

Comparative Analysis of Burnout among Medical and Psychiatric Social Workers in a Tertiary Care Hospital

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ABSTRACT

Background. Medical and psychiatric social workers carry the psychosocial work of the clinical team, including counselling, discharge planning, welfare linkage, and rehabilitation. Heavy caseloads and emotional labour place them at risk of burnout, yet comparative data on the two cadres in India are scarce. **Objective.** To assess and compare burnout between medical social workers (MSWs) and psychiatric social workers (PSWs) in a government tertiary care setting in North India. **Methods.** A hospital-based cross-sectional survey enrolled 100 social workers (50 MSWs, 50 PSWs) by purposive sampling. Burnout was measured with the Copenhagen Burnout Inventory (CBI), covering personal, work-related, and client-related domains. Continuous variables were compared using the independent samples t-test and categorical variables using the chi-square or Fisher's exact test. A two-tailed $p < .05$ was treated as significant. **Results.** PSWs scored higher than MSWs on all three CBI domains: personal burnout (26.16 ± 1.55 vs 24.74 ± 3.10 ; mean difference 1.42, 95% CI 0.45 to 2.39; $p = .005$), work-related burnout (27.40 ± 1.56 vs 26.26 ± 2.57 ; mean difference 1.14, 95% CI 0.30 to 1.98; $p = .009$), and client-related burnout (27.72 ± 1.75 vs 26.42 ± 3.51 ; mean difference 1.30, 95% CI 0.20 to 2.40; $p = .021$). Effect sizes were moderate (Cohen's $d = 0.47$ to 0.58). The groups also differed in marital status, religion, education, employment type, domicile, and posting. **Conclusion.** PSWs reported greater burnout than MSWs across all CBI domains, and the null hypothesis was rejected. Because the cadres differ on several background variables, the difference is associational rather than role-specific. Support should be directed toward psychiatric and contractual staff, alongside action on the structural conditions linked to higher burnout.

Keywords: medical social workers; psychiatric social workers; burnout; Copenhagen Burnout Inventory; occupational stress; India.

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INTRODUCTION

Burnout is a syndrome that develops when occupational stress goes unmanaged over long periods. Freudenberg first described it in the 1970s among workers in helping professions (Freudenberg, 1974). Maslach and her colleagues later gave the construct its working shape, defining it through three features: emotional exhaustion, depersonalisation, and a shrinking sense of personal accomplishment (Maslach & Jackson, 1981; Maslach et al., 2001). The syndrome matters in healthcare because the work is emotionally heavy and rarely lets up. Burnout harms the worker, and it reaches the patient through poorer judgement, thinner empathy, and weaker continuity of care.

Medical and psychiatric social workers sit inside the

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clinical team and carry the psychosocial load that medicine alone cannot address. Their day moves across counselling, patient advocacy, discharge planning, crisis response, linkage to welfare schemes, and follow-

up in the community. Much of this is emotional labour. They absorb distress, broker between families and the system, and work with limited resources. These conditions push them toward stress, and over time, toward burnout.

The path into burnout tends to follow a sequence. Heavy caseloads, role ambiguity, administrative pressure, and repeated exposure to suffering produce emotional exhaustion. Exhaustion can harden into depersonalisation, where the worker pulls back from clients as a way of coping. The detachment protects in the short run but erodes the therapeutic relationship. The third element, a reduced sense of personal accomplishment, brings feelings of inefficacy that feed the cycle.

Several studies single out medical and psychiatric social workers as more exposed than many of their healthcare colleagues. The reason lies in the nature of the work, which asks for sustained emotional contact with people facing serious illness. Frequent contact with death, relapse, stigma, and structural barriers produces moral distress and compassion fatigue, both close cousins of burnout.

The costs do not stay with the individual. Burnout raises the risk of depression, anxiety, sleep disturbance, and physical illness. At work, it lowers job satisfaction, increases absenteeism, and drives turnover, which strains already thin services. For patients, a burnt-out worker is a less safe worker.

Most occupational stress research in Indian healthcare has examined nurses and physicians. Social workers, despite their distinct role, have received little attention, and direct comparisons between medical and psychiatric social workers are rarer still. The present study addresses that gap. It compares burnout between medical and psychiatric social workers in a government tertiary care setting in North India, and it examines how the two groups differ in their social and occupational profiles.

Work on social worker burnout has grown over three decades, though the evidence still leans toward Western settings. A recurring observation is that social workers in developing countries report sharper occupational stress than peers in the West, a gap usually traced to weaker institutional support and heavier informal demands.

Vyas and Luk (2010) studied a Hong Kong non-governmental organisation and identified six stressors: workload, organisational policy, organisational culture, relationships with supervisors and peers, and the complexity of the work itself. Drawing on 166 valid responses, they found these pressures harmed both staff and the organisation, and that junior workers carried more stress because their career paths were narrow.

Haj-Yahia and colleagues (2002), working with Arab social workers in Israel, reported that a sense of challenge and mastery at work shaped both satisfaction and burnout. In Turkey, Yurur and Sarikaya (2012) surveyed 222 social workers and showed that workload predicted emotional exhaustion and depersonalisation, while role ambiguity raised burnout. Supervisor support softened exhaustion and lifted personal accomplishment, but it did not affect depersonalisation.

Hamama (2012) examined social workers serving children and adolescents and found moderate burnout overall. Burnout fell as age, seniority, favourable working conditions, and collegial support rose. The protective weight of organisational support runs through much of this literature.

Theoretical accounts have tried to connect these threads. Um and Harrison (1998) proposed a stress-strain-outcome model that places role stressors upstream of burnout and job satisfaction. Acker (1999) reported that working with clients who have severe mental illness related to lower satisfaction and higher burnout among social workers, a point with obvious bearing on psychiatric settings. Sze and Ivker (1986) argued that both the setting and the role shape a social worker's stress, while Alarcon and colleagues (2009), in a meta-analysis, linked personality traits to burnout risk. Gellis (2002) compared how social workers and nurses cope with occupational stress, and Marine and colleagues (2006), in a Cochrane review, assessed interventions to prevent stress in healthcare workers.

Indian evidence sits mostly in nursing and general hospital staff. Studies of Indian nurses and health workers have documented substantial occupational stress and its links to job satisfaction and wellbeing (Agarwal & Sharma, 2011; Jathanna et al., 2012; Saha et al., 2011; Tankha, 2006). Comparable work on medical and psychiatric social workers is scarce, which is the space this study enters.

Research Gap- Indian research on occupational burnout has concentrated on nurses and physicians, and the distinct position of social workers has stayed in the background. Medical and psychiatric social workers handle continuous emotional engagement, structured psychosocial interventions, and care for vulnerable groups, yet the stressors specific to their roles remain poorly mapped. Direct comparisons between the two cadres are almost absent in the Indian literature. This study assesses and compares burnout between medical and psychiatric social workers, with the aim of informing workplace conditions and professional wellbeing in healthcare institutions.

Aim and Objectives

Aim. To assess and compare the level of burnout between medical social workers and psychiatric social workers in a government tertiary care setting.

Objective 1. To assess and compare burnout, across its personal, work-related, and client-related domains, between medical and psychiatric social workers.

Objective 2. To compare the sociodemographic and occupational profiles of the two groups.

Hypothesis- Null hypothesis: there were no significant difference in burnout between medical social workers and psychiatric social workers.

Methodology

Study design and setting This was a hospital-based cross-sectional survey. Participants were recruited by purposive sampling from different Medical College/Institute.

Participants and sample size- The sample comprised 100 social workers, 50 medical social workers and 50 psychiatric social workers.

Eligibility criteria-Inclusion criteria were employment as a medical or psychiatric social worker in a government healthcare setting, at least two years of professional experience, and willingness to provide written informed consent. Both men and women were eligible.

Exclusion criteria were a history of major psychiatric or medical illness, less than two years of professional experience, and age outside the eligible range.

Instruments-[i] Sociodemographic proforma. A semi-structured proforma recorded personal and occupational details.

[ii] Copenhagen Burnout Inventory (CBI). The CBI (Kristensen et al., 2005) measures burnout across three subscales: personal, work-related, and client-related.

Procedure- After institutional approval, eligible participants were approached individually. The investigator established rapport and obtained written informed consent before data collection. The proforma and the CBI were administered in person during participants' available time. Anonymity and confidentiality were maintained throughout.

Ethical considerations- The study followed the principles of the Declaration of Helsinki. Written informed consent was obtained from every participant.

Statistical analysis- Data were analysed in SPSS version 22. Continuous variables are summarised as mean and standard deviation, and categorical variables as frequency and percentage. Group comparisons used the independent samples t-test for continuous variables and the chi-square test for categorical variables. Where expected cell counts fell below five, Fisher's exact test was applied. All tests were two-tailed, and $p < .05$ was treated as significant. Exact p-values are reported.

Results

Table 1 compares the two groups on categorical sociodemographic and occupational variables. The groups were similar in sex ($p = .221$) and in yoga practice ($p = .414$). They differed significantly in marital status ($p < .001$), with more married participants among medical social workers (74.0%) than psychiatric social workers (38.0%). Religion differed (Fisher's exact $p = .001$): all psychiatric social workers were Hindu, while the medical social worker group also included Muslim and Sikh participants. Education differed ($p = .012$), with a higher share of M.Phil holders among psychiatric social workers (30.0%). The starkest difference was in employment type ($p < .001$): every medical social worker held a regular post, whereas 56.0% of psychiatric social workers were on contractual appointments. Domicile differed ($p = .001$), with psychiatric social workers drawn overwhelmingly from rural areas (96.0%), and posting differed across OPD, IPD, community, and other settings (Fisher's exact $p = .002$). Family type did not differ significantly ($p = .071$).

Table 1. Comparison of medical social workers (MSWs) and psychiatric social workers (PSWs) on categorical sociodemographic and occupational variables (N = 100)

Variable	Category	MSW n (%)	PSW n (%)	Statistic	p
Sex	Male	27 (54.0)	33 (66.0)	$\chi^2 = 1.50$, df 1	.221
	Female	23 (46.0)	17 (34.0)		
Marital status	Married	37 (74.0)	19 (38.0)	$\chi^2 = 13.15$, df 1	< .001
	Unmarried	13 (26.0)	31 (62.0)		
Religion	Hindu	37 (74.0)	50 (100.0)	Fisher's exact ^a	.001 ^a
	Muslim	6 (12.0)	0 (0.0)		
	Sikh	7 (14.0)	0 (0.0)		
Education	Master's (MSW)	45 (90.0)	35 (70.0)	$\chi^2 = 6.25$, df 1	.012
	M.Phil	5 (10.0)	15 (30.0)		
Employment type	Regular	50 (100.0)	22 (44.0)	$\chi^2 = 38.89$, df 1	< .001
	Contractual	0 (0.0)	28 (56.0)		
Domicile	Urban	14 (28.0)	2 (4.0)	$\chi^2 = 10.71$, df 1	.001
	Rural	36 (72.0)	48 (96.0)		
Family type	Joint	22 (44.0)	31 (62.0)	$\chi^2 = 3.25$, df 1	.071
	Nuclear	28 (56.0)	19 (38.0)		
Posting	OPD	9 (18.0)	19 (38.0)	Fisher's exact ^a	.002 ^a
	IPD	31 (62.0)	31 (62.0)		
	Community	4 (8.0)	0 (0.0)		
	Other	6 (12.0)	0 (0.0)		
Yoga practice	Yes	22 (44.0)	18 (36.0)	$\chi^2 = 0.67$, df 1	.414
	No	28 (56.0)	32 (64.0)		

Note. Percentages are column percentages within each group. ^a Fisher's exact test was used because expected cell counts were below five; the chi-square approximation is not valid for these variables (Religion: $\chi^2 = 14.94$, df 2; Posting: $\chi^2 = 13.57$, df 3).

Table 2 compares the groups on continuous variables. Medical social workers were older, more experienced, and had a higher personal monthly income than psychiatric social workers, while family income was similar between the groups.

Table 2. Comparison of MSWs and PSWs on continuous sociodemographic variables (N = 100)

Variable	MSW (M ± SD)	PSW (M ± SD)	t (df 98)	p
Age (years)	35.24 ± 7.59	30.12 ± 6.57	3.46 ^b	.001
Experience (years)	8.18 ± 6.39	4.00 ± 3.13	3.84 ^b	.001
Monthly income (₹)	93,380 ± 33,645.5	53,680 ± 28,694.3	2.61 ^b	.010
Family income (₹)	127,760 ± 51,318.0	121,200 ± 48,201.7	0.40 ^b	.697

Note. Values are mean ± standard deviation; t = independent samples t-test. ^b The reported test statistics do not reconcile with the descriptive statistics and require verification (see box below).

Table 3 presents the CBI scores. Psychiatric social workers scored higher than medical social workers on all three domains, and every difference was statistically significant. The gap was largest for personal burnout (mean difference 1.42, 95% CI 0.45 to 2.39; $t(98) = -2.89$, $p = .005$), followed by client-related burnout (1.30, 95% CI 0.20 to 2.40; $t(98) = -2.34$, $p = .021$) and work-related burnout (1.14, 95% CI 0.30 to 1.98; $t(98) = -2.67$, $p = .009$). Effect sizes were moderate, with Cohen's d ranging from 0.47 to 0.58. The null hypothesis of no difference in burnout between the two groups is therefore rejected.

Table 3. Comparison of MSWs and PSWs on Copenhagen Burnout Inventory (CBI) domain scores (N = 100)

CBI domain	MSW (M ± SD)	PSW (M ± SD)	t (df 98)	p	Mean diff (95% CI); d
Personal	24.74 ± 3.10	26.16 ± 1.55	-2.89	.005	1.42 (0.45–2.39); 0.58
Work-related	26.26 ± 2.57	27.40 ± 1.56	-2.67	.009	1.14 (0.30–1.98); 0.54
Client-related	26.42 ± 3.51	27.72 ± 1.75	-2.34	.021	1.30 (0.20–2.40); 0.47

Note. Values are mean ± standard deviation. The mean difference is PSW minus MSW; a positive value indicates higher burnout in PSWs. CI = confidence interval; d = Cohen's d. Negative t-values reflect the MSW-minus-PSW direction of the test.

Discussion

The central finding is straightforward. Psychiatric social workers reported higher burnout than medical social workers on every CBI domain, and the differences were statistically significant. The gap was largest for personal burnout (mean difference 1.42, 95% CI 0.45 to 2.39) and held for work-related burnout (1.14, 95% CI 0.30 to 1.98) and client-related burnout (1.30, 95% CI 0.20 to 2.40). Effect sizes were moderate, between 0.47 and 0.58. On this evidence, the null hypothesis of no difference is rejected.

Several features of psychiatric social work plausibly account for the pattern. The work involves sustained contact with severe, often relapsing illness, with stigma, and with families under strain. Acker (1999) reported that working with clients who have serious mental illness related to higher burnout, which fits the present result. The two groups also differed sharply in their employment conditions. More than half the psychiatric social workers held contractual appointments, most came from rural backgrounds, they were younger, and they earned less. Insecure employment and a weaker structural footing are recognised contributors to occupational strain, and they may compound the emotional demands of the role.

The two cadres were not alike to begin with. They differed in marital status, religion, education, employment type, domicile, and posting. Medical social workers were older, more experienced, more often in regular posts, and better paid. This matters for interpretation. Because the groups differ on many variables at once, the higher burnout among psychiatric social workers cannot be attributed to the role in isolation. Employment insecurity, age, and posting may each carry part of the effect, and the present design cannot separate them.

The result sits within the wider literature. Workload and role ambiguity have repeatedly predicted emotional exhaustion and burnout among social workers (Yurur & Sarikaya, 2012), while collegial and supervisory support have shown a protective effect (Hamama, 2012). Um and Harrison's (1998) stress-strain-outcome model offers one frame for the present data, with role stressors upstream, burnout as the strain

and job conditions shaping the outcome. Indian evidence on nurses and hospital staff points the same way, linking occupational stress to lower satisfaction and poorer wellbeing (Agarwal & Sharma, 2011; Tankha, 2006).

Two implications follow for human resource practice. First, support should be targeted rather than uniform. Psychiatric social workers, and contractual staff in particular, carry a heavier burnout load and need priority attention. Second, the structural drivers deserve direct action. Regularising insecure posts, setting manageable caseloads, building regular clinical supervision, and strengthening peer support are concrete steps that address the conditions this study links to higher burnout. Generic wellness messaging will not reach the staff who need it most.

Limitations

This study has limits that bear on its conclusions. The sample was modest and drawn from , so the findings may not generalise to other settings. The cross-sectional design rules out causal claims; it shows association, not direction. Self-report invites response bias, and social desirability may have shaped answers on a sensitive topic. The two groups differed on several background variables, so the comparison is confounded by design and the role effect cannot be isolated. The analysis did not assess general psychological distress, organisational role stress, or coping strategies, each of which would deepen the account.

Conclusion

Psychiatric social workers in this tertiary care setting reported greater burnout than medical social workers across all three CBI domains, with moderate effect sizes, and the null hypothesis was rejected. The two groups also differed in their social and occupational profiles, which means the burnout gap should be read as associational rather than role-specific. The practical message is to direct support toward the staff most exposed, especially those in contractual and rural posts, and to act on the structural conditions that sustain burnout. Prospective and mixed-methods work would help establish how burnout develops in these cadres and which interventions hold over time.

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