0.05$).

Table 2 - Scores, prevalence of predisposition to Burnout according to the dimensions of the MBI-HSS and levels of coping according to the BRCS and Aggregation in Clusters - (Portugal and Spain, 2020).

N = 336	A	SD	Min-Max	Variation
MBI-HSS				
Emotional exhaustion	19.04	9.777	1.00-54.00	0.00-54.00
Depersonalization	4.54	3.848	0.00-20.00	0.00-30.00
Personal accomplishment	30.69	7.531	8.00-48.00	0.00-48.00
Resilient Coping (BRCS)	14.03	3.008	7.00-20.00	4.00-20.00
			n	%
MBI-HSS				
Emotional exhaustion	No predisposition to Burnout		264	78.6
	With a predisposition to Burnout		72	21.4
Depersonalization	No predisposition to Burnout		330	98.2
	With a predisposition to Burnout		6	1.8
Personal accomplishment	No predisposition to Burnout		273	81.3
	With a predisposition to Burnout		63	18.8
	Low		158	47.0
Levels of Resilient Coping (BRCS)	Moderate		100	29.8
	High		78	23.2
		Custer Center		
	Cluster 1	Cluster 2	Cluster 3	
Emotional Exhaustion	13.05	15.46	31.53	
Depersonalization	3.03	4.79	6.59	
Personal accomplishment	36.11	22.19	30.40	
Resilient coping	15.41	11.95	13.88	
	n = 148 (44%)	n = 91 (27%)	n = 97 (29%)	

Table 3 - Scores on the dimensions of the MBI-HSS according to the type of health unit in which the social worker works and direct intervention in a COVID-19 unit - (Portugal and Spain, 2020).

		Burnout (MBI-HSS)			
		Emotional exhaustion	Depersonalization	Personal accomplishment	BCRS Resilient Coping
	n		M (SD)		M (SD)
			% prediposed to Burnout		
Health Care Unit					
Primary care	99	20.85 (11.3) 30.3%	4.56 (3.94) 1.0%	29.72 (6.93) 18.2%	13.62 (3.07)
Hospital care	133	19.26 (8.38) 20.1%	4.53 (3.52) 1.5%	31.44 (6.73) 16.4%	14.05 (3.01)
Specialized care	37	17.22 (9.87) 16.7%	4.86 (4.39) 2.8%	29.68 (8.59) 27.8%	14.53 (2.81)
Other care levels / Other units	67	16.93 (9.51) 13.4%	4.34 (4.08) 3.0%	31.21 (9.06) 22.4%	14.33 (2,99)
	F	2.603	0.214	1.049	1.177
	df	3; 332	3; 332	3; 332	3; 332
	p	0.052	0.887	0.371	0.318
	Eta²	0.023	0.002	0.009	0.011
Works at COVID-19 Unit					
No	175	18.65 (9.83) 21.1%	4.15 (3.95) 1.7%	30.19 (8.15) 22.3%	13.93 (2.94)
Yes, directly in an exclusively COVID+ unit	31	18.77 (10.04) 25.8%	6.13 (3.76) 3.2%	33.94 (5.57) 0.0%	14.94 (2.35)
Yes, but not directly in an exclusively COVID+ unit	130	19.62 (9,69) 20.8%	4.68 (3.65) 1.5%	30.59 (6.89) 18.5%	13.95 (3.21)
	F	0.384	3.690*	3.314*	1.554
	df	3; 333	3; 333	3; 333	3; 333
	p	0.682	0.026	0.038	0.213
	Eta²	0.002	0.022	0.020	0.009

Notes: F - One-Way ANOVA); p - Sig. (2-tailed); *p < 0.05; **p < 0.01; ***p < 0.001. Eta² - Effect Size measure in ANOVA; df - degrees of freedom in ANOVA.

Table 4- Stressors associated with the pandemic: level of fear, impact, difficulty, and multidimensional support - (Portugal and Spain, 2020).

N = 336	N	M	SD	Min-Max	
Fear of Multidimensional Implications when working with COVID+ patients or suspected [a b]	258	3.34	0.996	1	5
Fear of implications at a personal level	262	3.27	1.123	1	5
Fear of implications at the family level	263	3.71	1.128	1	5
Fear of implications at the interpersonal level	261	3.18	1.104	1	5
Fear of implications at the professional level	260	3.19	1.146	1	5
Multidimensional impact of the public health emergency [a b]	336	3,78	0,755	1	5
Level of impact on unit	336	4.02	0.851	1	5
Level of impact on the multidisciplinary team	336	3.90	0.879	1	5
Level of impact on the relationship with the sick person	336	3.99	0.919	1	5
Level of impact on the patient's relationship with their family and informal network	336	3.99	0.917	1	5
Level of impact on the relationship with other community institutions	336	3.82	0.885	1	5
Level of impact on Social Work of its health unit	336	3.56	1.044	1	5
Level of impact on the members of the Social Work team	336	3.47	1.073	1	5
Level of impact on you as a social worker	336	3.61	1.014	1	5
Level of impact on you as a person	336	3.65	1.029	1	5
Level of Difficulty in Multidimensional Intervention (compared to the situation before the Pandemic) [a c]	257	3,79	0,644	1	5
Level of difficulty in intervening with the sick person	303	3.99	0.848	1	5
Level of difficulty in intervening with the family and informal network	310	3.97	0.927	1	5
Level of difficulty in intervening with the multidisciplinary team	297	3.14	0.844	1	5
Level of difficulty in ensuring discharge/continuity of care	294	3.93	0.893	1	5
Level of difficulty in articulating responses with the network of institutions in the community	317	3.85	1.078	1	5
Level of Difficulty in finding timely responses to ensure users' rights and resources	317	4.01	0.994	1	5
Level of Difficulty in finding alternative responses to the usual ones	314	3.97	0.995	1	5
Level of Difficulty in following legal norms	309	3.40	0.961	1	5
Level of Difficulty in implementing compliance with legal standards	307	3.50	0.975	1	5
Level of support perceived at the health unit [a b]	274	3,36	0,820	1	5
Level of support from the health unit's administration	328	2.93	1.115	1	5
Level of support from the Social Work coordination	286	3.45	1.291	1	5
Level of support from the Social Work team	308	3.62	1.113	1	5
Level of support from the multidisciplinary team	332	3.58	0.963	1	5
Level of support from the organizations with which they work	329	3.48	0.997	1	5

Notes:
a) Composite variables – relative total score of ordinal variables.
b) Variable evaluated on a Likert scale from 1-None to 5-Very high.
c) Variable evaluated on a Likert scale from 1-Much easier to 5-Much more difficult.
Source: Own elaboration.

Table 5- Correlation between the MBI-HSS and BRCS scores and the stressors associated with the pandemic (levels of fear, impact, difficulty in intervening, and support perceived in the health unit) - (Portugal and Spain, 2020).

N = 336		Burnout (MBI-HSS)			Coping Resiliente
		Emotional Exhaustion	Depersonalization	Personal accomplishment	
Fear of Multidimensional Implications when working with COVID+ or suspected patients	Pearson's r	0.154*	0.037	0.227**	0.028
Multidimensional impact of the public health emergency	Pearson's r	0.250**	0.033	0.188**	0.159**
Level of Difficulty in Multidimensional Intervention	Pearson's r	0.131*	0.010	0.000	0.016
Level of support felt at the health unit	Pearson's r	-0.160**	-0.103	0.301**	0.223**

Notes: Stressors: composite variables (Table 4); p - Sig. (2-tailed); *p < 0.05; **p < 0.01; ***p < 0.001

Source: Own elaboration.

Table 6- Levels of stressors associated with the pandemic (levels of fear, impact, difficulty in intervening, and support perceived in the health unit) according to the three Coping and Burnout Profiles in the Sample (Clusters) - (Portugal and Spain, 2020).

N = 336	Coping and Burnout Profiles in the Sample (3 Clusters) ANOVA and Games-Howell Post hoc						
	1 *M*	2 *M*	3 *M*	F	1 vs. 2 p	1 vs. 3 p	2 vs. 3 p
Fear of Multidimensional Implications When Working with Patients	3.487	2.792	3.579	14.911*** p < 0.001 df = 2; 255 Eta2=0.105	.000	.775	.000
Multidimensional impact of the public health emergency	3.781	3.469	4.059	15.610*** p < 0.001 df = 2; 333 Eta2=0.086	.005	.008	.000
Level of Difficulty in Multidimensional Intervention	3.763	3.709	3.914	2,162 p = 0.117 df = 2; 254 Eta2=0.017	.805	.300	.103
Level of support perceived at the health unit	3.602	3.112	3.246	10.072*** p < 0.001 df = 2;271 Eta2=0.069	.000	.006	.565

Notes: Cluster 1, 2 and 3 (Table 2); Stressors: composite variables (Table 5)
F - One-Way ANOVA); p - Sig. (2-tailed); *p < .05; **p < .01; ***p < .001.
Eta2 - Effect Size measure in ANOVA; df - degrees of freedom in ANOVA.

DISCUSSION

The work in the health area, as the epicenter of the response to the COVID-19 Pandemic, required professionals to make an increased effort to adapt to the uncertainty of the evolution of a potentially disruptive situation. Although we are facing "a perfect storm for Burnout in social workers", as characterized by Melanie Sage[33], due to the exposure to very adverse situations in a short period of time, during the first wave of the Pandemic, more than ¾ of the participants were not predisposed to o Burnout, which suggests their ability to face challenging crisis situations and resist.

This study identified three profiles of social workers facing of the Pandemic, the most frequent being a profile with low to moderate risk of Burnout and moderate level of coping

(Cluster 1), followed by a profile with greater predisposition to Burnout and moderate levels of coping (Cluster 3), and a profile with low coping and opposite predispositions in the Burnout dimensions (Cluster 2). Burnout dimensions are associated with coping, which is higher when PA is higher and when EE and D are lower.

The social workers in the sample had moderate levels of Burnout associated with EE, low levels of D, but high levels of Burnout associated with PA. Previous studies with social workers in different countries show higher scores than the results of the present study concerning EE and D, with greater evidence of moderate burnout[34, 35] or even high burnout associated with the two dimensions[36]. However, regarding PA, the results show mean values higher than the study in a United Kingdom[36], but lower than those obtained by a study in Portugal[34], and slightly lower than a study in the United States of America[35].

A small percentage (1.8%) showed feelings compatible with depersonalization, whereas 18.8% had feelings towards personal accomplishment that could enhance Burnout, and 21.4% had emotional exhaustion that predisposes to Burnout. These are indicators of a lower prevalence of Burnout than indicated by Ribeiro and Amaro[34] for each of the three dimensions. In a systematic review of the literature on Burnout in social workers in Spain, the prevalence was always higher than that found in the present study, varying between 23.5% and 29.9%[37]. Regarding the EE dimension, it varied between 33.2% and 62%, and regarding D it was between 22.1% and 70.1%, with only one study showing high D for 6.7% of the sample; meanwhile, PA was between 21.2% and 77.9%[37]. EE is the dimension highlighted as the highest in the reviewed studies[37]. It should be noted, however, that the possible use of different cutoff points referred to in the literature presents different information. De-la-Fuente-Roldán and Sánchez-Moreno[17] identified that 25.3% had Burnout and more than half of the professionals had Burnout potential associated with one of the three dimensions, with a strong association between Burnout and psychological illness among professionals, which affected 42% of social workers.

In Portuguese health professionals, the occurrence of Burnout syndrome is considered frequent (21.6% with moderate Burnout and 47.8% with high Burnout) and is associated with the perception of poor working conditions and less seniority in the service[24].

In the present study, the PA of social workers tends to decrease with advancing age and years of service, with the lowest PA levels being indicative of Burnout. These results, however, do not meeting the conclusions of Romero-Martín *et al.*[37] who stated that years of work experience favor the increase in EE and D, or by Ribeiro and Amaro[34] who stated that older professionals are the ones who manifest higher EE, higher PA, and lower D; whereas, we did not find significant correlations.

Social workers who worked in health services exclusively dedicated to patients with confirmed COVID-19 show a higher frequency of EE and D but were also the ones with higher levels of PA, a situation that may be associated with the direct experience of the risks of Pandemic, on the one hand, and the perception of social recognition and professional valorization in view of the challenges posed by organizations during an exceptional crisis, on the other. Between levels of care, significant differences are also noted for levels of EE, highlighting social workers in primary health care with higher levels and higher prevalence of EE.

This is probably because they are part of community-based services and the location of where the public health services are, impacting their daily professional life.

The uncertainty and instability of the evolution of the pandemic and of the responses, the level of impact felt at work, the fears, and perceived difficulties constitute a challenging framework. The context dominated by uncertainty and fear can enhance a feeling of social exhaustion associated with overload and the observation of an accelerated increase in social problems[14].

EE is favored by the fear of implications in different areas of personal, family, interpersonal, and professional life, as well as by the multidimensional impact of the emergency situation. The levels of support perceived within the health unit, on the other hand, are protective factors for EE and favor PA and resilient coping.

The most immediate fear was the fear of self and family-contagion. A study of Colombian doctors revealed that more than 70% of respondents were afraid of infection, of infecting family members, and of dying, showing high levels of anxiety and stress at work[38]. This evidence is also underscored by other studies with health professionals[9,38,39,40]. The situation among social workers in Portugal and Spain would likely be identical to other health workers, with participants in the present study showing moderate to high levels of fear of implications for themselves and others related to working with patients. One of the reasons mentioned by Santamaria *et al.*[39] is the feminization of health care and care professions in general, including Social Work.

Although this study does not imply an analysis of the results from a gender perspective, 94.8% of the participants are women, as well as in the study by Velazquez and Benitez[40] which had the participation of 93% of female social workers, which highlights the feminization of the profession. The dominant role of women in society in the health care professions but also in informal care within the family environment[41] may explain that the greatest fear is the possible implications upon the family. A study on the psychological impact of COVID-19 on health professionals shows that it is women who have higher levels of anxiety, stress, depression, and insomnia associated with contact with the virus in the workplace and fear of infecting families[39], assuming greater concern with the risk of contagion.

The perceived impact of the public health emergency on the intra- and inter-institutional dimensions of relationships, as well as the appreciation of the difficulties added by the pandemic in professional intervention, which correlated with EE, is in line with the idea that Burnout among social workers is due to internal and external factors; mainly external factors that condition it, namely working conditions and work relationships[37]. In fact, the multidimensional impact of the pandemic is also the variable that best distinguishes the three analyzed profiles, which is the one that best explains the level of Burnout risk in the sample, as the highest average is associated with the profile with the highest risk of developing Burnout (3), followed by that associated with a moderate risk profile (1), while the lowest average was associated with a profile of lower risk (2).

Unlike Khasne *et al.*[3], who argue for a safe environment that promotes well-being for health professionals, in the first wave of the Pandemic, the uncertainty in the availability of protective equipment in services and in the community may have hindered the activation of self-care and coping skills.

The levels of resilient coping presented by the participants in the face of the

pandemic were mostly low (47%), followed by moderate levels (29.8%), with less than ¼ of the sample at high levels. BRCS intends to describe an active pattern of problem solving, through attitudes of optimism, perseverance, creativity, and growth in the face of adversity[5], which are competences that are very much conditioned by the disruptive situation, heightened in the first wave by its unknown contours. The exacerbation of ethical dilemmas in this context[20] and the need to maintain the capacity for action, requires attention given the impact of emotional exhaustion (sometimes not self-declared) on the ability to analyze the ethical implications and rethink the intervention. Therefore, it is essential that organizations provide support and guidance, and favor the protection and well-being of social workers[21]. As suggested by a study on the action of social work during the COVID-19 Pandemic, there is a need for intervention measures to improve coping strategies of social workers during crises such as the Pandemic[16]. We highlight the dampening role of the support perceived in the health unit in the face of EE, positively favoring the levels of PA and coping.

This study presents relevant data to consider concerning the implications of a public health crisis in the professional group of social workers. There are, however, some limitations of the study to be mentioned. The most relevant is the heterogeneity of the sample across countries. If in Portugal, the sample represents 24.4% of the known community of social workers in the health system[42], in Spain this sample's representativeness is lower. Another limitation resides in the fact that the study focused on stressors related to the Pandemic context at work and in professional intervention, not having characterized psychosocial and socioeconomic impacts on the personal and family situations of the participants; especially since the transformation that the assistant's work suffered made it difficult to establish boundaries between personal and professional life[43].

Finally, this study initially explored differences in results between national sub-samples and did not report evidence of significant differences. However, the scale of the pandemic impact was felt differently in Spain and Portugal during the first wave, with Spain experiencing a more serious situation concerning the incidence of infection and mortality.

CONCLUSION

Despite the disruptive pandemic situation, high levels of fear, perceived impact, and difficulties in intervention processes, Burnout risks were moderate to low among social health workers in Portugal and Spain during the first wave of the COVID-19 pandemic. The risks of Burnout due to depersonalization were residual, requiring special attention to those more exposed to Burnout due to low personal accomplishment and high emotional exhaustion, taking into account that the profession is considered as an at-risk profession[19]. The risk may increase in the medium- or long-terms because most of the sample had low levels of resilient coping or had difficulties in activating skills to deal with the challenges of the Pandemic, or among those who felt less support from the health unit. Thus, the hypothesis raised by the study was rejected. However, the profession deserves special attention, given its position in ensuring the well-being and rights of citizens

in situations of social vulnerability, through the promotion of collective and organizational strategies that favor psychosocial and professional well-being, specifically during crisis situations that are highly challenging for the health area and for society.

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