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Professional distress in clinical social workers: an understanding through social representations

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Outline of content

Abstract

Canadian social workers rank amongst the highest for professional distress. We know from both theoretical models of occupational stress and empirical research that increasing systemic pressures, organizational changes and funding restrictions have been correlated to a rise in workplace dissatisfaction, exhaustion and even burnout in front-line practitioners. Yet, despite this solid ground for inquiry, a limited body of literature has explored the representational factors at play in clinical social workers' occupational experience. These matters have garnered even less interest in the francophone linguistic minorities of this professional group. A broad exploration of professional distress is hence required to transcend the mere statistics of the phenomenon at hand and reveal how institutional experience, identity and language interact together under shared representations of profession and distress to shape the daily realities of clinical social workers.

This research project thus seeks to further our understanding of professional distress in francophone clinical social workers in a minority setting. This was achieved through four distinct study under the same data sample. 30 semi-directed interviews were conducted within three distinct provinces: Manitoba (Winnipeg), Ontario (Ottawa) and New Brunswick (Moncton) with an equal distribution of participants. Our sample consisted of female social workers working in a healthcare setting and identifying as francophones having experienced professional distress in the past year. The interview guide was comprised of three large themes: the representation of social work, the formal training and experience of social workers and their professional distress. Matters of linguistic relevance was explored throughout.

The data was apprehended by way of an integrated content analysis (Negura, 2006) performed on the relevant text transcriptions for each study. Simple measures of frequency and cooccurrence were retained to assist the interpretation of results based on subjective importance. We first sought to uncover the social representation of social work held by professional social workers in a Canadian healthcare setting. Was identified the elements and structure of the social representation of social work. Each element has implications for the daily practice of the profession, the cultivation of resilience and the core values of social work. Was further discussed the respondents' perception of outside views of the profession and explores the tensions between the values of social work and its implementation in an institutional setting.

With the professional representation of social word at hand, we were able to narrow our inquiry to the social workers' lived experience of organizational constraints and its ties to professional distress. Discussions of daily work life, responsibilities, limitations and subjective appreciation of the social worker's role revealed which organizational constraints were the most significant in everyday practice and how they relate to identity and mandate. Healthcare reforms were found to be generally negative for social workers, whose struggles

for recognition were impaired by the fundamentally neoliberal ideologies behind large-scale restructuring, themselves are at odds with the humanistic principles of social work. Our inductive approach further allowed us to expand on the links between these reforms, professional distress and workplace well-being.

A clearer prospect of the lived experience of healthcare social workers guided our progression to the core inquiry of the thesis: workplace well-being. We thereby sought to investigate the professionals' social representation of professional distress directly. This exploration of the social workers' shared workplace well-being builds on our previous findings by focusing on the representational elements at the root of their occupational suffering, thereby conciliating matters of identity, organizational norms and professional experience. Perceived attitudes, expectations, work-life imbalances and negative workplace experiences were all allege to increase the subjective experience of distress. The latter's ties to societal norms, ideological pressures and value clashes within the institutions is discussed.

Lastly, workplace well-being was approached through the lens of linguistic affiliation and its role in the representation of the professional distress of francophone healthcare social workers in minority settings. Faced with a contradictory literature on the influence of linguistic affiliation on mental health and workplace well-being, we argued that a representational inquiry could provide insight into these incongruences. Our results indicate that linguistic affiliation relates to the social representation of professional distress on matters of recognition, discrimination, employment precarity and role boundaries. These findings were discussed in terms of their ties to professional identity, the lived experience of our participants and the power relations that they involved.

Overall, this research project seeks to open new lines of inquiry about the social work profession based on the experiences and points of view of front-line practitioners. In proposing our representational analysis of the professional identity of social workers, their experience of the workplace and their representation of professional distress, we hope to further the understanding of social work in general. With clear empirical evidence of the undue stress experienced by healthcare social workers, we also hope that this research may serve to assist policy makers and administrators to rethink healthcare reforms beyond the aims of financial efficacy and individualized care, but also in terms of their feasibility and symbolic significance for care providers. This thesis ultimately seeks to highlight the importance of organizational improvements of the workplace through systemic changes targeting managerial expectations, resources allocation, work life balance and the respect of professional values concurrently.

Keywords:

Social representations; professional distress; francophones in a minority setting; clinical social work; professional identity; occupational experience

Introduction

Neoliberalism: an ideological setting to professional distress?

The Canadian context of public provisions is showing increasing semblance to the American regime of privatized and individual-based social services. This similarity can be attributed to the shared neoliberal ideology of North American decision-makers, best summarized by Harvey (2010) as:

> *[…] a theory of political economic practices that proposes that human well-being can best be advanced by liberating individual entrepreneurial freedoms and skills within an institutional framework characterized by strong private property rights, free markets and free trade. The role of the state is to create and preserve an institutional framework appropriate to such practices. (p. 2)*

For most, work efficiency, individual achievements and personal entrepreneurship has been the norm over their lifetimes and has garnered limited controversy. Only very recently, in times of increasing uncertainty brought about by climate change, economic difficulties and, as of writing this thesis, a worldwide pandemic, has there been more assertive debates over welfare and the role of government in strengthening public securities (Lee, 2018).

Indeed, following the recent onset of the covid-19 pandemic, we've observed unprecedented national and provincial efforts by governing bodies to strengthen public provisions, likely only for the duration of the crisis. These initiatives align with the functioning of a Welfare State. Described as a governmental trend aimed at balancing earning inequalities and providing greater opportunities for poverty emancipation (Barr, 2020), Canada was overall regarded as a Welfare State upon adopting numerous reforms during the early 1900s until the turn of the 1980s. These public provisions namely include old-age pensions, family allowances, unemployment insurance, universal health care and federal and provincial pension plans (Guest, 2013). At the start of the 1980s however, a major economic recession brought about new scrutiny to government spending, leading to a rise in political austerity (Moscovitch, 2015). This normative shift was led by Macdonald (1985) and Axworthy (1994), whose reports promoted equal opportunities for all by relegating the management of public services to the free market (Beauchemin et al., 1995).

Known as the neoliberal ideology, this normative trend now defines our government's *modus operandi* and has served as the foundation of Canadian public policies for decades. Blame avoidance politics[1], globalized economic

[1] A political strategy aimed at countering the negativity bias of voters by focusing more on the avoidance of blame than on pursuing credit for positive gains. They include, among others, "agenda limitation, scapegoating, 'passing the buck' and defection" (Weaver, 1986: 371).

pressures and veto players[2] have since succeeded in introducing a succession of policy retrenchments and service cutbacks, thereby emulating the United-States and increasingly leaving the accessibility of essential provisions to principles of offer and demand (Starke, 2006). Chomsky and Drèze (2014) somberly describe this state of affairs as a "'virtual parliament', a parliament of investors and lenders who have veto power over government decisions, sharply restricting democratic options" (p. 130). With politicians incentivized by the economic promise of radical capitalism, welfare is left shunted to a derogation to the free market, an economic burden and a circumvention to personal determination (Lamarche, 2017). Decades of neoliberalism have thus prompted a generalized erosion of solidarities, whereby the ideology's emphasis on auto determination leaves each citizen responsible for societal plights while simultaneously making them the cause of the social adversity they face (Beauchemin et al., 1995).

From the start, social workers have fiercely contested the neoliberal agenda and advocated for the preservation of the Welfare state (Gray et al., 2015; Harris, 2014; Savignat, 2009; Strier, 2019). As neoliberalism poses a direct threat to the humanistic principles of front-lines practitioners (Payne, 2011), academics and front-line workers alike have rallied to condemn this ideology's wide-ranging disturbances. To name a few, Canadian researchers Weaver, Habibov and Fan (2010) exposed the deleterious impacts of the devolution of government services by demonstrating its inability to reduce poverty nationally by rather increasing income disparity. Herd (2002) remarked on the retrenchment of provincial welfare in favour of "workfare", a form of assistance focused on regimenting poor people's lives on a moralistic basis (the so-called "deserving poor"), thereby restricting eligibility to social supports. By simplifying the policy's success to mere caseload reductions, many are left worse than before and unable to petition for help. A comparative study by Spolander et al. (2014) even challenges the fundamental applicability of neoliberal economic reforms by stating its inability to serve public interests and integrate with a critical social work practice transnationally.

Unfortunately, these efforts have proved insufficient to deter Canadian lawmakers. In the context of institutional practice, neoliberalist standards have been gradually emboldened through New Public Management (NPM) reforms, a thinly veiled expression of corporatist beliefs exercised through governmental policy. Broadly, it serves to integrate principles of free market in publicly funded entities by separating buyers from their service providers and introducing additional competition amongst the latter. The provision of assistance is further regulated by favoring the measure of results (outputs) rather than the contributions of employees (inputs). These strategies are ultimately consolidated by restructuring administrative priorities around regulation and procedure production to maximize employee efficiency (Banks, 2011). In the healthcare

[2] Coined by professor George Tsebelis (2002), it describes a form of political behavior under the lens of game theory. More precisely, veto players refer to political actors with the power to counter a bill, act of law and/or proposal presented in parliament.

sector, these reforms have commanded radical changes in practices and guidelines (Sebai & Yatim, 2018).

To best understand the embedment of NPM norms in the Canadian healthcare sector, we may look at recent examples of healthcare reforms on the provincial stage. Ontario passed new legislation to ensure that standards of care and costs are upheld, in a plan tellingly named *Ontario's Action Plan for Health Care: Better patient care through better value from our health care dollars*. It entails increased monitoring of healthcare professionals through mandatory statistic reporting. These bureaucratic responsibilities are incentivized by the monetary compensation of executives' achievements of targets and the tying of funds to the efficiency of services (Government of Ontario, 2012). New Brunswick has similarly aimed at reducing primary healthcare costs by promoting community care and assistance outside of emergency clinics and hospitals where services are most expensive (Government of New Brunswick, 2018). Manitoba has focused on centralizing its healthcare services, delegating them to a provincial agency (Shared Health) mandated with structuring funding while simultaneously strategizing services to optimize cost efficiency and reduce wait times (Government of Manitoba, 2018). In British-Columbia, the delivery and management of healthcare is already said to have been optimized through "public-private partnerships" (Corey, 2014: 5), a rapidly growing initiative across the nation whereby the provision of services is contracted to private agents by government bodies. Globally, these arrangements have led to inconsistent results and threatened the equity of services in a bid for efficiency (Flynn, 2007).

This shared occupational reality is further complexified by the singular role clinical social workers occupy amongst their peers; being amongst the few professionals without a medical background. This is less a cause for concern in the context of adaptative patient-care, where the continuity of services and individual satisfaction takes the foreground and social workers are permitted to stand as an essential articulation of the provision of care. The managerial narrative changes, however, upon integration of NPM reforms. Thereafter, social workers' subjective priorities of well-being, empowerment and advocacy present as contrary to a standardized, efficiency-focused administrative paradigm (Wilson et al., 2011). Where service retrenchment reins as the supreme drive for employee accountability, immeasurable norms of care such as therapeutic relationship-building are disregarded in service valuation and leaves social workers particularly vulnerable under the managerial gaze (Baines, 2004). Employment precarity takes center stage as social workers increasingly prescind from their original mission to accommodate stringent casework loads and bureaucratic tasks in hopes of upholding their role in a healthcare setting (Baines, 2004; Burton & van den Broek, 2009).

These coping strategies are unsustainable in the long-term, however, and do a disservice to the profession's integrity. Clinical social workers are aware of the inherent contradictions occasioned by NPM reforms and resist its influence by supporting their own narrative, more in line with their original values (Hyslop,

2018). Nonetheless, this is of little consequence to their workplace conditions and cannot compensate entirely for the impacts brought about by the adoption of a neoliberal ideology in protocol. Indeed, for a profession fiercely advocating for its disciplinary recognition, current institutional standards only undermine the claim to a unified practice and confine social work as a "go-between craft" (Beddoe, 2013: 25). It is hence clear then that the experience of organizational change cannot be considered in isolation and must be explored together with the identity concerns woven into the social workers' shared professional representation.

Institutional constraints are also instrumental in defining the daily experience of clinical social workers and ought to be looked at carefully. They begin with expectations in mindset, whereby the quality of services is demanded in spite of budgetary restrictions. Social workers have to compensate for a loss in resources by devoting more of their personal time and efforts without an equivalent compensation (Bart & Hupfer, 2004). Further, in a phenomenon entitled the "bureaucratization of social work", the administrative focus on outputs leads to the stringent monitoring of efficiency through case notes, reports, forms and minutes, which rise in significance under a micro-managed practice at the expense of individual rapport and human care (Burton and van den Broek, 2009). The organizational constraints placed on healthcare professionals initially present as contradictory with the neoliberal ideology, whereby the State is expected to recede and promote individual liberties (Harvey, 2010). However, in the context of public services, the scrupulous records of clinical social workers' activity stand as the last line of defense against termination on the premise of service inefficiency (Baines, 2004). Without adequate resources, social workers are additionally left powerless to help their vulnerable services beneficiaries, essentially leaving the institutionally underserved to assists the socially underserved and contributing to their subjective distress (Pooler, 2008). Overall, not only have NPM reforms not equated with better primary care (Gray et al., 2015), it has generated greater challenges for social workers who perform an already taxing job (Lloyd et al., 2002). Indeed, the managerial strategies adopted in past decades have led to an exhaustion of the organizational resources needed by workers to perform their tasks, while simultaneously limiting the "subjective resources permitting the individual to define themselves" [translation by author] (Safy-Godineau, 2013: 1), thus removing administrators from the realities of their employees.

Unsurprisingly, Canadian social workers face the highest rates of burnout and work-related stress as a whole (Wulsin et al., 2014; Evans et al., 2005). A social epidemiology study conducted by Wulsin and colleagues (2014) found that within the occupations most impacted by psychological distress in the workplace, social work had the highest prevalence of effort-reward imbalance and experiences of a poor mental health day within the last 30 days. In comparison to high-stress professions, healthcare and social services were additionally ranked third in depression prevalence at 14.60% and stood in close second on its reported need for stress tolerance in practice (Wulsin et al., 2014). Sick leave and staff loss due to turnover among Canadian social workers are also

observed to be unusually high in comparison to other employment branches (Weinberg, 2009) While prevalence of other types of distress is most often surveyed in medical professionals such as nurses, hospital social workers were found to report similarly elevated levels of moral distress (Fantus et al., 2017). The latter were highest during discharge planning when clinical social workers are confronted with insufficient structural resources to adequately support their patients (Houston et al., 2013). As far as secondary traumatic stress is concerned, a condition arising from "witnessing or listening to the accounts of disturbing experiences or traumatic events" (Wagaman et al., 2015: 202), the nature of social work leaves its professionals at great risk. A study by Bride (2007) suggests that 70% of social workers manifest at least one symptom of secondary traumatic stress, which span from simple emotional strain to greater psychological responses, including the experience of trauma itself.

These statistics are said to have only increased over decades of neoliberal reorganizations, namely with regards to moral conflicts in the workplace (Jessen, 2015). Negative workplace experiences are ultimately compounded by a fluctuating autonomy in practice, a rising employment precarity, the difficult conciliation of professional and personal lives, the diminution of available social support and the tying of funds to monitored services of front-line practitioners (Almudever et al., 2012; Ben-Zur & Michael, 2007; Bouterfas et al., 2016; Kim & Stoner, 2008; Marchand, Demers & Durand, 2005; Sánchez-Moreno et al., 2014). Together, these results point toward institutional constraints as a grounding factor for the alarming rates of work-related stress observed among clinical social workers.

The workplace well-being of clinical social workers should additionally not be considered separately from its linguistic context. Subjective appreciations of health are indeed tied to their sociopolitical context of emergence, as past research indicate that francophones report a poorer subjective health (Negura, Moreau & Boutin, 2014) and bear additional responsibilities for their community and their employer outside of their official obligations (Savard et al., 2013). Francophones in minority settings also report high rates of depression (14,3% in comparison to 11,4% in Anglophones) (Chomienne et al., 2010). With regards to objective health outcomes, the literature offers conflicting results on the impact of linguistic affiliation. Gallo et al. (2009) and Mossakowski (2003) both posit the positive effect of cultural belonging in protecting minority groups. Comparative researches nation-wide further argue the lack of significant variation between Anglophones and Francophones in a minority setting (Bouchard et al., 2018; Puchala et al., 2013). It should be noted however that these results originate from general demographic research and may not apply similarly to francophone social workers working in a minority setting. Properly contextualizing the challenges brought on by linguistic affiliation also requires the consideration of the healthcare equity challenges faced by Francophone minorities (Bouchard et al., 2018) and the role Francophone social workers play in advocating for their community. More could be said still on the impact of language barriers on the creation of a therapeutic relationship, central to social work practice, or the pressures of providing equal quality of service in both

French and English. While research on Francophones in a minority setting has diversified, the particular ramifications of this linguistic affiliation in the context of institutional social work remains to be investigated (Molgat and Trahan-Perreault, 2015).

This preliminary literature review on neoliberal management, workplace experience and professional distress in clinical social workers bespeaks the need for a more comprehensive inquiry on the dynamics at play in the Canadian healthcare setting following NPM reforms. We argue that an exploration of the lived experience and identity of francophone clinical social workers is required to situate the current information at hand and refine our understanding of professional distress in healthcare social workers.

Terminology and conceptual clarification

To preface a research project on professional distress, it is essential to clarify the terminology involved and to specify our object of study. The scientific literature on workplace stress comprises many models of occupational stress and concepts of interests which can be easily confused with each other. Indeed, what do we mean by professional distress and how does it relate to burnout, compassion fatigue, moral distress and secondary traumatic stress in general?

Concepts germane to professional distress have been inconsistently wielded in theory (Najjar et al., 2009; Thomas, 2013). Professional distress itself is not a formal diagnosis nor a definite syndrome, but a broader category which subsumes a spectrum of workplace experiences, ranging from sympathetic distress, to chronic stress to burnout (Ekman & Halpern, 2015). For the sake of this research project, professional distress was described to presumptive participants as: “a notion used to encompass the many forms taken by psychological distress at work, including stress, depression, professional burnout, suffering, etc.”. Our purpose is in fact to enrich our understanding of professional distress in clinical social workers based on their social experiences and shared representations in a healthcare setting. We posit that their subjective experience of distress will allow us to access their social representation of distress, which may be different from its medical definition.

An overly restrictive approach to professional distress in clinical social workers would have limited our sample to previously diagnosed cases of professional exhaustion and burnout, thereby excluding the front-line practitioners with likely milder, yet equally valid experiences of workplace stress. Our project being that of a qualitative exploration from a representational perspective, it matters not whether individuals are formally categorized based on expert recognition. Rather, a flexible design allows us to delve into the subjective lives of front-line practitioners as a whole and explore the complex web of meanings and dynamics involved in their workplace experience. Finally, we argue that providing a synoptic view of Canadian clinical social workers’ reported professional distress

is sufficient to unravel its ties to neoliberal reforms, occupational identity and linguistic affiliation concurrently.

To account for the variety of work-related stressors and experiences composing the occupational reality of clinical social workers, we mobilized the concept of professional distress to account for the multiple forms taken by psychological distress at work. These include, but are not limited to, occupational stress (Rout & Rout, 2002), depression (Siebert, 2004), burnout (Lloyd et al., 2002) and secondary traumatic stress (Figley, 1997). Each bear their own particularities in shaping the experience of distress in the workplace. Hence, it is imperative that we may situate them in relation to our object of study: professional distress.

Professional distress is first distinguished from occupational stress. While the 'professional' and 'occupational' semantic components are virtually interchangeable in literature, 'distress' and 'stress' are here understood separately. 'Distress' includes 'stress' in its realm of possible manifestations of psychological strain while reflecting a deeper subjective experience at the cognitive level. 'Distress' is understood, rationalized and incorporated within shared narratives and experiences. It is contrasted with 'stress' as a concept relating to biological indicators of discomforts in the workplace. In other words, 'stress' is limited to a description of acute symptoms in the workplace which contribute to particular illnesses, as it was first theorized by occupational psychologists (Dewe et al., 2012).

We employ professional distress in close conceptual proximity to Dejours' (1980) workplace suffering. While we consider jointly the expected challenges of the social work profession in our exploration of professional distress, we acknowledge the important distinction made by Dejours and Moliner (1994) between 'normal' work grievances and 'abnormal' or 'pathogenic' workplace suffering, described as:

> *"the experience that emerges when the subject faces insurmountable and durable obstacles, after having exhausted every resource to better the real organization of his work with regards to quality and security. In other words, pathogenic suffering begins when the relationship between the subject towards the organization of his work is blocked" (p. 147) [translation by author].*

Indeed, systemic barriers remain at the forefront of our investigative interests and will be highlighted throughout when untangling the dynamics at play in the lived experiences of clinical social workers.

Professional distress as a whole also subsumes more precise experiences of workplace dissatisfaction. Compassion fatigue, namely, presents as a recurring form of professional distress in clinical social workers (Thomas, 2013). It is defined as a type of secondary traumatic stress (STS) and is best summarized by Najjar et al. (2009: 271) as "a secondary traumatic stress reaction resulting from helping, or desiring to help, a person suffering from traumatic events". Eloquently described as the "cost of care" (Figley, 1997), it is most common in

human care workers and involves the difficult balance of interpersonal engagement with self-preserving emotional boundaries (Ekman & Halpern, 2015; Thomas, 2013). Workers are left exhausted from a succession of challenging exchanges and unable to recover, leading to an increase of psychosomatic symptoms to unsustainable degrees (Najjar et al., 2009).

Depression further colours the palette of experiences comprised under the professional distress of front-line practitioners. A study by Siebert (2004) found that out of 751 actively practicing social workers in North Carolina, 19% scores with depressive symptoms on the Epidemiologic Studies-Depression Scale, 20% were currently treated for this condition and 60% identified with the diagnosis. Most importantly, depressive symptoms were found to influence the work experience and practice of social workers, leading the author to support the significance of occupational and personal variables in the condition's emergence. Depressive symptoms (fatigue, concentration troubles, helplessness, insomnia, suicidal thoughts, etc.) are accounted for by the concept of professional distress as elements shaping the psychological reality of the workplace. While no diagnostic claims are made throughout this thesis, the nature of the occupational experience of healthcare social workers is understood in light of these shared manifestations of distress.

While social work as a discipline should not predispose anyone to undue stress, contemporary circumstances of practice have made clinical social workers particularly vulnerable to yet another type of professional distress: moral distress (Oliver, 2013). Mänttäri-van der Kuip (2015) describes this malaise in social workers as an incoherence between permitted practice and morally desired actions, either due to internal or external barriers. Moral distress is then uniquely distinct from compassion fatigue and depression, being neither an exposure to trauma nor a consequence of stress, but a novel experience directly linked to ideological differences in the workplace. Given the incongruencies between NPM standards and social workers' core priorities (Hyslop, 2018), distress of this type should be expected throughout.

Burnout presents itself once professional distress, must it comprise elements of compassion fatigue, depression, moral distress or otherwise, is prolonged and impairs effectiveness. As a condition, it does not necessarily involve the erosion of empathy, but does feature a significant physical and emotion exhaustion rooted in one's occupational circumstances (Bährer-Kohler, 2012). It is best summarized by Lloyd et al. (2002), who characterize burnout by its three most common features: "emotional exhaustion, depersonalisation and reduced feelings of personal accomplishment" (p. 256). The authors further posit that the very philosophy of clinical social work renders its professionals inherently vulnerable to burnout as it facilitates overinvolvement with service beneficiaries.

Of note is the high susceptibility of clinical social workers to multiple kinds of workplace stress given their particular occupational circumstances (Lloyd et al., 2002; Thomas, 2013). Focusing on one at the detriment of others would risk refuting essential parts of the subjective experiences of front-line professionals.

By extending our project's inquiry to professional distress, we may encompass variants of the workplace experience and complexify our analysis to the multiple components at hand. It should be mentioned however that while likely types of distress might be mentioned in support of arguments, diagnostic categorizations and formal condition comparisons will not be made a part of the data analyses, as it defeats this research's purpose. Rather, by considering the shared experience of clinical social workers wholly, this project provides a consolidated overview of professional distress and a glimpse into its inherent dynamics.

Given the inductive approach of the research project, no specific hypothesis was posited to be tested through statistical means. An educated intuition was however required to properly identify the elements at play in the experience and representations of clinical social workers (see in Research strategy, originally and relevance). It was honed by referring to existing occupational stress models. Indeed, contemporary models of workplace stress provide essential insight into the mechanisms involved in the emergence, persistence and eventual alleviation of professional distress. While other theoretical traditions are worth pursuing in the exploration of professional distress (e.g. Dejours' (2007) psychodynamic of work, Clot's (2001) clinic of activity), occupational stress models are of particular interest as they are widely used to inform practices and stress prevention programs (Richardson & Rothstein, 2008).

Currently, three occupational stress models stand as the most recognized by scholars: Karasek's (1979) Job Demands-Control (JD-C) model, Siegrist's (1998) Effort Reward Imbalance (ERI) model and Demerouti et al.'s (2001) Job Demands-Resources (JD-R) model (Schaufeli & Taris, 2014). Each are built upon the same straightforward premise, that "employee health and well-being result from a balance between positive (resources) and negative (demands) job characteristics" (Schaufeli and Taris, 2014: 44). They differ according to their conceptual focus, which shifts between three perspectives: individual, interactional or environmental (Batista-Taran & Reio, 2011). Karaseks' (1979) Job Demands-Control model predicts work-related stress in relation to job demands (intensity and quantity of work required) and individual control (decisional margin and personal level of facilitating expertise). It allows the authors to conceptualise four employment types according to variations in either factors (Karasek and Theorell, 1990). While shown to have been instrumental in correlating various mental and physical health problems to universally applicable working conditions (Batista-Taran & Reio, 2011), the model is not exempt of limitations. As detailed in an article by Marcus James Fila (2016), the JD-C has been widely criticized for its semantic inconsistencies and its failure to account for individual differences. On its own, the model does not account for elements of meaning or symbolic significance in the practice of work. As it isn't intended to reveal the mitigating factors involved in the perception of one's profession, it would be unsuccessful in investigating professional distress beyond restricted organizational and individual considerations.

The two other most influential models of occupational stress, the ERI and JD-R, also fall prey to similar limitations. The Effort Reward Imbalance model

(Siegrist, 1998) was praised for conceptualizing the contractual nature of workplace well-being, whereby reward expectations must balance with the efforts required by the job (Batista-Taran & Reio, 2011). This model better accounts for some subjective factors at play in occupational distress, namely by considering individual motivation and career prestige as components influencing the perceived level of effort and reward respectively. While the ERI model expands on Karasek's (1979) ideas, it remains focused on individual modes of coping. It is hence unsuitable to achieve our thesis' objectives which interrogates shared processes of thought.

Demerouti et al.'s (2001) Job Demands-Resources (JD-R) model, in turn, resembles its predecessors. It focuses on the balance between resources, the positive element of the occupational experience, and demand, the negative aspect of the job, to predict occupational stress. It has gained popularity over its breadth of scope. Indeed, previous models such as the JD-C and the ERI have more restricted variable categories of demand, control, effort and reward. According to Schaufeli and Taris (2014), the JD-R was intended to include any and every type of demand and resource. As the authors contend, this is one of many flaws plaguing the JD-R, which is found lacking in generalizability and epistemological and conceptual consistency. In similar fashion to previous models, the JD-R only applies to individual considerations. Since it was conceived with the strengthen of its correlational abilities in mind, it also requires an important level of specificity, thereby disregarding confounding factors influenced by culture, mindset and group relations.

In recent years, a revised transactional model of occupational stress and coping was introduced by Goh, Sawang and Oei (2010) in an attempt at exhaustivity. This model combines Lazarus and Folkman's transactional theory of stress (1987) with Karasek's (1979) Job Demands-Control (JD-C) theory, thereby considering environmental interactions jointly with greater risk factors. Indeed, Goh and colleagues' model postulates two stress responses in individuals (primary and secondary), based on immediate and longer-term appraisals of their experience. Most notably, the work by Goh et al. (2010) clearly demonstrates the crucial role of an initial appraisal of stress and how it subsequently impacts the experience of workplace stress as a whole along with its outcomes.

While this latest contribution does expand on previous occupational stress models by integrating the aspect of time, its purpose does not align with this thesis' priorities. As with every predictive model, the need for rigid semantic categories and static causalities restrict the apprehension of the workplace experience in its given sociopolitical context. The intersubjective nature of workplace well-being is lost in favour of individual risk factors and concerns. Overall, a review of workplace stress models consolidates the need for a comprehensive theoretical framework to professional distress. Where work-stress theories provide a strong basis for individual outcome predictions, a qualitative inquiry into a shared occupational experience is best carried out with a paradigmatic approach of greater breadth and versatility.

Relevance of the theory of social representations

Social representations' theory presents as the optimal choice to investigate the professional distress of francophone clinical social workers in a Canadian healthcare setting. For context, the paradigmatic approach was first coined by Moscovici (1961) in an unprecedented demonstration of insight into the world of common sense. By revisiting Durkheim's (1898) notion of collective representations, Moscovici aimed at providing a theory for ordinary thought-building and its transmission. Given the transformative and polemic nature of social representations, its founding figure has remained purposely vague in its definition (Doise, 1982). For the sake of simplicity however, this thesis maintains Abric's (2003) summarized description as stated:

> *"A social representation is an organized amalgam of information, opinions, attitudes and beliefs regarding a given object. Socially produced, it is greatly impacted by the values corresponding to both the socio-ideological system and the history of the group from which it is conveyed." (p. 60)* [translation by author]

Following decades of innovation in the field, the social representations' theory now offers multiple investigative avenues for phenomena exceeding disciplinary boundaries at the intersection of individual and social knowledge (Jodelet, 2015). As a unique praxeology, it offers numerous conceptual tools along with an interpretative compass to explore the nature and origin of common sense, its transmission, its transformation and its inner logics within fully contextualized groups and societies. The wide-ranging applicability of the theory of social representations is deemed one of its greatest assets within increasingly intersecting social sciences. Indeed, it differs from most conceptual framework as it "construct[s] scientific knowledge based on the object [of study] rather than on its disciplinary method" (Garnier, 2000: 32) [translation by author].

Given its conceptual breadth, contemporary mobilizations of the theory of social representations have mostly related with one of its three main sub-branches (Rateau et al., 2011): structural (Abric, 1989) sociogenetic (Jodelet, 1989) and sociodynamic (Doise & Palmonari, 1986). Within the scope of this thesis, our research strategy could be said to align at the crossroad of a sociogenetic (Jodelet, 1989) and a critical approach (Howarth, 2006). For one, this thesis not only studies the social representations held by clinical social workers on their professional identity and distress, but their impact on the front-line practitioners' lived experience and interpersonal relations (Jodelet, 2007). In line with the sociogenetic approach, professional distress is situated at the nexus of formative intersections of context (political, institutional and cultural). Experience and meaning are thereby apprehended jointly in an effort to understand the shared occupational thought of clinical social workers within their place of work. The influence of institutional changes can thus be explored with professional distress at its core by highlighting the content and dynamics inherent to the healthcare social workers' social representations. These social representations and the experiences that they inform are further grounded in the clinical social workers'

sociopolitical setting, thereby providing a contextualized understanding of professional distress.

This initial paradigmatic stance pairs well with Howarth's (2006) critical approach to the theory of social representations. To achieve the aims of a social work research, this thesis could not forgo the importance of agency and resistance in the construction of self-identities (Howarth, 2006). To start, the concepts of nucleus and periphery (Abric, 1994) can be retained to argue the structure of the professional representation (Bataille et al., 1997) of healthcare social workers. While germane to a structural approach, these conceptual tools serve first to determine the occupational identity of front-line practitioners, an essential step to its critical appreciation. Interpersonal relations and the clinical social workers' interactions with their respective institutions can then be discussed in light of the legitimization processes involved in the negotiation of competing representations (hegemonic, polemic and emancipated). We also argue that the complex dynamics shaping the lived experience and social representations of clinical social workers is best contextualized with NPM reforms in light of the power relations constitutive of the Canadian healthcare setting. The reification of knowledge systems can indeed be investigated through the social representations' subjectivity levels (trans-subjective, inter-subjective, subjective) (Jodelet, 2008), which relates to the differing operational realities of social representations and the modalities by which power relations can be actualized (Negura et al., 2019).

Ultimately, by retaining a conceptual approach grounded in a given sociopolitical context, we avoid the individualization of a shared professional distress while critically situating the ties between identity, lived experience and language. Professional distress is thereby related to its institutional frame of actualization through the filter of clinical social workers' experiences. This allows us to ponder on matters of agency and veiled administrative intent (see Rivest & Moreau, 2016 as an example). As social representations are indissociable from their cultural, social and political matrix of emergence, their theorization proves congruent with a critical lens of interpretation (Howarth, 2006).

As a whole, the theory of social representations best suits a project on the professional distress of clinical social workers by permitting the concurrent consideration of matters of identity, experience, perception and language under a single paradigmatic approach. This multidimensionality thus facilitates the joint investigation of distinct aspects of the workplace experience while maintaining a necessary analytical coherence. Beyond its descriptive capacity, the study of social representations provides useful explanatory paths of interpretation by interrogating the social dynamics uncovered between and amongst groups (Sauvé & Garnier, 2000).

Moreover, as many proponents of the theory have demonstrated, social representations not only guide professional practices but inform their symbolic significance (Negura, 2016). The occupational group's singular functioning and

logics ought to be known prior to recommending systemic changes intended to diminish rates of burnout, otherwise risking the misrepresentation of the issues at hand. Indeed, it matters more that perceptions and feelings of dissatisfaction be contextualized as part of a shared experience than to restrict our understanding of psychological distress to individual symptom manifestation and resilience variability. In its ability to capture a shared thought on a given reality, the theory of social representations offers more applicable data to initiate a dialogue with professionals, inform their practices and carefully dismantle pervasive beliefs with potentially negative impacts. As eloquently summarized by Howarth (2006):

> *It is not that social representations simply reflect or inform our reality, but that in doing so they become what reality is inter-subjectively agreed to be. What is critically significant here is that different representations compete in their claims to reality, and so defend, limit and exclude other realities. (p. 69)*

Under the theory of social representations, the study of professional distress may hence not only provide critical insight into the subjective lives of clinical social workers but supply the means to initiate positive societal changes. The reflections provided throughout may further support the front-line practitioners' collective ascent to a recognized and dignified profession in the Canadian healthcare setting.

Research strategy, originality and relevance

The research strategy was formulated around the thesis' overarching questions: 1) What socio-professional representations lie at the basis of francophone clinical social workers' identity, workplace experience and professional distress? and 2) How do these shared notions of identity, workplace experience and linguistic affiliation interact to define the subjective appreciation of professional distress in clinical social workers?

Our specific objectives were distributed among four studies on data collected from the same sample of participants. Our first study's goal is to uncover the clinical social workers' social representation of social work in order to situate their professional identity in their context of practice. By this professional representation, we mean to study the self-perception of front-line practitioners as built through shared practices and expertise (Bataille et al., 1997). Ties to neoliberal service expectations and workplace dissatisfaction can then be made by revealing apparent contradictions between occupational beliefs and expectations within healthcare social workers. We proceed with our second study by exploring the ways in which the professional experience of social workers is influenced by the current organizational constraints of the Canadian healthcare setting. Under a representational lens, matters of autonomy, managerial pressures and conflicting expectations can be contextualized together with the subjective experience of participants. These two articles ultimately lay the groundwork for the third study, which focuses directly on the

clinical social workers' professional distress by exploring it in relation with occupational identity and experience concurrently. The thesis then concludes by circling back to linguistic affiliation with the aim to study its impacts on the shared experience of clinical social work as bilingualism is instrumentalized and discussed critically within its minority settings.

To achieve the objectives of this thesis, 30 francophone clinical social workers were sampled equally throughout 3 distinct Canadian provinces, namely Manitoba, New Brunswick and Ontario. This selection was intended to provide a greater degree of representation nation-wide, albeit without the contribution of territorial or West-bound clinical social workers. The participants were recruited exclusively in a healthcare setting and invited to partake in the research provided they identified as having experienced an episode of professional distress within the last year. This eligibility criterion was set in place in order to ensure that every participant could conceivably discuss matters of workplace stress.

While we recognize the important distinctions in workplace experience that may arise in clinical social workers who show more resilience to their occupational conditions, the project aims first and foremost to understand the perspectives of those within the profession that do suffer from distress. In turn, this allows the determination of the nature of this distress, its relationship with current workplace conditions and its ties to identity constraints. From a critical standpoint, this project further sought to unite the clinical social workers who solicit changes in their professional environment. By developing an understanding of the deeper representational elements and dynamics at play in the front-line practitioners' workplace well-being, we hope to provide tools to assist clinical social workers in their pursuit of a fairer, more conducive workplace environment.

The data for this research project was collected from semi-directed interviews held at the healthcare social workers' place and time of convenience. The interview guide (see in Appendices) was composed of three overarching sections: the representation of social work, the formal training and experience of social workers and their professional distress. Matters of linguistic relevance was explored throughout. The research received the full approval of four distinct institutions: the University of Ottawa, the University of Moncton, the University of St-Boniface and the Montfort Hospital (see certificates in Appendices).

The research strategy follows a fairly straightforward approach of qualitative studies of social representations: a content analysis. More precisely, we retained components of an integrated content analysis (Negura, 2006) to support our inductive findings with two key statistical measures. More precisely, the data was coded within the NVivo 11 software, permitting the organization of themes while weighing their respective importance through measures of frequency (i.e., the number of participants whose narratives included this component of the representation) and occurrence (i.e., the number of time a component was mentioned as a whole). Co-occurrences were further mobilized to help determine the underlining relations of particular representational components. These

statistical measures were used as a means to validate the thematic content analysis performed on the interview transcriptions. It comprises three large processes established by Miles & Huberman (1994): the reduction of the data based on the focus of the research, its organization and its verification. After an initial identification of the elements at play, the significance of the uncovered themes was discussed by both candidate and supervisor on the basis of recurrence and coherency among participants.

This analytical method has been shown to be particularly effective to explore the inner dynamics of representational content (Dany, 2016; Negura, 2006) and has been previously established as an effective technique in social representations' studies to explore the more complex subjectivities of shared professional knowledge (Morant, 2006). Our understanding of the lived experience and the socio-professional representations of clinical social workers hinges on this qualitative analysis of content. When focusing on the professional representation and professional distress of front-line practitioners, the use of a basic statistical description as a validating technique further allows us to get a sense of the representational structure at hand, while also advancing our hypotheses on the centrality of the themes uncovered and their relative ties to each other.

Broadly, we argue that the methodology retained for this thesis fulfills an epistemological need. Indeed, the exploration of the influence of professional practices, identities and linguistic affiliation jointly on the professional distress of healthcare social workers has garnered insufficient interest under the theory of social representations. This ought to be rectified, as prior studies have demonstrated the usefulness of mobilizing the theory to expand our knowledge base on work-related stress (de Souza Oliveira et a., 2013) and professional identity (Opazo-Valenzuela & Jarpa-Arriagada, 2018), with much more to be done regarding linguistic affiliation.

A research project on the professional distress of clinical social workers is further made relevant by seeking the betterment of clinical social workers' workplace well-being. By understanding the subjective factors at play in the interpretation of a shared occupational experience, we may first provide recommendations to administrators and policy makers that may mitigate the deleterious effects of NPM reforms. Ideally, we may spread awareness on the causes behind the high rates of workplace dissatisfaction in front-line practitioners. Further, the normalization of the malaise lived by social workers may assist in reducing the guilt incurred by their undue expectation to shoulder the deflected responsibilities of their institution.

Outside the concrete applications of a research on social representations, the discipline of social work itself can benefit from a broader use of the theory. As a research approach, the theory of social representations can assist in consolidating the currently fragmented academic field of social work (Rullac, 2014). Given the theory of social representations' focus on the dynamics between groups and individuals, it relates directly to social work's main concerns, namely exclusion, marginality, social justice and practices (Payne,

2014). In fact, both Abric (2003) and Nagels (2011) suggest that social representations influence the interactions of marginalized groups within society and that its study should not be left to mere description but lead to a general increase in activism and societal sensitization. This is made possible by the fact that the sociogenetic study of social representations is indissociable from the sociopolitical context in which they are shaped. Further, an inquiry on social representations allows us to uncover and possibly explain the components involved in the reproduction of unjust attitudes, beliefs and practices. Finally, this paradigmatic approach may offer insight into the internalized mechanisms of oppression impacting marginalized communities and incite the denaturalization of politically incapacitating modes of thinking (Lorenzi-Cioldi, 2002).

In the realm of work-stress research, this project also contributes to dispel the myth of individual accountability in shared occupational dissatisfaction. While psychosocial risks are placed at the root of work-related distress by administrators and policy makers, employees are made solely responsible for their inadequacy to adapt to stringent NPM reforms. As cogently described by Vidaillet (2013), what is promptly evacuated from the dominant narrative are precisely "the conflicts of interests inherent to a salaried relation" (p. 425) [translation by author] between employer and employee. By focusing on the individual management of professional distress, the institution is absolved from considering its own flaws and implementing changes that benefit the workers at a systemic level. In situating the neoliberal climate of care at the center of the clinical social workers' experience, this thesis counters the normative bias underlining individual-focused research of work-related stress.

Study 1

Social representation of social work in the Canadian healthcare setting: Negotiating a professional identity

Introduction

In North America, the social work discipline possesses a dually professional and academic status. Its rise within the social sciences was hard-earned, as its recognition was persistently fraught with obstacles. Social work was first derided as a work of instinct (Flexner, 2001; Prescott, 2019) with overly situated knowledge and practices. Today, the field is supported by its very own methods and epistemologies, building its legitimacy on autonomous theorization efforts (Rullac, 2011). Controversies persist, however, around the discipline's paradoxes and resistance to definition (Rullac, 2011). While the necessity of social work research is acknowledged even amongst the most seasoned objectivists (Sheldon, 2001), its scientific status continues to be disputed (Gibbs, 2001). Contemporary social work academics have strongly pursued the claim for an applied research unique to the field, steadily advancing its recognition worldwide (Rullac, 2011).

The literature about the social work profession identifies a number of conflicts that derail the path to a generalised conception of social work. Therefore, the construction of a professional identity, said to be the "formulation of foundational stories common to a professional ethos, that is to say a system of representation involving practices" (Chouinard and Couturier, 2006: 176), is jeopardised as it requires some form of consensus, from both the professionals themselves and other stakeholders (Caza and Creary, 2016). This lack of consensus is in part rooted in the history of social work. Indeed, the profession evolved from competing visions, which espoused different ideologies and pursued divergent finalities (Augustine and Gentle-Genitty, 2013), thus rendering ambiguous the "professional ethos" (Chouinard and Couturier, 2006: 176) needed for constructing a professional identity.

A unified view of the profession is further impeded by the breadth of its areas of practice (Fook, 2001; Molgat, 2015). The diversified and challenging contexts in which social workers intervene expose practitioners to situations conflicting with their professional values and in which they find themselves powerless to act according to their core beliefs (Bouquet, 2017). This is particularly true in a healthcare setting, where the social work profession has long been defined in relation to medicine as a "go-between craft" (Beddoe, 2013: 25). Echoing Abraham Flexner's critique in 1915, early 20th century sociologists and doctors invoked the need for social workers to present a unique knowledge base to assert their distinctiveness from other disciplines (Beddoe, 2013). While much has been achieved by social workers over the past century to transform the biomedical paradigm to a psychosocial one (Beddoe, 2013), this "knowledge

base" required to claim the discipline's uniqueness has yet to be clearly defined and is said to rely too heavily on outside theories (Thyer, 2002). This debate continues today with arguments for social work to be resolutely multidisciplinary (Verba, 2012) and/or to distinguish itself as more of a "social engineering" field of study (Vulbeau, 2011).

Despite these points of contention, there has been limited interest in how representational divides about professional identity impact the daily experiences of social workers (Webb, 2016). Only recently has a growing body of research on the subject emerged. Staniforth, Beddoe and colleagues (2016; 2017) have shown how social workers in New Zealand underestimate the public's perception of their profession and experience great ambivalence in their self-perception, oscillating between pride and stigma. While research to date has been promising, further research is still required to deepen our understanding of the professional identity of social workers within varying contexts and to comprehend how they experience these symbolic disparities.

The importance of identity dynamics in a professional context

Zouhri and Rateau (2015) argue, like many researchers before them (Blin, 1997; Breakwell, 2011; Cohen-Scali and Moliner, 2008, etc.), that social representations are intrinsically linked to social identities. Social representations both aid in the construction of social identities cohesive with group norms and are defined by the identity-oriented goals of such groups (Zouhri and Rateau, 2015). Since it is imperative for intra and inter-group functioning, a lack of consensus on social identity comes at a substantial cost. As Asquith *et al.* (2005) report:

> "Whether in crisis or not, there are clearly a number of serious issues confronting the profession of social work which are not simply to do with shortage of numbers and resource distribution. Rather, the "crisis" has more to do with loss of professional identity, which impacts on recruitment, retention, and service provision" (39).

To explore this line of inquiry and to further our understanding of how social workers view their professional identity and its impacts, we interviewed social workers practicing in a healthcare setting. Front-line social work practitioners are of particular interest because their organisational context requires them to reconcile competing demands between service users and health care institutions, while juggling with the values inherent to their code of ethics and the priorities imposed by their employers (Bouquet, 2017; Gallina, 2010).

On employing social representations to explore professional identity

A professional identity far exceeds the particularities of a label, since the group that it defines is required to transform expert knowledge into practices, where

reified and consensual universes meet (Grossi Porto, 2018; Moscovici, 1979). This junction is precisely what the theory of social representations seeks to explore. Both a process and a result of social thought, a social representation has as its object something significant to a given social group (Negura & Lavoie, 2016a). Professional identity not only has symbolic value to social workers, but also has value in practice: it informs action and at the same time is reinforced or transformed by the practices themselves.

Social representations contribute to the identity of groups, in this case the professional group of social workers, by allowing them to define a symbolic social positioning and to rely on social objects to assert the specificity of the group and enhance its value (Cohen-Scali and Moliner, 2008; Deschamps and Moliner, 2012; Duveen, 2001; Oyserman and Markus, 1998). This social representation does not exclude diverging views and each individual's margin of influence upon it (Doise and Palmonari, 1986). The representation is further understood as an organised apparatus of thought, where each element has influence on and is important to the overall structure. Central elements primarily inform the thought process and resulting action in contrast to peripheral elements, which, although not as influential, are most receptive to change and likely to evolve over time (Abric, 2005). Such structures of social representation must be explored in order to uncover the intersubjective dynamics at play, not only in the construction of a professional identity, but also in its preservation, transformation and exteriorisation in practice (Negura, 2016). In this perspective and in order to gain a broader understanding of the professional identity of social workers, this article examines the specific content and organisation of the social representation of social work through professionals' view of their field and their perceived position with regards to their community, colleagues, workplace and service beneficiaries.

Method

Sample description

Our sample consisted of 30 participants from three Canadian cities: Moncton, Ottawa and Winnipeg, with equal numbers from each city. All of our participants were female francophone social workers practicing in healthcare settings (see Table 1).

Table 1
Distribution of the sample (n=30)

Sociodemographic characteristics		(n)
Age	20-25	1
	26-35	15
	36-45	10
		2

	46-55 56-65	2
Municipality	Moncton Ottawa Winnipeg	10 10 10
Years in current position	0-5 6-10 11-15	15 11 4
Workplace setting	Institution Community	25 5

This sample remains consistent across every study comprised by our research on the professional distress of clinical social workers. In every case, the participants had to identify as having experienced professional distress, described to them as "a notion used to encompass the many forms taken by psychological distress at work, including stress, depression, professional burnout, suffering, etc.". This definition was created by the research team and was provided to participants in the interview guide to clarify the object of our study. The sample had two additional restrictions: the participants had to identify as francophone and female. This served our overarching inquiries in that it is hypothesised that francophone women in a minority setting would experience greater challenges in the workplace. While our sample presents some restrictions, we believe that these factors do not significantly alter our results on professional identity: which is more contingent on prevailing cultural mentalities, knowledge base and daily practice (Fargion, 2008). The implications of theses methodological limitations are discussed later in the article. Crucially, the professional representation (Bataille, 1997) of clinical social workers has to be explored in order to situate the front-line practitioners within their work environment and to account for the dynamics at play in their shared experience of professional distress.

Our participants were recruited through a combination of means, namely by *viva voce*, in-person meetings with teams of social workers and posters in community organisations and institutional healthcare facilities. No remuneration was provided and the interviews were held in a setting chosen by the participants. The interviews were audio-recorded and transcribed in their entirety. To preserve anonymity, respondents were asked to either choose a pseudonym known only to them or accept that one would be given to them at random. This research received the approval of the University of Ottawa's Research Ethics Committee.

Data collection

All the data were obtained through semi-directed interviews that were audio-recorded and transcribed. The verbatims were translated by the authors from French to English, with as little modification in the phrasing as possible. The

interview guide was subdivided into three large themes: the representation of social work, the formal training and experience of social workers and their professional distress. For the purpose of this study, only the first theme was analysed and discussed. This section of the interview explored questions such as the behaviours and values held by the social worker, the image of a social worker in society and the view of the profession thought to be held by service beneficiaries, colleagues from other professions and workplace administrators. Additionally, to encourage the production of extended responses on the topic of social work, we used a word evocation technique where participants named up to eight words best characterising their profession and provided each word with a personal definition. The participants then had to select the two most important terms and elaborate on their significance. Employing a specific questioning technique called the "mise en cause" method (Moliner, 1988, 1994), they were invited to indicate whether every selected word was necessary for social work to be described as such. Such "non negotiable" components are essential characteristics of the central elements of a social representation (Moliner, 1988, 1994) and were thus retained as a centrality criterion during the analysis of the representation's structure. The transcriptions of the interviews were formatted for Nvivo 11, a software designed to thematically organise unstructured qualitative data such as interview transcriptions, in order to facilitate qualitative analysis.

Data analysis

To uncover which parts of the social workers' narratives pertained to elements of the social representation of social work and their relative importance within it, we performed an integrated content analysis (Negura, 2006). Through the NVivo platform, we isolated the content characterising the discourse around social work. By means of a thematic analysis, significant ideas regarding social work were drawn from the transcriptions. This allowed us to identify the elements relevant to the representation of social work. These elements were then contextualised in light of their organisational properties, such as their importance, influence and positioning within the structure of the social representation. Relevant text fragments were grouped into a corresponding semantic unit (or fundamental element). These units were then linked to each other by means of a thematic arborisation, a process best described as relating the semantic units to each other in terms of conceptual proximity and importance, thus modelling the emerging structure of the social representation. The weight of each representational element was subsequently determined according to its frequency (i.e., the number of participants whose narratives included this component of the representation) and occurrence within interviews. The meaning and significance of each proposed element was ultimately determined by the co-occurrences underlining the relations between one element and the others. Subsequently, the test of centrality using the "mise en cause" method (Moliner, 1989) allowed us to distinguish between central and peripheral elements of the social representation (Abric, 1994) and to determine its larger structure. Lastly, the contradictions between the representation of

social workers and what they perceive to be the views of others were explored as mirrors of more conflictual, less attractive aspects of the social representation of the profession. Because social identity is constructed in part by looking at oneself through the eyes of others (Machat-From, 2017), these perceived views of others must be taken into account.

Results

Four elements were uncovered at the foundation of the social representation of social work: "counselling for support", "empowerment and respect", "social justice" and "compassionate vocation". Other elements of the social representation were found by exploring social workers' perceptions of the view of "others'", including society, patients, colleagues and administrators. Considering professional identity from an outside perspective helped uncover conflicts that mirrored nuances of the social work identity. Ultimately, every element of the representation provides crucial insights about the social work profession and has a substantial impact on the way social workers carry out their work on a daily basis.

A profession of the heart: A reflection of core values

Counselling for support

Four recurrent representational elements were extrapolated from the narratives. The most widespread element, found in 27 distinct interviews and alluded to 54 times, pertained to the role of counsellor who provides generalised support, the main function being to "find solutions" to problems. We labelled this element "counselling for support". This role involves referring service beneficiaries to outside resources, being a "tool box" of sorts, but, importantly, not imposing a course of action. Rather, the prevailing idea was that of collaborative guidance provided by social workers, less focused on imposing norms of conduct than on helping the clients progress in their lives as they intended:

> *In social work you really need to understand where the person is in their journey and know where they want to go because you can't just give them solutions, you need to let the person find their own answers. - Monique*

This observation is supported by the fact that empathy and the ability to listen, which are characteristics of a very humanistic approach to practice (Payne, 2011), were recurring notions when describing social work through the word association exercise.

Empowerment and respect

Empathy and ability to listen are linked to another important element emerging throughout the interviews, that of "empowerment and respect". Where "counselling for support" was identified as a clear duty, the element "empowerment and respect" reflects a value held as "sacred" by the professional. Although not mentioned by as many participants (26) as the first theme, the "empowerment and respect" element had the greatest number of references (86), indicating that while less prevalent, those who did mention it were more convinced of its importance.

Social workers indicated a desire to restore an individual's power to act and improve their own lives. They also manifested a genuine humility in the awareness that as much as they have an expertise to provide, they also learn from their service beneficiaries. Further, to practice in an empowering fashion, social workers spoke of the importance of acceptance and of the dangers of judging someone. Without this right attitude, the necessary therapeutic relationship based on honesty is compromised:

> *The absence of judgment means learning to know the person with their own values, their own ways of thinking, their education […] - Laëtitia*

For social workers, empowerment and respect are hallmarks of the profession that distinguish it from other professions. While advice can be given by any well-intentioned individual, the uniqueness of social work lies is the combination of expertise and a collaborative approach that aims to help people realise their full potential:

> *[…] it's really to me the fundamental purpose, it's to help people become better persons. To improve […] to build on their strengths, their abilities, to empower them as we said. - Laëtitia*

It is important to add that while this respect is seen as inherent to the culture of social workers, the respondents made it clear that it is by no means passive. As for truly learning from others, to be a social worker one must actively put aside one's prejudices and constantly aim at reflecting the values embraced by their profession.

Social justice

Appropriate practice is also pursued at the macroscopic level, with "social justice" being an element of importance in the definition of social work (23 respondents; 59 references):

> *To me, I think it's [social justice] at the basis of why there are social workers. It is the foundation. - Bella*

While identified as a *sine qua non* characteristic of the profession, this representational element is controversial for front-line practitioners. Indeed, the institutional setting of the majority of our sample impedes or even completely prevents front-line practitioners from seeking change either within or outside the system that employs them:

> *There are limits with the government and it often requires of social workers to reinforce policies that are not, uh, that don't fit well with social values. – Bella*

As revealed in many of the narratives, social workers face daily conflict in an environment that does not align with their values and which has authority over the way they choose to carry out their practices. In acts of small rebellion and as a way to maintain their professional integrity, social justice is sought regularly, even daily, by advocating for the service beneficiaries and standing by their side when faced with a reluctant system of care:

> *Again, it's linked, to me, with social justice that our role is, very often, to be the voice of compassion, especially in systems where there is little compassion for people. - Bella*

In this sense, social workers may respond to the needs of service beneficiaries before those of their employer by endorsing the roles of guides, counsellors and problem-solvers.

Social work as a compassionate vocation

The only element that was not described in terms of concrete actions and endorsed roles was that of "compassionate vocation" (24 respondents; 51 references), an element better understood as a charitable disposition shared by social workers:

> *It's like in old times, you know, nuns were dedicated to doing good all around them. For me, social work is a vocation. […] I imagine that we are comfortable in that role because we're dedicated, we want… it's like we are made for this. - Fleur*

The history of social work is rooted in charity and has now partly replaced the church in many traditional roles (providing food to the poor, finding housing, providing guidance, welcoming refugees, etc.). There has been a humanist appropriation of the religious principles that used to shape the rationale of collective assistance. These compassionate undertones are employed as an additional indicium of social work:

> *As an ergotherapist, physiotherapist, you do treatments, you practice therapy. In nursing, you do all that. But us, we are bearers of hope. - Sasha*

This distinction is of utmost importance as it manifests in the very way front-line practitioners talk about social work, outside of the medical lens and closer to a humanistic orientation anchored in the importance of the human condition. It appears as though social workers resist the dominant medical paradigm, even when performing clinical work, in an effort to make up for increasingly impersonal services and to remain true to who they are:

> *I think, to me, social work requires as much brain as it does heart. When we bring all of it into a situation, we can often help. - Mireille*

The shared ethos of unprejudiced engagement and vocational work serves a dual purpose. It helps define the profession, and it also functions as a rationale for remaining in a difficult position, for continuing to practice a profession characterised by challenges. The expressed difficulty of social work is reflected also in how respondents describe other peoples' representations: they recall often hearing colleagues from other professions saying: "I could never do what you do". Outside the pragmatic imperatives of the medical lens, social workers justify taking on the hardships of the underprivileged by this call to help those around them:

> *When I graduated, my mother told me "all your life was a preparation for becoming a social worker". So, for me, social work is something that, for me, it's in my heart. - Alasha*

The reward is not one of prestige: it is best compared to a spiritual journey.

> *When you are in context with people who are suffering, there is something really special that happens with them when they see that you are present for them and that you are contributing in some way to help them -- to me, it's a profound privilege which reaches my soul. – Mireille*

<u>Others' views of social work: A source of tension</u>

A complementary occupation

The dissociation from a medical paradigm is confirmed by the social workers themselves when questioned on the representations that others have of social work. Practitioners reported that colleagues of other disciplines recognise that they bring something unique to healthcare services, usually characterised as "complementary". However, this so called "complementary service" is poorly

understood by colleagues of other disciplines and is experienced by social workers as chaotic, with sometimes muddled expectations from interdisciplinary teams. The perception of colleagues outside the profession is viewed as a double-edge sword. Two thirds of respondents report being respected by the interdisciplinary team members even though their work is seen as "less medical":

> *I think they really see us as allies, like we are part of the team even if we are less medical than everybody else. - Michèle*

At the same time, social workers face condescension, and are viewed as mere appendages of the medical system:

> *It's anything goes, very minor things that have nothing to do with our profession sometimes, but it's like everyone can do that really, but no, it's like "oh, [ask] the social worker". It's in the tone in which it's being asked sometimes. […] For us, it's like we're always stuck plugging in the holes. - Fesefel*

A misunderstood profession

Colleagues' misconceptions do not appear as jarring as the obliviousness of administrators whose lack of knowledge of the profession was mentioned by more than two thirds of respondents and referenced 31 times:

> *I don't think they know about all the things that we do, at all. […] I don't think they recognise how much we prevent readmissions or understand the importance of taking the time to address a social problem precisely to prevent someone from coming back to the hospital, you know. – Michèle*

Moreover, this misconception is characterised by a paradoxically reductive view of the profession. Social workers are expected to be involved in all problems with a social origin (thus viewed as broad) yet with a skillset and mandate confined to case management. This lack of understanding between employee and employer creates distress in daily work, especially as administrations adopt business models that are devoid of humanity and care for their employees:

> *The administration doesn't take the time to meet employees. You're not taken care of, you're a number, you're an employee, you work, you do your work. – Rachelle*

Additionally, because there is a lack of knowledge about what social workers can effectively bring to the table, front-line practitioners report not being involved in decision-making processes that have a direct impact on their day-to-

day work. This systemic pressure to conform to managerial norms regardless of the realities experienced by social workers is maintained in part by knowledge barriers and an absence of dialogue. Such an inaccurate representation of social workers by those in power hinders social workers from practicing in accordance with their values and, as a result, fails to dispel some of the prejudices held by the population at large.

Child Snatchers

The negative view that social workers believe is held by society weighs heavily on practitioners. The most recurring notion in the testimonies of social workers is that society thinks of them as "child snatchers", an image still heavily imprinted in the collective imagination:

> *We are often linked to the social workers who work for child protective services. It happens a lot, a lot, when I go to introduce myself as a social worker that people reply: "oh, well, I don't have any kids" or "ah, I hate you, you take away children". - Lillian*

Social workers' self-perception as devoted caregivers clashes profoundly with the view society has of them as agents of control who steal children from their families. This contrast is only partly mitigated by the complementary representation thought to exist in society and mentioned by only a minority of social workers (four to be precise), that of "aid providers":

> *And, in society in general, I also think that people imagine that social workers […] are going to save you, that they will find solutions to impossible situations. - Fleur*

Saviors and punishers

A contradictory representation, where both negative and positive aspects of social work are present, is reflected in a view deemed to be held by service beneficiaries:

> *We can be the people that are going to help, to save, to find solutions to social problems, but also the people that are going to call child protective services or that are going to, you know, enforce justice or whatever. - Philomène*

Social workers believe that service beneficiaries hold a similar view to that of society in general. Their representation becomes more positive once they actually get accustomed to social workers and become aware of their services. Further, when service beneficiaries are aware of the help that social workers

provide, the latter report that the beneficiaries' views can skew to another extreme, where front-line practitioners are expected to be miracle workers:

> *It seems like the words "social worker" means the person with the magic wand. So, I would say we are perceived a bit like a magician. - Sophie*

These unachievable expectations unavoidably generate conflicts when social workers are powerless to fulfill all of the requests made to them. They are then deemed to be the perpetrators of a negative outcome:

> *Sometimes, they see us as the point of control. Either we give them funds, or withhold them, and they don't understand the policies and the practices that are behind this. - Rayne*

This representational element of "aid provider", as such, is inextricably enmeshed with the control social workers are thought to possess and exert freely in society.

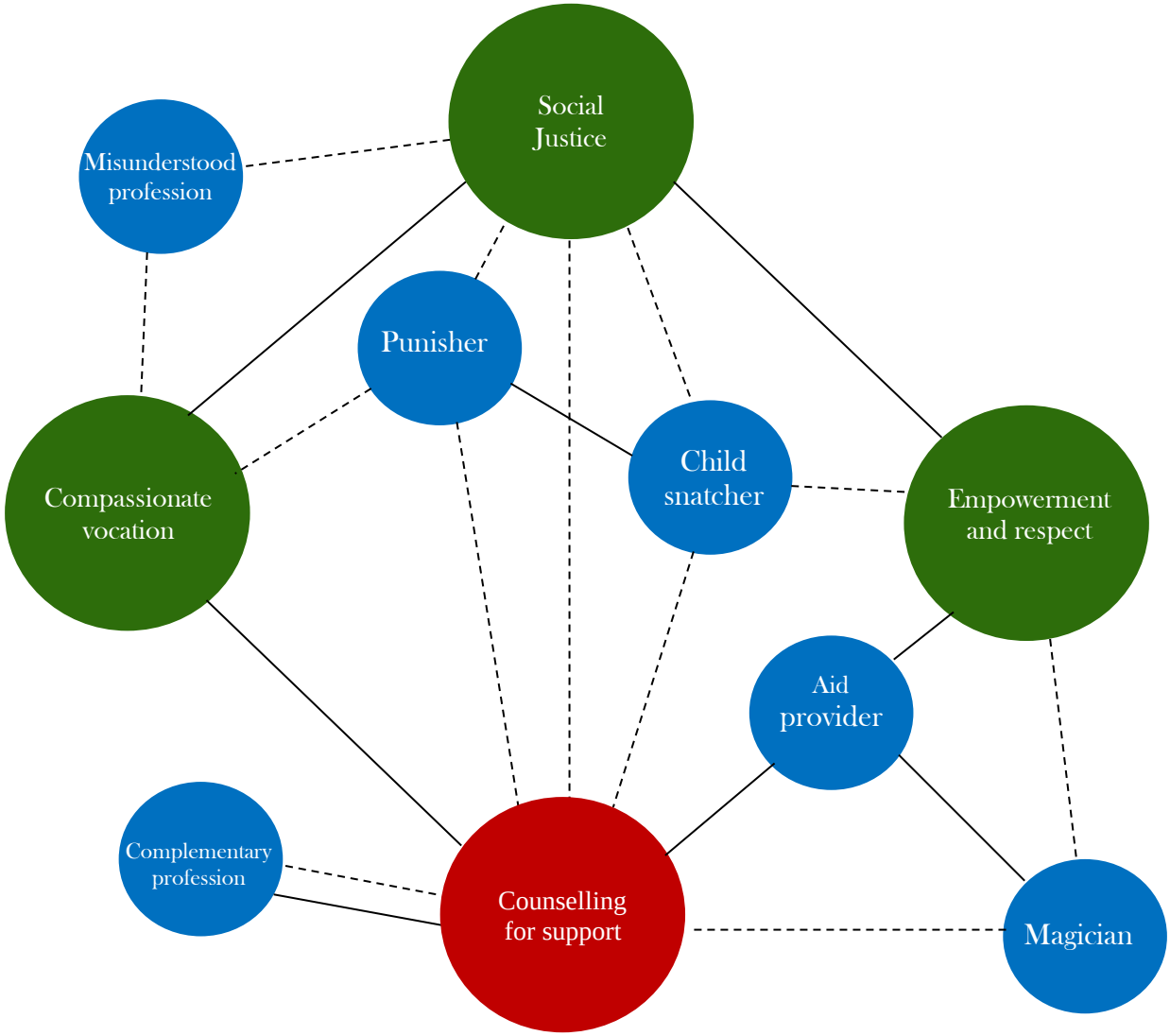
The structure of the social representation

We now turn to a description of the overall profile of the social representation. To this end, we provide a synoptic view through a diagram of its central and peripheral representational elements, designed to illustrate the dynamics at play and the relative importance of each element (see Figure 1). Moreover, the importance of each element within the structure can be clearly apprehended with the table of frequencies below (see Table 2).

Table 2
Frequency of elements of the social representation of social work

Element of the representation	Number of distinct sources	Number of occurrences
Counselling for support	27	54
Empowerment and respect	26	86
Compassionate vocation	24	51
Social justice	23	59
Misunderstood profession	22	31
Complementary profession	20	24
Child snatchers	16	17
Punishers	8	10
Aid providers	8	8
Magician	4	4

Figure 1
The structure of the social representation of social work



Legend

- Peripheral element reflecting the reported representation held by others
- Central element of the social representation of social work
- High frequency peripheral element of the representation (not central because it is not a "necessary" element to represent social work)
- Oppositional bonds in the representation
- Reinforcing bonds in the representation

Discussion

The four pillars of the social representation

There is much to unravel in the answers provided by the participants. Let us begin with the four high frequency elements of the representation: "counselling for support", "empowerment and respect", "social justice" and "compassionate vocation". These are all mainly value-based and framed by a client-centred expertise. Each is characterised by its own specificities, influence and significance within the social representation and thus will be discussed separately below.

Counselling for support

The "counselling for support" element is paradoxical in the representation of social work. It is the most recurrent element of the representation across participants (Table 2), yet, it fails to be deemed a "must-have non-negotiable feature" of social work and, as such, cannot be considered central. This contradiction reveals a disparity between idealised and actual practice. What is expected of social workers, particularly in an institutional setting, is at odds with the true purpose of the profession. These results corroborate earlier findings (Carpenter and Platt, 1997) where the professional identity of social workers was manifestly strained by the pressures of the health care system in which organisational constraints prevent some key values of the profession to be put into practice, mostly those pertaining to social justice and compassionate care.

Hence, while it can be complementary to the central elements of the professional identity (for instance by encouraging activism with individual support), the "counselling for support" element is rarely described as a means to further social change. Rather, it affects most aspects of daily practice. This element has a particular focus on practical and contextual expertise and on problem-solving skills. These very competencies are used only with a non-judgmental approach founded on a concern for collaboration and human empathy. This very state of mind is embodied in the second representational element, "empowerment and respect".

Empowerment and respect

"Empowerment and respect" typify the attitude behind the practice of social work, characterised through values such as "non-judgement", "honesty", "empathy", "listening", etc. and identified as necessary to make social work what it is. Described as an active pursuit of positive individual change, this element frames the essence of practice for social workers, who are also expected to learn from the service beneficiaries that they advise. The "empowerment and respect" element is greatly affected by the negative representations thought to be held by others. It contradicts peripheral elements such as "child snatchers"

and “punishers”, which are viewed as oppressive and ill-intentioned. Further, it is compromised by a more insidious peripheral element of the representation, that of “magician” which, although positive in appearance, removes all agency from service beneficiaries and overwhelms front-line practitioners with unrealistic demands. The role of the community and social networks, essential in social workers’ interventions, ends up being overlooked by those in need of help.

Consistently facing flawed expectations of practice comes at a great cost to social workers. While more empirical research is needed, Chouinard and Couturier (2006) are convinced that feelings of inadequacy and ultimately distress arise in social workers when social and professional identities do not align, particularly in the case of contradictions between the self as viewed from within and the self as reflected by others. This disconnect is further reinforced in our subsequent central element: “social justice”.

Social justice

The “social justice” element suffers similar tensions and oppositional dynamics in the representation. “Social justice”, like “counselling for support”, refers to tangible tasks and lines of action, namely those of advocacy, activism and community service. That said, since it fails to be put into practice in the healthcare setting, it is rather idealised in the representation and comes into conflict with both the actual practice and peripheral elements of the representation. While influenced by peripheral elements such as “child snatchers” and “punishers”, it is mostly hindered by the “misunderstood profession” element, which reflects administrators’ and colleagues’ flawed expectations of practice. This element was discussed by our participants mostly to mitigate the risk of forgetting what they stand for and the purpose of their profession. They stressed the fact that social workers are greatly burdened by the impositions of the healthcare workplace, which fails to wholly respect their professional identity and to recognise their contribution.

Compassionate vocation

Finally, even more deeply anchored at the center of the social representation is the pervasive sentiment that colours every aspect of the profession, the backdrop of the entire representation, which we labelled “compassionate vocation”. Focused on results which echo humanistic practices and philosophies (Payne, 2011), social work is imbued with a deeply humbling quality, where its professionals are both called upon and shaped by the profession to follow a humanitarian mission and bring positive changes within and outside the pragmatic confines of establishment-imposed mandates. As mentioned by the participants themselves, the roots of the profession date back to charity workers (Walkowitz, 1990), whose engaged nature and altruistic ethos have been inherited by today’s social workers. The participants’ narratives reveal that this

element assists in distinguishing the profession from others, and also serves to protect them by constructing a rationale to endure daily hardships. Further, this very rationale can serve as a warning for candidates to the profession: only those who are motivated by the necessary set of values should pursue their ambition.

Other's view of social work: a chronicle of misconception

An entirely new facet of the social representation of the profession was revealed when social workers were asked how they thought others viewed them. Revealing how social work is misrepresented at various levels of interaction (in society, with beneficiaries, with interdisciplinary teams and with administrators), the respondents deplored the prevailing negative view perceived to characterise almost all representations outside the profession. For society and service beneficiaries, social work is systematically associated with child protective services, an agency with a controversial mandate. Seen as oppressors and agents of control, social workers are perceived as the opposite of how they view themselves. As victims of a persistent fallacy, respondents argue that they are unable to dispel it, since the organisational context of their workplace hinders attempts at systemic changes and activism. Hard pressed to lead militant efforts, social workers thus engage in small acts of rebellion by prioritising their role as allies to those seeking support, a coping strategy observed by Lipsky (1997) in so-called "street-level bureaucrats".

A second issue arises when exploring the perceptions of interdisciplinary teams and administrators. While these perceptions are not negative *per se*, the profession is still poorly understood and thus lacks boundaries. Indeed, social workers in our study affirm that they are often tasked with menial work completely outside of their field. The fact that they report being the only ones asked to perform such tasks is seen as a discriminatory practice. Although most of our sample reported feeling accepted and, to some extent, respected by their medically-oriented peers, this is contingent on providing "complementary" services that respond to the needs not specifically assigned to other professionals.

Implications of the social representation on practices and the workplace experience

Until recently, there had been little discussion of how professional experience and practice are influenced by inter-relational and representational dynamics. In the work contexts of our participants, being a social worker involves dealing daily with the misrepresentations of figures of authority (interdisciplinary teams and administrators) who contribute to set expectations and mandates. This constant negotiation of roles leads to heightened tensions between service providers, colleagues, administrators and society in general.

Institutional constraints also involve the gradual disconnection of social workers' formal practices to promote a professional activity often far removed from their recognised mandate. This leads to a devaluation of the profession for its lack of focus and standardised approach (Thyer, 2002). Caught in a vicious cycle, social workers seem to be guilty of wanting to make up for limited services, to prove themselves useful to their interdisciplinary team and to attest to the wide skillset required to enter the profession. Further research on the matter would offer the possibility to focus on what these power dynamics, which result in broad and imprecise workplace expectations, entail for social work teaching and training.

As a first crucial step, this study has revealed the dissensions at play which affect social workers' self-perception. Our findings have specified the particular elements shaping the social representation of social work, their relative importance and the dynamics that tie them to each other. Through an integrated content analysis, matters of context were understood within the framework of the social representation, thus revealing the strong influence of organisational protocols, work conditions and direct administrator relations in the construction of professional worth. Specific lines of action to target the systemic flaws that plague social workers in a healthcare setting would provide a much-needed contribution to workplace strategies and best practices that ensure the well-being of all.

Limitations of our research

As mentioned above, all participants in our sample have experienced an episode of professional distress in the past year. This specificity may have generated some nuances in the content of the social representation of social work due to a more negative bias within their or others' views. Their experience of distress may have aggravated some of their perceptions in a manner which we are currently unable to identity. Furthermore, we cannot claim to have interviewed a representative sample of social workers in Canada. While our sample is regionally diverse, our data on professional identity carries two areas of focus in the healthcare setting: the gendered and linguistic reality of francophone clinical social workers. Additional studies on the social representation of social work could further contribute to our understanding of the profession by actively considering other factors such as gender, culture and linguistic affiliation. Nonetheless, we hope that our results will be of interest to academic and professional social workers alike, as they help us understand the social representation of social work, its structure and genesis, and how it both impacts and is impacted by workplace dynamics.

Conclusion

Our research has aimed at furthering academic debates on the professional identity of social workers by studying how they view their profession. In contrast with many theoretical discussions, the exploration of their representation of

social work has real implications in day-to-day practice. Our study demonstrated the fundamentally contentious nature of the professional identity of social workers. Four elements, three of which were central, were found to shape their social representation: “counselling for support”, “empowerment and respect”, “social justice” and “compassionate vocation”. We discussed how each has implications in the daily practice of the profession, the cultivation of resilience and the core values at the centre of idealised and actual practice. Organisational constraints appeared to be at the root of contradictory practices in a healthcare setting, maintained by the biases of administrators and interdisciplinary teams. The internal tensions within the representation of social work arose mainly from discrepancies among the views held by social workers, service beneficiaries and society at large. Front-line practitioners argued for the importance of educating colleagues, administrators and the general population on what makes social workers who they are, so as to allay persistent misrepresentations, to make those in need willing to seek help and, they hoped, to make their professional lives easier in the process. We urge researchers to delve further into the implications of the social representation of social work and its significance for other social workers outside the clinical and/or institutional context.

Study 2

Organizational context, healthcare reforms and professional distress in Canadian social workers: understanding the epidemic

Healthcare reforms and social work: a tumultuous affair

Healthcare in Canada has been the subject of numerous reforms over the past decades. These reforms have been introduced by provinces which have all kept with the general tendencies of the *New Public Management* (NPM) (Hutchison et al., 2011). Briefly, in the healthcare sector, NPM equates the management of public services with the management of services in the free market and seeks the optimization of services primarily through an efficient use of economic resources and consumer-centered interventions. As such, it promotes a result-oriented governance for both patients and taxpayers (Sebai & Yatim, 2018).

Within every reform, the cost of public services was amended with the highest scrutiny. This has led healthcare institutions to foster business-like order, expecting evermore quality, efficiency, professionalism and overall devotion from their employees (Bart & Hupfer, 2004). The computerization of the workplace has paved the way for the constant monitoring of front-line practitioners, whose work hours are increasingly devoted to filing reports, work notes and minutes for every act performed in what is now called the "bureaucratization of social work" (Burton and van den Broek, 2009). These scrupulous records are a key factor in obtaining funding for community organizations and public institutions alike. The required constant amelioration in service is paired with the will to optimize expenses, so as not to indulge in frivolous public spending. Under such scrutiny, social workers have to grapple with increasing austerity and licensure dubiously rationalized in terms of deficit control (Baines, 2004). To ensure the renewal of funding, institutions are thus forced to increase the demands addressed to their employees without additional resources.

The performance pressures arising from this acute monitoring have not necessarily resulted in better primary care. As the unit of measure of performance is that of reports, bureaucracy has been placed at the forefront of work priorities, even superseding patient/client care itself (Burton & Van den Broek, 2009; Gray et al., 2015). This shifting emphasis has been particularly challenging for social workers, whose ethics compel intervention and client interaction above managerial duties (Burton & Van den Broek, 2009). Social workers in a healthcare setting have also been requested to reframe their professional role from a value-based setting (deemed inefficient) to standardized practices (mainly evidence-based), which are better suited to broad monitoring and institutional integration (Walshe & Rundall, 2001).

The gradual erosion of humanistic principles through organizational constraints has been difficult for social workers and is strongly associated with rising tensions and workplace dissatisfaction (Burton & Van den Broek, 2009). Although significant, the complexity of this association has not been fully explored. The most predominant reported effect of organizational constraints for this occupational group concerns the transformation of the mandate of social workers to a regulatory-based practice, thus prompting value conflicts and moral distress (Jessen, 2015). A limited autonomy in practice, the difficult conciliation of professional and personal lives and the tying of funds to monitored services have also been shown to negatively impact the work experience of front-line practitioners (Ben-Zur & Michael, 2007; Bouterfas et al., 2016; Kim & Stoner, 2008). This comes in addition to the fact that social work is known to be amongst the professions with the highest rates of burnout and work-related stress (Wulsin et al., 2014; Evans et al., 2005). Yet, the questions of how and under which conditions organizational constraints affect social workers' well-being, although crucial, has seen little empirical exploration under the lens of social experience and professional representations. Rather, workplace stress theory dominates the broader inquiries about healthcare professionals as a whole.

We know from the founding figures of the theory, Karasek and Theorell (1990) and later Siegrist (1998), that autonomy, social support, higher demands and discrepancies between effort and reward are determinants of workplace well-being. In the context of neoliberal reforms, healthcare professionals' occupational welfare is primarily threatened by two overarching factors of professional distress (Lornudd et al., 2015; Vézina & St-Arnaud, 2011): a deficit in managerial support (Blackstock et al., 2014) and a reduced job control (discretionary autonomy) (Day et al., 2017; Wilson, 2015). While highly relevant, the available literature offers limited insight into the lived experience of healthcare social workers outside individual determinants of well-being. A qualitative inquiry is further required in light of the organizational changes observed in healthcare institutions following the advent of NPM.

Social representation theory and the workplace experience: toward a deeper understanding of professional life

We turn to the theory of social representations in order to consider the complex subjectivities inherent to the front-line practitioners' shared self-perception. Occupational stress models, while useful, often fail to account for interpersonal conflicts, individual differences and the broader sociopolitical context faced by Canadian clinical social workers in a healthcare setting (Fila, 2016). Similarly, few work-related stress studies have investigated the professional lives of healthcare social workers as a matter of shared experience (see Graham & Shier, 2014 for how expectations of social workers affect their workplace well-being). This experience, as per its meaning within the social representation theory, is best defined by "the behavioral logics which the social actor combines and prioritizes to shape his subjective self" (Negura, 2017: p. 106). Under the theory of social representations, the shared experience of clinical social workers is

understood as a dynamic, ever-transforming social reality, where the individual conscience both reaches and is reached by its group's cognitive elaborations (Jodelet, 2006b). Multiple objects of social representations inform the professional experience of healthcare social workers by participating in the construction of meaning on their occupational lives. Studying the lived experience of front-line practitioners thus entails the joint consideration of the intersecting social representations at its core. Every representational element comprised by the lived experience of healthcare social workers will thus be explored in the context of the organizational workplace changes brought on by the NPM.

To best understand the operational realities of the social representations intersecting with the lived experience of clinical social workers, Jodelet's (2008) subjectivity levels (subjective, inter-subjective, trans-subjective) will also be mobilized to discuss the power dynamics at play in the workplace. They serve to reify the functions of the representations uncovered and discuss them critically in the context of organizational changes. Ultimately, on the path to understanding professional distress, the professional experience of clinical social workers must be investigated wholly as it allows us to understand how their professional practice is negotiated and incorporated into their self-perception. Amidst growing systemic limitations, it further provides a window to the healthcare social workers' shared occupational thought, thereby shedding light on the underlying hardships occasioned by neoliberal reforms.

When contextualized to the workplace, social representations can take the specific form of professional representations. As such, they are defined as thought-systems on a given social object co-constructed by a professional group (Bataille, 2000; Moscovici, 1976). They contrast with the social representations of non-professionals which lack the shared practices at the heart of the professional representation's edification. As presented by Bataille and colleagues (1997), professional representations are distinct as they are elaborated through practice and come to define the social identities of professionals.

For social workers in a healthcare setting, the study of professional representations offers a unique hermeneutic to professional experience by investigating not only the group's knowledge system around the workplace, but also the logic behind professional practices, their symbolic meanings and the structural dynamics at play (Bataille, 2000; Jodelet, 2006a). It is crucial to remember that experience is intrinsically linked to representations, as it requires common knowledge systems to be navigated by groups of individuals. While perceptions do arise in response to external circumstances, Jodelet (2006b) reminds us that representations provide independent meanings to situations and inform the importance granted to distinct aspects of the experience. As such, to understand how organizational constraints impact the professional lives of social workers, it is not sufficient to look only at what policies and protocols have been subjected to change; one also needs to understand how these workplace

transformations have been received, interpreted and integrated by the professional group they impact (Bataille et al., 1997). Mobilizing representations as a gateway to lived experience allows us to uncover the ways in which healthcare reforms have transformed the workplace, how the ideologies they feature have been integrated or resisted by front-line practitioners and how, finally, they may have influenced the professional distress of social workers. These avenues of inquiry thus inform our general research question: how is the professional experience of social workers influenced by the current organizational constraints of healthcare settings?

Assessing professional experience through an inductive qualitative approach

Thirty participants were retained for our sample from three large Canadian cities, each from a different province: Moncton (New Brunswick), Ottawa (Ontario) and Winnipeg (Manitoba). Our participants all shared four key characteristics: being francophone, female, a registered social worker and practicing in a healthcare setting. The interviewed social workers were equally sampled from every city (see Table 1).

Table 1
Distribution of the sample (n=30)

Sociodemographic characteristics		(n)
Age	20-25 26-35 36-45 46-55 56-65	1 15 10 2 2
Municipality	Moncton Ottawa Winnipeg	10 10 10
Years in current position	0-5 6-10 11-15	15 11 4
Workplace setting	Institution Community	25 5
Employment situation	Part-time, determined duration Part-time, undetermined	0 3

	duration Full-time, determined duration Full-time, undetermined duration	 4 23

The gendered and linguistic demographic restrictions of our sample were elected to better explore specific nuances in the experience of healthcare social workers. Based on our earlier studies (Lévesque et al., 2019), the minority linguistic affiliation was generally expected to influence the experience of daily life (whether in terms of professional standing, added tasks or stigma). We also posited the possible link between a minority linguistic affiliation and the experience of professional distress in a healthcare setting as this population's social capital is lower than its anglophone counterpart (Bouchard et al., 2006) and the perceived health status of individuals differs according to linguistic groups (Bouchard et al., 2009). Finally, we restricted our sample to a self-identifying female demographic to better account for the gendered reality of the profession, with 83% of social workers being women (Statistics Canada, 2019). Beyond our specific interests, the methodological implications of these criteria are explored in the limitation section of our paper.

The second article to a series of four on the professional distress of clinical social workers, this study also features the same sample as before along with the initial eligibility criteria set for participation. To reiterate, the members of our sample were initially invited to partake in a broader study on the professional distress of social workers. They had to self-identify as having personally experienced professional distress, a concept defined by the research team in our interview guide as "a notion used to encompass the many forms taken by psychological distress at work, including stress, depression, professional burnout, suffering, etc.)".

The recruitment was conducted on a voluntary basis without the incentive of remuneration between April 2017 and August 2018. It was carried out through three distinct methods: by word of mouth, through posters in healthcare establishments (both institutional and community-based) and through meetings with teams of social workers in healthcare settings. Our participants were offered the choice of a convenient location for the interviews, leading many to opt for either public coffee shops or private spaces at their own workplace. Pseudonyms were either chosen by or randomly assigned to participants to protect their privacy. The research was reviewed by the University of Ottawa's ethics committee and received its full approval.

Data collection

Our data was collected through semi-structured interviews conducted by three research assistants, each assigned to their own city. The data collection efforts were part of a larger study whose general purpose was to better understand professional distress in social workers. As such, our interview guide touched upon three larger themes which are each thought to play a part in the professional distress of social workers: 1) professional identity, 2) education and professional experience through organizational constraints and 3) the specific manifestation of professional distress. For the purpose of this paper, only the verbatims related to the second theme were retained for analysis in order to focus on the shared experience of healthcare social workers' in reformed settings. The education and professional experience theme presented participants with questions about the workplace experience, their organizational constraints and the value conflicts arising from disparities between academic and their field experience. The transcriptions of the interviews were coded by the main researcher within the Nvivo 11 platform, which organizes the qualitative data and facilitates the ensuing analyses.

Data analysis

This study aims to develop our understanding of the lived experience of social workers in a healthcare setting following the past decade of healthcare reforms which impacted not only their mandates, but also their values and priorities. Towards this goal, we sought to explore the representational elements that inform the professional experience of healthcare social workers. These elements were conceptualized in accordance with the theory of social representations' definition of lived experience as a situation affectively understood through a representational lens (Jodelet, 2006b). As such, all identified theme had to pertain to the shared meanings given to practices and their symbolic contextualization in the workplace as manifestations of a common occupational experience.

To achieve this, a thematic content analysis was performed on the relevant sections of interview transcriptions. It comprises three large processes established by Miles & Huberman (1994): the reduction of the data based on the focus of the research, its organization and its verification. After an initial identification of the elements at play, the significance of the uncovered themes was discussed by both authors of the article on the basis of recurrence and coherency among participants. The NVivo 11 platform facilitated the inductive exploration of the content to be further structured by a quantitative measure of frequencies. The frequencies of the uncovered representational elements were calculated in two manners. The number of participants evoking a given element of their workplace experience was interpreted as a sign of its prevalence, while the number of times this element was mentioned within all interviews was an indication of its importance for social workers (Negura, 2006). Every calculation was corroborated with the thematic analysis of content to validate the assertions of significance about a given representational element.

This analytical method has been shown to be particularly effective to explore the inner dynamics of representational content (Dany, 2016; Negura, 2006) and has been previously established as an effective technique in social representations' studies to explore the more complex subjectivities of shared professional knowledge (Morant, 2006). The use of a basic statistical description as a validating technique allowed us to apprehend the representational ties between the issues at play for the professionals themselves while also providing us with a manner of seizing the strength of the representational components related to their shared experience. It follows that each of these elements was debated not only in terms of its subjective significance but also with regards to its popularity among social workers and its relative importance for them.

It should be noted that the analytical approach retained for this study contrasts with the previous article on the professional representation of clinical social workers, which employed a structural lens to assess the social representation of social work. Here, as the main focus concerns the lived experience of healthcare social workers, Jodelet's (2006a; 2008 respectively) conceptual tools of lived experience and subjectivity levels were more suited to achieve our second study's objectives and comment on the occupational reality of front-line practitioners.

Results

Matters of daily professional life for social workers in a healthcare setting were analyzed according to both concrete practices (e.g. interventions, protocols) and the subjective interpretations (mandates, expectations, values) they generate. Two encompassing elements emerged from our data that organize the lived experience of healthcare social workers: organizational constraints and a paradoxical autonomy. Organizational constraints were found to be the most meaningful element for describing practices in light of reform changes and political climate, whereas narratives pertaining to autonomy presented more representational element necessary for conceptualizing the shared experience of the workplace. Each bear implications for front-line practitioners' well-being, identity and likelihood of experiencing professional distress. Let us begin by exploring what constitutes organizational constraints for healthcare social workers and the meanings attributed to these constraints.

Organizational constraints

The lived experience of healthcare social workers consists of two equally important aspects: the practices and the representations determining their occupational circumstances. Here, organizational constraints tie into the daily restrictions that play on their lived experience and fashions their expectations regarding their practice. A lack of time and resources, an excessive workload and confusing guidelines all compound the stress associated with an emotionally charged profession and shape the representation of their shared distress along institutional causes and concerns.

The trinity of hardships: time, resources and workload

Lack of adequate time, the need for additional resources and a disproportionate workload represent by far the most prevalent constraints deemed to worsen the workplace experience of social workers, comprising half of all occurrences pertaining to organizational constraints (49.18%). Their interrelation is indisputable, as with more time available, the caseload could be better managed, and with adequate resources workloads could be completed more efficiently or delegated, freeing up more time or reducing the number of tasks, etc.

Of the three elements, the work overload was sourced from the largest number of interviews (n=25) and referenced most often (50 times). The excess work imposed by organizational constraints was found to have a variety of impacts, both pragmatic and emotional. For one, it negatively affects the social workers' feeling of professional competency:

> *[…] once it [the work] started overflowing in one case, it had an impact on all of my other cases… I didn't feel competent as a social worker. – Emma*

This erosion of practitioners' self-assurance is further exacerbated by the very nature of the work. With most front-line practitioners describing their mandate as "putting out fires" and dealing with constant crises, many had difficulty coming to terms with not offering the full extent of services they could have provided if given appropriate time and resources:

> *We have too much to do with too little time, so we have to cut our work in two or three because I can't pursue step parenting with families. Yes, I have some time to meet with them but definitely not to sit down and complete psychological assessments. Lacking time impacts the quality of my work. – Bernadette*

Participants emphasised the difficulty of the work itself, revealing, in essence, how work cannot be solely measured in terms of time spent in an office. Work overload is thus not only a matter of hours in a day, but of the types of tasks performed:

> *A young girl screamed at the top of her lungs for 45 minutes without pause […] She was in a complete crisis, with screams, screams and more screams. I couldn't hear myself speak and I didn't know what I was doing anymore, I needed help and couldn't calm her down over the phone. After 45 minutes of that on the phone, it's exhausting. – Monique*

This issue of overload was found to be difficult to explain to the higher administration, which only pay attention to the statistics made available to them. When documentation prevails over patient care, the priority shifts:

> *We have more constraints with statistics, documentation and we can't always be with the patient or their family. – Sasha*

The mandated paperwork was described as ever growing, expropriating services that should have been directed to clients:

> *For every hour that I spend with my client, I can't tell you how many hours I have in paperwork afterwards. – Maria*

The prioritization of documentation, while counter to the preferences of social workers, is the last line of defense against budget cuts, a necessary evil:

> *The supervisor I had before could see the work that we needed to do and the volume of cases we had so she really pushed for more workers and we got them. She conducted studies, research, she had basically written a little booklet to show the numbers to prove that we needed people […] – Jordana*

Social workers have to shoulder the dual responsibility of providing services to clients while concurrently advocating for their jobs to their own employers. Legitimately, the growing frustration felt by social workers, who perceived budget cuts as the decision-making authorities' way of undermining the profession, pertains to recognition:

> *You know, I am pretty sure that if you gave them [politicians and other government authorities] only the clothes they have on their back and left them under an overpass, they wouldn't cut our jobs quite as fast, you know. They have no idea what the reality of our patients is or even that of their employees for that matter. – Héloïse*

This decrease in resources perpetuates the worsening of the workload, as a rapidly decreasing number of social workers have to take on their former colleagues' responsibilities:

> *I: […] In reality, there should be two, maybe three people for the work that I do. If we go back 15 years ago, there were three social workers that did my job for 26 clients. Now I am alone.*
>
> *R: Do you know why it changed?*

I: Budget cuts. – Héloïse

The mistrust in the administration is heightened not only by the implementation of social policies or budgets cuts but also by the management of tasks in the workplace. The way in which the work is assigned was described as deceitful and engendering uneasiness in front-line practitioners, who viewed management as purposefully creating caseload excess:

> *[…] It was really horrible, I was told I would start little by little with 4 casefiles and then, you know, I would suddenly have 5, then 6. Well I was thrown to the wolves as by the end of my first month. I had 33 as a brand-new social worker coming out of university […] - Jordana*

Social workers are thus left to their own devices to deal with excessive workloads, as well as lack of resources and a justified sense of insufficient time. Further difficulties are revealed when breaching the topic of supervision and workplace guidance, where standards have changed in accordance with managerial reforms.

Confusion and misdirection: a precarious work management

Managerial concerns emerged in the discourse as another more immediately observable aspect of the lived experience of social workers. As for the previous organizational constraints, it predominantly affects the font-line practitioners' practices while bearing symbolic implications for the shared meaning given to their experience. To start, it perpetuates a state of confusion around the autonomous management of workloads since, for more than a third of our sample, expectations and guidelines were not immediately apparent.

Some attest to having a general impression of, or "a feel" for, what managers expect, but without receiving any specific instructions for the work itself:

> *I: What are the expectations that management has for your work?*
>
> *R: Hum, for us to have respect, I think to respect patients, to work in teams and to encourage a good synergy. That's about it, nothing concerning our work at all. – Philomène*

As standards of practice and guidelines are not readily available to counsel social workers on their duties, it leaves the team of front-line practitioners scattered along a spectrum of practices, standards and priorities:

> *So, what are the instructions for our work, well…there is nothing written. For example, we need to make case notes and conduct*

> *interventions, but we have nothing that tells us for how long it should be done. And for the notes that we use to describe our interventions, we do them all differently. – Michèle*

Social workers rationalized this lack of guidelines in terms of the difference between managers and social workers with regards to their vision of care:

> *Ah, expectations… well it's a different perspective, you know, the medical one. For us, we have a different perspective on things […] it's a bit hard, they share a different line of thought. – Fesefel*

This divergence in perspectives creates tensions among the social workers' own deontology, their formal training and their employer. While not specific, the administration's expectations rarely align with the values of social work:

> *[…] we struggle to be able to meet the demands of our employer while being faithful to our role, our training or simply to how we see ourselves as social workers. – Monique*

> *Like working in a hospital, sometimes they don't have the same vision as we do so they push us to do certain things that contradict our mandate, so we end up playing tug-of-war. – Bernadette*

Unarticulated guidelines, while not a source of tension in themselves, are paired with an absence of the clinical support deemed imperative to practice in a healthcare setting, as reported by 23 participants:

> *Another constraint is that we lack clinical supervision. That's really lacking. Yes we help each other, but sometimes it's really above our abilities, you know, narcissistic personality disorders and stuff like that, we don't all have training for these things, like for me it's just not my expertise at all. – Maria*

The additional professional training sought after by front-line practitioners is not an available alternative for supervision, as funding is in short supply:

> *The lack of training comes from the lack of funding. You know the budget this year is 200 dollars or something per social worker for training. 200 dollars, you know, it makes no sense. – Maria*

The absence of supervisors incurs further unexpected burdens on social workers, who depend on each other for both pragmatic and emotional support:

> *First, we would need clinical supervision because that's something we don't have. We have a supervisor, but he isn't a clinical supervisor as I said because he has no idea what our job is […] there's always a lot of staff turnover, so the personnel have very little experience, and when I experience something difficult I feel bad to go see them because they can't help. Most of the time the opposite happens, and they come to vent to me, so on top of having my clients, I have all the team to take care of. – Monique*

Overworked and pressured on all fronts, social workers are compelled to sacrifice their own rights to complete their duties within a workday:

> *We just can't, sometimes we just don't take breaks, we skip lunch at times. – Fesefel*

They must further display great self-reliance to practice with very limited resources, with some social workers resigning themselves to the fact that they will be working with perpetual deficits:

> *I try not to think about it [lack of resources]; I don't want it to affect my daily life […] I work with what I have, with the resources available. Becoming frustrated by the lack of resources is just going to exhaust you and nothing positive will come out of it. So, you just have to accept it and work with what you have. - Lillian*

The greatest risk to well-being emerges when drastic coping mechanisms are employed to manage competing expectations and overbearing constraints in an attempt to correspond to the professional representation (Lévesque et al., 2019), resulting in the shattering of boundaries between professional and personal lives reported by 18 distinct sources. In the following excerpt, our participant shares such an instance of compensatory overworking immediately prior to her burnout:

> *I went beyond my work. I went to the store. I purchased her clothes, underwear and make-up because the lady told me that, before, she would never leave without her lipstick. I bought everything from my own pocket. I also went to my grand-mother's wardrobe to take the clothes that she wasn't wearing anymore. I washed them all and brought them to the patient for her to have something, a little something of her own, you know. – Sophie*

While genuine devotion is consistent with the social worker's ethos, no mechanisms are put in place to ensure balance and relieve front-line practitioners when they voice a need for some time off, leaving them arguably chained to their responsibilities at all times:

> *When you miss a day at work for a family emergency, or you decide to go on vacation or whatever the reason is for you to miss a day, you know you'll be paying for it. You know that day that you want off isn't worth it because you'll be so overwhelmed when you come back it doesn't make sense. – Héloïse*

Paradoxical autonomy

Autonomy was found to be the most significant characteristic of the workplace, after organizational constraints. Mentioned by 17 participants and referenced 19 times, close to two-thirds of our sample discussed it in terms of its paradoxical nature. Paradoxical autonomy encompasses three elements of the workplace that together frames the shared experience of healthcare social workers: the *value-based representation of professionalism*, the *exposure to litigation* and the *primacy of field experience*. When combined, these elements all point to the lack of guidance identified earlier as a constraints. Together, they reflect the representational tensions brought on by the clinical social workers' need for self-reliance.

Value-based representation of professionalism

Let us begin with the *value-based representation of professionalism*, which was referenced by slightly less than a third of our participants. It is a matter of consensus that social workers require professional training to mobilise concrete techniques in order to fulfill their mandate:

> *If you don't know how to intervene, if you require specific approaches, then you need social workers. There are just cases that can't be dealt with normally. That's why you need to have the techniques of a social worker, you need to be a social worker to intervene in these cases. – Letitia*

For some participants, professionalism does not necessarily involve specific techniques but rather is described broadly in terms of a general attitude, tying into the representation of social work itself (Lévesque et al., 2019):

> *Professionalism, that's important. I would say it implies neutrality, you know, impartiality I should say. I mean, the behaviour you must have, it's to be always listening, amicable, smiling, empathetic, patient. Very, very patient. – Sophie*

Our participants' insistence on professionalism can be fully understood only when contextualized by the other defining characteristics of their workplace experience. This brings us to the *exposure to litigation*, a matter referenced 15 times by the 8 sources that brought it to our attention. The innate sense of

professionalism, or possessing the correct behaviour in difficult work scenarios, is vital in light of the constant threat of lawsuits faced by social workers. As they perform difficult tasks, manage delicate information and are at the mercy of contradictory expectations from a misinformed administration, social workers are often the first targets of offended clients:

> *Since high-ranking managers don't know what we do, they impose tons of things on us without consulting our professional Order. They will impose stuff that doesn't make sense, and if there is a lawsuit, they aren't involved, they aren't even named! Last summer my manager ordered me to send out pictures of a patient who had run away which I couldn't do because of confidentiality reasons and I got reprimanded for that. I thought it didn't make any sense! – Philomene*

The constant threat of litigation weighs heavy on social workers, not only due to its long-term implications, but also by how it undermines their very role as professionals and endangers their shared identity:

> *I could only see the negatives* [when talking about her work]. *You know, I would question myself on why I even became a social worker; if I'm just going to get in trouble or have my judgment questioned or be questioned with regards to my obligations towards the law. Is it really worth it to be a social worker? It's the risk that comes with lawsuits, you know. – Lillian*

This is particularly troublesome in the context of an autonomous practice, as protections are said to be limited for clinical social workers who provide services to a highly vulnerable clientele. These circumstances are aggravated by the unaccountability of administrators, who are described by social workers as distancing themselves at the sight of trouble and refusing to assume responsibilities:

> *It happens sometimes that you have a very difficult patient. When we can't manage the patient, we go to our manager. "This is a difficult family, could you offer me some help?" […] She immediately throws the ball back at you "Well do this and that". But I already did it. She throws the ball back again: "Well do this and that!" It feels like she's distancing herself. And us, we are always the intermediary, so yeah, it's tough! – Leti*

The *primacy of field experience* is a vital aspect of this professionalism, as discussed by 12 sources, because the challenges of the work environment cannot be addressed through formal education alone. As attested by many social workers, nothing prepares them for the realities of work life:

> *In university you aren't trained on how to protect yourself, never. So the first day on the job for me it was with child protective services and in my very first week I removed a child… no one prepares you for that. – Maria*

First-hand experience is also crucial because it helps social workers to manage their role, which they describe as autonomous. In the scientific literature, discretionary autonomy is often identified as an empowering feature in the professional context (Papathanassoglou et al., 2012). In contrast, for our participants, autonomy was far from a positive aspect of their work experience due to the context in which it was granted. Indeed, an undue burden is felt by clinical social workers who describe navigating in an environment where their role boundaries are not consistently understood by their medical peers. As such, it is easy for interdisciplinary teams to delegate unrelated tasks to social workers, disturbing their work schedule and role expectations:

> *What happens generally is that I come in and organize my own agenda. But what ends up happening usually is that I am tasked with something else. We're being called upon by nurses or chief-nurses or anybody. So a nurse that comes to you or a doctor says things like "Oh! Could you do this or that?" And the day never unfolds the way we planned it, it changes a lot. – Fesefel*

In this way, autonomy permeates every aspect of the workplace experience. For one, it tends to aggravate the vulnerability of social workers to litigation because they are accountable for each decision they make:

> *I eventually decided to place a call* [to child protective services]. *So, anyway, I think it was six months later, I was informed by the administration that the lady, her family, was prosecuting the hospital because they were my employer, because of me, because I had made the call and brought emotional harm to the family. – Lillian*

> *I think sometimes we are being made responsible for things that we haven't instigated. Like, I'm not the one who caused the issue and yet, I'm the one who is responsible for problems caused by the administration, the ministry […] I find that very difficult. – Leti*

Similarly, the *value-based representation of professionalism* and the *primacy of the field experience* only gain importance in the narratives of social workers due to the autonomy they possess. Indeed, as part of the social workers' expected flexibility, every task is more cognitively taxing and requires the elaboration of adaptative strategies:

> *I take notes. I put everything on sticky notes in my agenda. And the sticky notes move around depending on what is happening. […] I do*

> *a lot of overtime. I manage crises before what's less important. – Beatrice*

Professionalism and the knowledge gained by field experience are thus key to help counterbalance the strain caused by this *paradoxical autonomy*. Participants with more years of experience were thus more at accustomed with the particular practice constraints they were faced with. This did not however altered the meanings attributed to their lived experience nor the rationale behind its inherent challenges. Across participants, their given autonomy was hence not deemed fully authentic, as it is given without the appropriate tools to actualize the institutions' requirements:

> *The administration comes to us with a new initiative and says "make it work". […] So with that it's pretty much us deciding on our own tasks and sometimes we miss the boat on what to prioritize which creates stress in organizing everything. We don't have an administrative office either […] so we do it all.* - *Alexa*

In summary, healthcare social workers experience unnecessary challenges, as they are made responsible for a professional practice without adequate resources or protections. They must further navigate confusing expectations and demands from their medical peers who unknowingly undermine the clinical social workers' genuine professional values. Autonomy is made conditional on the fulfillment of managerial priorities, while legal accountabilities are placed on social workers. Ultimately, autonomy without the appropriate support is denounced by our participants as adding to their workload in a context of where they must constantly reinvent their practice and rearrange their schedules according to the needs of unpredictable clients and managers alike.

Discussion

Our results attest to the decisive influence of healthcare reforms on the professional experience of clinical social workers. The numerous organizational constraints faced by front-line practitioners are perhaps the most tangible evidence of the problematic transformation of the workplace. These external systemic challenges are further compounded by a paradoxical autonomy of practice, structured its representational components of *value-based representation of professionalism*, *exposure to litigation* and *primacy of field experience*. Each is a necessary gateway to understanding the meanings that social workers assign to their lived experience and the power dynamics involved. Beyond the reach of this study, the shared occupational experience of healthcare social workers may help situate the systemic roots of their professional distress, thereby participating in the achievement of our broader research objectives.

<u>The end of the line: social workers as a palliative solution to a flawed system</u>

Our qualitative analysis uncovered how social workers must contend with four concrete barriers in the exercise of their functions: a deficit in resources, a limited time, an excessive amount of work and an unsupportive management. This quaternary of obstacles was the most prevalent aspect of the professionals' narrative and points to multifaceted issues in the work life of social workers in a healthcare setting.

As presented in the results section, all four elements lead to similar consequences: the inability to complete the mandated tasks set by their representation of the profession and/or a decline in the quality of available services under the subjective standards of practice. The harm caused by these unsatisfactory outcomes is much more adverse than what is immediately observable. Indeed, the need to work in a constant state of urgency leaves long-term, more successful interventions aside to prioritize stress-inducing, high-pressure crisis management. This negatively impacts the lived experience of clinical social workers by reinforcing tensions between institutional work expectations and shared occupational values. The inability to practice holistically is felt as eroding the social workers' sense of competency and purpose because they are limited to providing insufficient help. These findings could help explain the retention problem observed amidst the profession (LGA, 2009; Kim & Stoner, 2008) beyond the simple difficulty of the job. Put simply, the gratification of clinical social workers is compromised by the rushed casework of the institutional environment, thereby limiting their job's rewards while heightening its demand. The resulting strain felt by front-line practitioners subscribes to the predictions of the Job-Demands Reward model (Siegrist,1998), thereby providing an avenue of explanation to the unusually high rates of professional turnover (Weinberg, 2009).

In this high-pressure environment, the obligatory documentation of practices further destabilizes front-line professionals by imposing an unnatural shift from client-centred priorities to managerial ones (Phillips, 2017). The clinical social work practice thereby transforms to incur undue financial responsibilities (Chow et al., 2019), as healthcare social workers advocate their contribution through statistical monitoring. Their lived experience is consequentially burdened by mandatory bureaucracy, increasing their overall work demands. Said demands are alleged to be unfairly valued by the administration, whose statistical tools are unsuited to account for the emotionally draining nature of the task. The alarming ratios of compassion fatigue (Thomas, 2013), moral distress (Jessen, 2015) and depression (Siebert, 2004) in healthcare social workers attest to the importance of considering not only the extent of a given workload, but its inherent challenges together.

What becomes apparent throughout the interviewing process is that while systemic failures are objectively understood by clinical social workers, their emotional weight is integrated within their lived experience at the price of great frustration. NPM reforms have entailed heightened work precarity for social workers (Baines, 2004), leaving them reportedly forced to juggle between

witnessing the hardships of their clients, the first victims of public retrenchments, and enduring their own sense of precariousness as under-recognized members of the team. This conflictual experience in front-line practitioners is one well-documented by Lipsky (1997), whose 'street-level bureaucrats' come to incarnate the policies that they actualize. They deal first-hand with the discontent of services beneficiaries while bearing the responsibilities of inadequate policy. While clinical social workers are not at fault for organizational changes, they pay its price in practice.

The struggles incurred by the new procedural expectations is worsened by the relationships healthcare social workers have with immediate supervisors and, more importantly, higher management. No guidelines or supervision is directly provided, leaving many in a place of confusion with varying standards of practice across their occupational group. More conflictual still, managerial demands are said to align with differing finalities of practice, as cost-efficiency is prioritized over patient well-being. The lived experience of clinical social workers is therefore strained by the competing ideas of practice held between them and their employers. As eloquently described by Abramovitz (2018), the managerialism of the workplace leaves little place for social justice, community and compassion by branding social work itself as a form of business within an agency. Our findings align with those of Abramovitz (2018) by attesting to the self-reliance of clinical social workers who 'make do' without appropriate support, as funding is unavailable to promote organizational resilience in the form of external training.

True to the managerial spirit of neoliberal institutions (Abramovitz, 2018), the workplace was found to foster self-sacrifice in front-line practitioners who allege lacking a sufficient recognition for their contribution. Social workers end up sacrificing their well-being in and outside their workplace in order to prove their value, for example by skipping breaks, by working additional hours from home or by paying out of pocket to provide for a patient's basic needs. From a conceptual perspective, the response elicited in clinical social workers operates at a trans-subjective level (Jodelet, 2008) where the social representations informing the lived experience of healthcare social workers legitimize together the power of the institution and the compensatory strategies deemed acceptable (Negura et al., 2019). As per Jodelet (2008), the normative background organizes the context wherein individuals endorse social representations. Given the potency of neoliberal values within their place of work, mobilizing individual recourses to palliate the patients' needs is the only option available to honour one's professional values without directly opposing the authorities in place. Consciously or not, this bid for recognition benefits the system in that social workers, at their own expense, do more than they should and provide services with limited resources, thereby cutting costs for the institutions and government agencies that employ them.

<u>Autonomy: from friend to foe</u>

To our surprise, during the interview process, autonomy was identified as one of the most significant elements of a negative workplace experience. Its problematic role comes in direct contradiction with previous research on general well-being in an occupational setting (Papathanassoglou et al., 2012), challenging even primary workplace stress models such as Karasek and Theorell (1990), which identify autonomy as a central feature of workplace well-being. Under the theory of social representations' however, we are able to understand how group subjectivities shape the meanings underlying a particular context of practice and, in turn, transform its shared experience.

As detailed in our result section, four interrelated factors define the experience of autonomy for healthcare social workers. First, discretionary autonomy is challenging when the profession is poorly understood (Lévesque et al., 2019), with interdisciplinary teams and administrators taking advantage of imprecise role boundaries to task social workers with unrelated work, adding to their already heavy workload. The *value-based representation of professionalism* is here mobilized to protect the integrity of social workers' identity and its original contribution to a team of medically-oriented colleagues in light of conflicting representations of practice.

Second, within the lived experience of clinical social workers, autonomy aggravates their vulnerability to litigation by increasing their accountability, as they are required to take on more responsibilities. Through an overview of the *exposure to litigation* element, it becomes clear that social workers' role and judgment are formally questioned in the legal process, thus reinforcing the self-doubt already triggered by the neglect of their practical skills by administrators and the lack of guidelines. As such, lawsuits serve to undermine front-line practitioners' path to recognition, as every aspect of their practice is individually questioned before they may move forward as an occupational entity. This vulnerability is experienced as a threat to the integrity of their professional identity and the legitimacy of their practice.

Thirdly, full autonomy is not granted to social workers; instead, they constantly struggle to reconcile the expectations of higher management with their own representation of social practice. This conditional quality is key, as it deprives social workers of the benefits of a discretionary autonomy which would otherwise allow front-line practitioners to conduct themselves in alignment with the values they hold dear as professionals. The *primacy of field experience* was voiced as an effective means to mitigate these conflicts. Through honing their skills, setting a precedent for practice and being prepared for inevitable litigations, experienced social workers could allay the negative impacts of their uneasy autonomy. That being said, the inner tensions experienced between representations of practice and professional identity never ceased to weigh on our participants, regardless of their seniority.

Finally, as discussed earlier, the lack of clear guidelines and support from management speaks of the tensions between the representations of social

practice and strips the social workers' discretionary autonomy of its advantages. The latter thus only adds to the social workers workplace stress and further exacerbates the tensions inherent to their lived experience.

While in direct contradiction with psychosocial models of workplace stress (Karasek and Theorell, 1990), our findings on autonomy parallel a previous research on workers' professional suffering. In an article by Negura and Maranda (2013), autonomy in a workplace environment dominated by *New Public Management* philosophies led workers to adopt dysfunctional behaviours. In this study, drug consumption was used as a coping strategy to meet impossible standards of practice set in a context of higher autonomy, where the individual assumes all responsibilities related to their work without access to the necessary resources. As with our findings, this research points to the Canadian neoliberal reforms in a healthcare setting as unsustainable for front-line practitioners, reflecting a flawed ideology of social service provision at the political level.

Increasingly devoid of moral thought, healthcare reforms have encouraged an oppressive managerial climate through normative tactics. As demonstrated by Fabio Lorenzi-Cioldi (2009), the deference of accountability and the homogenization of the marginalized all legitimize the power in place. The increased monitoring of clinical social workers indeed work to transfer the responsibility of services on the individual workers rather than on the institution which employs them. The administration's alleged rejection of legal accountability further increases the precarity of front-line practitioners, leaving little opportunity to challenge the establishment in solidarity. The limited recognition of the social workers' values and mission, in addition, encourages the individual endorsement of the norms in place to better one's own workplace conditions and systemic support, eroding the core loyalty to the professional group. Ultimately, these power dynamics come to define the lived experience of social workers by leaving them struggling to maintain a sense of purpose and of consistency in a neoliberally-dominated work environment.

Limitations of our study

Having elaborated on our findings, it is important to address the limitations of our study and how they may have impacted our results. As participants were required to self-identify as having recently experienced distress in the workplace, it is possible that their reactions to organizational constraints and their perceived significance could have been heightened by a compromised psychological disposition or a previously vulnerable state of mind. All appropriate measures were taken, however, to ensure an adequate state of mind from our participants during the interview. The interview questions were additionally formulated in order to promote discussions on experiences applicable to themselves and their occupational group more broadly in hopes of limiting this personal bias. Given the inductive nature of our approach, our methodology is also not immune from researcher bias. While the data was

reviewed by both authors independently and organized in terms of significance through frequency and occurrence, prior expectations could have influenced our understanding of the results.

We also recognize that our data is not wholly representative of all Canadian social workers in a healthcare setting, given the eligibility criteria for participation (female, francophone and form urban centres only). Further, our recruitment efforts yielded a majority of Caucasian participants with a limited representation of other cultural or ethnic groups than French-Canadian. We have no way of determining at this time how this restricted diversity could affect our results. That said, as our sample was recruited from three distinct provinces through a number of healthcare institutions, we argue that our study still offers generalizable results. Indeed, the organisational context remains stable across provinces regardless of linguistic affiliation, gender or individual cultural heritage. In summary, this exploratory study provides fruitful avenues of reflection about social workers' experience of their professional environment and remains of value to inform future research on front-line practitioners' professional distress, workplace experience and the subjective impacts of healthcare reforms.

Conclusion

Our findings attest to the variety of challenges experienced by social workers following the last decade of healthcare reforms in Canada. Front-line practitioners endure numerous organizational constraints which reorient their practice in a direction which does not align with their sensibilities, priorities and values. In this context, autonomy is an unwelcome characteristic of their profession, as it masks deficient guidelines and supervision under the guise of discretionary practice.

Ultimately, the lived experience of the workplace by healthcare social workers is shaped by the multifaceted representations and dynamics subsumed by a neoliberal workplace context. The conflicts in practices, values and identities maintained by representational dissensions negatively influence the work lives of clinical social workers. With clear empirical evidence of the undue stress experienced by healthcare social workers (Evans et al., 2005), this research may serve to assist policy makers and administrators to rethink healthcare reforms beyond the aims of financial efficacy and individualised care, but also in terms of their feasibility for care providers. Workplace well-being initiatives may equally gain from prioritizing changes at the organizational level, thus improving social workers' experience by alleviating their most impactful burdens. Finally, better supported practitioners would directly entail better patient and family services, as social workers would be enabled in their work.

Study 3
Understanding professional distress through social representations: investigating the shared experience of healthcare social workers in Canada

Introduction

Professional distress and social workers: a longstanding concern

There is little doubt that healthcare institutions are stressful and demanding workplace settings. Crises are a daily occurrence and must be managed concurrently with the required formalities of reports, paperwork and managerial meetings (Phillips, 2019). The general push toward efficiency in neoliberal policy reforms adds to the anticipated pressure by requiting service providers to devote more time, attention and resources in order to comply with administrative budget targets (Baines, 2004). Among healthcare professionals, social workers are especially affected by this reality as they work in a grey area, neither medical nor exclusively community-based in nature. At its worse, this vagueness delegitimizes social workers within their own institutions, posing a threat to the stability of their employment in the face of stringent financial cutbacks (Baines, 2004; Lévesque et al., 2019). At best, their role is undermined by flawed perceptions of practice, contrasting management philosophies and vague guidelines (Abramovitz, 2018; Lévesque et al., 2019; Lloyd et al., 2002).

Indeed, a systematic review of the literature by Lloyd et al. (2002) has led them to conclude that social workers experience higher levels of both stress and burnout compared to other occupational groups. A decade later, studies attest to the persistence of this issue, with social workers experiencing high levels of reported professional exhaustion (McGregor, 2013; Collins, 2015). Due to the nature of their work, social workers likewise face the strong likelihood of falling victim to secondary traumatic stress (STS) (Newell & MacNeil, 2010; Wagaman et al., 2015) and occasionally develop the range and intensity of symptoms associated with PTSD (Bride, 2007). As they provide direct patient care, clinical social workers are also the healthcare professionals with the highest ratios of moral distress (Jessen, 2015; Whitehead et al., 2015).

Apart from the devastating consequences that professional distress involves for the social workers themselves (Kim et al., 2011), its negative effects extend to their services beneficiaries by compromising the former's performance quality and their ability to attend work (Kinman & Grant, 2011; Morris, 2005). Professional exhaustion and stress in social workers are also at the root of the longstanding retention challenges in the profession (LGA, 2009; Kim & Stoner, 2008). In fact, fledging social workers maintain this occupation for an average of 8 years, a significantly lower number in comparison to doctors or nurses (Curtis, Moriarty & Netten, 2010). According to some researchers (Eborall & Garmeson, 2001), the perception of social work as a stressful profession explains

this high turnover. However, with mounting causes for worry, explanations of professional distress in social workers remain fraught with dissension.

A number of studies have elucidated the manifestations of professional distress in social workers through psychological factors such as stress management deficiencies or limited resilience (Collins, 2015; Wilberforce et al., 2014; Kinman & Grant, 2011; Rothmann & Cooper, 2008). Alternatively, the elevated incidence of professional distress in social workers has also been related to the specific characteristics of the profession, namely its relational nature (Aronsson, Astvik & Gustafsson, 2014), the challenges around the construction of a caregiver identity (Wu & Pooler, 2014), the profession's conflicting role (Coffey et al., 2009), the limited acknowledgement it receives (Coyle et al., 2005), its ethical dilemmas (Aransson et al., 2014) and the violence and harassment perpetrated by service beneficiaries (Kinman & Grant, 2011). Within the available literature, very few studies (see Roland-Lévy et al. (2014) for an exception) have documented how social workers themselves explain their professional distress and determined the role of professional experience in this representation.

Yet, the systemic constituents of professional experience should have prompted more academic interest in light of the extensive political reforms that have redefined Canadian healthcare in recent decades (Hutchison et al., 2011; Sweetman & Bukley, 2014). Whilst specifics vary from one province to another, the large majority of political changes brought about in recent years subscribe to a conception of active social State, a political ideal rapidly substituting the providence State model. In accordance with this perspective, healthcare institutions have been instructed to rely on individual responsibility (Barbier, 2009; Soulet, 2005) by "activating" their services beneficiaries along with their employees (Orianne, 2004). These reforms have signaled the integration of the *New Public Management* (NPM), a political trend consolidating public services with the free market. This trend aims above all to separate buyers from their service providers, introduce competition, measure results (outputs) instead of contributions (inputs), administer work by defining targets and produce regulations and procedures to maximize the efficiency of employees (Banks, 2011).

These rapid changes have proven quite problematic for social workers whose values conflict with the organizational norms of NPM reforms (Abramovitz, 2018). With rampant professional distress and increasing clashes in perspectives within their workplace, the plight of front-line practitioners remains unanswered. The issues at hand have extended beyond matters of psychological individual dispositions and need to be articulated together with the social representations they comprise and the concrete experiences of social workers.

Social representation of professional distress

To better apprehend the meaning granted to professional distress by healthcare social workers, we chose to employ the theory of social representations (Moscovici, 1976). This paradigmatic approach provides productive avenues to conceptualize the interconnection between professional representations and people's understanding of mental health in everyday thought and action (Bataille, 1997; Jodelet, 1989; Moscovici, 1961, 1976, 1981, 1988). As a common sense knowledge system shared within a specific group on a given social object (Negura, 2016), social representation has an identity function (Moliner, 1993). If, indeed, one wonders about the social representation of professional distress within social workers, it is essential to take into consideration the role of professional identity in this dynamic.

In accordance with our theoretical framing, we argue that the clinical social workers' professional distress cannot be understood apart from the social representation that shapes its symbolic grounding. Experiences are not strictly individual and carry the common sense that informs them (Jodelet, 2006). As the subjective background of practice (Negura, 2017), experiences bear key information with regards to the social mechanisms that inform the meanings given to circumstances while also guiding the resulting emotional reactions. As such, the theory of social representations offers a unique gateway to understand professional distress in social workers holistically.

To uncover the specific circumstances of healthcare social workers, the social representation of professional distress was first explored in the third and final part of our interview guide. Our previous studies' findings will however be mobilized to comment on the relation between the professional distress of healthcare social workers and their professional identity. Lived experience will be further discussed in its foundational role to inform the context of practice of front-line practitioners. This serves to answer the currently neglected question of how clinical social workers experience professional distress as a group and whether their self-perception and experience influences the meanings constructed around this phenomenon. More concretely, our objectives were to:

1) Uncover the content of the social representation of professional distress in francophone healthcare social workers.

2) Determine how the social representation of professional distress relates to the healthcare social workers' professional identity and their experience of social work practice in its current organizational context.

Method

To achieve our research objectives, we recruited front-line practitioners from three cities of three Canadian provinces: Manitoba (Winnipeg), Ontario (Ottawa) and New Brunswick (Moncton). We retained an equal number of participants from each location (see Table 1). In addition to being registered

social workers, our participants also had to identify as francophone and female and to execute their functions in a healthcare setting.

Table 1
Sociodemographic characteristics of the sample (n=30)

Sociodemographic characteristics		(n)
Age	20-25	1
	26-35	15
	36-45	10
	46-55	2
	56-65	2
Municipality	Moncton	10
	Ottawa	10
	Winnipeg	10
Years in current position	0-5	15
	6-10	11
	11-15	4
Workplace setting	Institution	25
	Community	5

To participate in our study, participants also had to identify as having experienced professional distress, a notion used to encompass the many forms taken by psychological distress at work, including stress, depression, professional burnout, suffering, etc. We purposely valued the self-identification of participants over a formal diagnosis of professional exhaustion. This is because our study assesses intrinsically subjective matters (representations and experiences) that require above all self-identification to relate individuals under a shared perspective. While a diagnosis is useful to measure the outward recognition of the individual's experience, a personal sense of distress is sufficient for the person to engage with the social representation.

We also chose to include only women in our study to reflect the gendered reality of the profession, with an estimated 83% of social workers being female (Government of Canada, 2018). This also served to evaluate the implications of the female majority on professional distress. Finally, we limited our data collection to francophone women in order to bring out the currently neglected perspective of francophone social workers in a minority setting. These methodological choices and their implications will be discussed later.

Data collection

The sampling was carried out through voluntary, non-probabilistic recruitment. Participants were approached at their places of employment and invited to partake in the study according to the eligibility criteria described above. They were not remunerated for their involvement. The data was collected through semi-directed interviews at the place of choice of the participants themselves, may it be at their workplace for convenience, or a public coffee shop for the sake of discretion. The social workers were invited to select a pseudonym to dually protect their anonymity and allow them to engage with their contribution later through personal recognition of the verbatim. We received the approval of the University of Ottawa's ethical committee to conduct this research.

In order to jointly assess professional identity, the professionals' workplace experience and the social representation of the professional distress, our interview guide was built around these three large themes. We have analysed in detail results from the first two sections and will thus focus on the matter of professional distress in this article, whilst always relating back to our previous findings. The final section of our interview guide comprised a number of exploratory inquiries to deepen our understanding of professional distress, namely about the personal experience of professional distress, the rationale behind its actualisation, others' experience of distress, its causes, the impact of the status of the francophone minority on professional distress, and the role of gendered experiences of distress for female social workers. Once transcribed, the interviews were manually organised using the Nvivo 11 software, a platform aiding the thematic structuration of the data to simplify qualitative analyses.

Data analysis

This article aimed to better understand professional distress in social workers practicing in a healthcare setting. More specifically, we hoped to improve our understanding of this widespread affliction according to front-line practitioners' shared perspective on their professional distress, how it relates to their professional identity and finally how it echoes the growing pressures of their daily workplace experience.

Like our previous studies, we employed an analysis of content to achieve our objectives. More specifically, was retained components of an integrated analysis of content (Negura, 2006) to determine the elements of the social representation of professional distress and their relative significance. Here, were analyzed the responses pertaining to the third part of the interview guide, in other words professional distress, for our analysis. The uncovered themes were organized as "nodes" within the Nvivo 11 software. We were then able to distinguish each node in terms of its relative weight within the social representation through co-occurrences. In other words, each element of the social representation of professional distress was coded either according to the number of distinct sources that mentions it (frequency) or the total number of times it appears in the context of the interviews (occurrence), regardless of the source. Globally, this enabled interpretations of significance for the group while providing a

measure of the relative importance of each representational element. These basic statistical measurements are used as a validating technique to the content found, while helping to determine the contextual ties between the elements themselves. The NVivo 11 software indeed permits the thematic arborisation of the themes retrieved, thereby explicating the conceptual links among them. This process is ultimately crucial to establish the social representation's complex ties with professional identity and lived experience, thereby commenting on the web of influences which shape this phenomenon.

Results

Balancing professional and personal lives

One of the first alleged and most persistent causes of professional distress within participants pertains to balancing the demands of professional and personal lives. Personal life is situated at the basis of workplace resiliency. When private matters are compromised, work becomes exponentially difficult:

> *I really love the work that I do, but it's hard. Combined with my personal life that is stressful as well, it makes a lot all at once. So, when both are not going well at the same time, it's definitely much harder. - Thérèse*

Conversely, work also impacts the clinical social workers' personal lives, persisting as thoughts and worries beyond office doors. This intrusion of case-related worries appeared to signify the emergence of distress:

> *I would tell you that, when I live a stressful situation at work, I will dream about it. […] That's when I know that, oh, oh no?, I am unable to disengage. That's when I'm most emotionally invested and at the greatest risk, you know. – Sophie*

> *Sometimes, I come home and I can't sleep. – Leti*

Often, working overtime is not genuinely voluntary. Systemic constraints leave little choice for the social workers themselves, who, through pressure alone, are compelled to prioritize work over familial responsibilities:

> *When you miss a work day because you have a family emergency, no matter why you take a vacation you know you'll pay for it. You know it's not worth taking the day off because when you'll be back, you'll be so overwhelmed; it's not even conceivable. – Héloïse*

Broadly, the blurred boundaries between personal and professional lives that is alleged to characterize the profession is said to contribute to professional

distress. These personal boundaries are additionally compromised by the very nature of the work and the commitment that it requires.

The challenging nature of social work

Social work is by no means an easy profession. The complexity of each case and the moral imperative of doing right by every individual who seeks assistance are made abundantly clear when discussing the meaning of the profession with our participants (Lévesque et al., 2019). This intrinsic difficulty is not, however, enough to cause distress. Rather, particular sets of circumstances, some more infrequent than others, manifest, according to our participants, as determinants of front-line practitioners' distress.

The first of those circumstances pertains to the difficult and vulnerable service beneficiaries and is closely tied with a recurring exposure to danger. Indeed, as they are sometimes involved in situation where freedoms are compromised (ex: having to call child protective services, recommending time at the hospital, calling the police, etc.), healthcare social workers are often seen by some service beneficiaries as agents of control and become the target of their indignation:

> *You have people when you tell them you need to send them to a hospital they said 'I know where you work I know what you do as a job and I'll find where you live and make sure that you'll pay for your decision […]. For months I would come to my office in the morning and I would be scared to open the door in case he was in the office, hiding somewhere or when I come in the parking lot. - Monique*

This image of social work comes in sharp contrast to the compassionate dimension of their professional identity (Lévesque et al., 2019) and is reportedly hard-lived by our participants. An added difficulty is the non-voluntary nature of the service provision, always in the midst of a crisis. The establishment of a caring therapeutic relationship is thus hampered:

> *How can I explain how it* [distress] *happens? Well, because, those scenarios are imposed right? Like, we are imposed. It's not someone that comes to see you from the community to ask for help. It's like, we're imposed in people's lives. And they are in crisis. - Sophie*

Within this contention, working to alleviate the hardships of service beneficiaries is expected. Rather, at the root of the distress lies the realization of the rising difficulties faced by clients and the overwhelming demands made upon social workers:

> *The situation, it was getting worse, and we got new information every day. And it was completely crazy. The stress grew because we didn't know what to do anymore with this situation, how to keep the people safe. – Béatrice*

> *The amount of work that we need to do to have the same result now compared to 5 years ago or even 2 is higher, because the complexity of health problems and social situations has increased. – Thérèse*

This reveals another distress-inducing consequence of the organizational changes implemented under NPM reforms: the powerlessness experienced by front-line practitioners on a daily basis. Limited by rising inequalities and social disparities beyond the scope of their practice, healthcare social workers are the first witnesses of welfare gaps and systemic limitations:

> *Sometimes, there are no solutions. You try to find more, you look in the community, you look for resources, you look everywhere, and you can't find anything. And the patient still expects that you will find what doesn't exist, you know. – Michèle*

While resource attribution, political power and decisional authority remains outside the influence of clinical social workers, they must deal with the consequences of large financial cuts to social programs and directly face the human misery that ensues. With advocacy as one of their core values, social workers risk aggravating their distress by absorbing this responsibility and making others' plight their own:

> *It's really tough for me because you can't do what you would like to do for people, to support them the way you would want. […] you're angry right, when you hear about social inequalities. I saw a lot of people in my area of work that are really angry when they hear that, you know, anything that has to do with the circumstances of families. They'll be really sad, ashamed even. - Tania*

Facing other's distress head-on is another contributor to distress, according to half of our participants. While a few difficult situations are tolerable, an accumulation of cases of overwhelming complexity leaves many at the brink of exhaustion:

> *So all of that human distress, that you see within a week, in a week I saw a lot. And then, I can say that I cried, I didn't know what to do. I was completely exhausted, morally exhausted. – Sasha*

Other than suffering from exposure to an accumulation of human misery, not all encounters are equal in their effects. In some cases, social workers may experience vicarious trauma when tackling devastating adversity:

> *As I was explaining our shell is solid until it starts to weaken due to what we hear day after day about people's suffering, and mine started to give this winter. […] It was the first time that, how would I explain it, that I was so shaken in front of someone's suffering. In other words, he traumatized me with his trauma […].* - *Rachelle*

In light of these intersecting challenges, keeping professional distress at bay is a feat in itself. Anchored in the professional values of social work itself, causes of professional distress extend not only to what is done but to what some deemed should be done on a daily basis.

What of workplace expectations?

Social workers in our sample denounced the unrealistic expectations placed upon them. Putting aside the disruptions to personal life, our participants alleged that workplace expectations exacerbated the risk of professional distress, with social workers shouldering impossible tasks:

> *Yeah, an impossible task. […] the patient expects us to find solutions and that causes us distress. And then, the employer of course. But the rest of the team. The rest of the team expects us to find solutions and we can't. – Michèle*

Simple and clear paths aren't always available to grief-stricken service beneficiaries, especially when resources and networks aren't in place to support them outside the institution. While this reality exceeds the boundaries of social workers' mandates, what expectations are placed upon them should be adjusted to the paucity of resources. When they do not, front-line social workers report shouldering the misplaced frustrations of unsolvable situations:

> *The team is always fed up with this person being here. It's always about when will he have his discharge... so there's huge pressure of working quick quick quick! Then you're told 'hey, he doesn't need to be at the hospital', but it's impossible to make a realistic discharge plan for him. – Michèle*

Apart from the problem-solving miracles clinical social workers describe being expected to perform, they also report being expected to execute them within a drastically short amount of time:

> *We don't always have the solutions. But when there is a problem, then it's like 'call the social worker, we'll solve a problem that's been going on for many years. But here! We'll solve everything within a few days'. – Thérèse*

The sheer number of caseloads allegedly tasked to front-line practitioners adds a layer of demand to the already unrealistic expectations they must contend with.

> *They* [managers] *say that they want every client to be seen within 5 business days after a first call. Already we have a month's worth of wait. They say that people evaluated at high priority should be assigned within 10 business days. We have people that have been waiting for 6 months in high priority. […] I said yeah you offer nice guidelines, but you don't provide the number of employees we need to meet those norms […]. - Monique*

Finally, while clinical social workers are conscious of the said unfeasible nature of administrative demands that must be formally (through guidelines) or implicitly (through norms or judgment) enforced, distress also arises from simply wanting to meet expectations and prove oneself as a worthy professional:

> *[…] you do tasks to please, just because someone asked you to and because it needs to be done, but it's never enough. Then you realize that you are draining yourself. No matter what you do, it's never enough. - Héloïse*

This matter of recognition is not limited to expectations alone and reflects a much broader issue that characterizes the professional lives of social workers in a healthcare setting.

<u>Beyond the day-to-day: recognition and the administration</u>

While not as explicit as an exposure to violence or a measurably overwhelming workload, a much more pernicious determinant of professional distress concerns the alleged lack of recognition of social workers' expertise and contribution. When gratitude is the prime reward of a profession, a lack of acknowledgment of the effort made from service beneficiaries comes as a devastating blow:

> *And you know, we are not very recognized by families, by the patients that we work for. We can sometimes work for days on end, for hours at a time to try to help those people and then, it's not acknowledged at all. – Sophie*

These occurrences are said to be particularly frequent in healthcare settings, as the clinical social worker's role contrasts with that of other members and is perceived to be poorly understood by the population at large:

> *So, we see it often, like the patients will say 'I want to thank the physiotherapist, the ergotherapist and the doctor. You are a fantastic team'. Social work is not often thanked because our role is a bit different. – Sasha*

Administrators and institutions are not exempt from this tendency and are also said to impair the healthcare social workers' sense of worth:

> *I've lost my voice. My voice is not wanted. And, if I say something, well people don't want to hear it. So, what's hard for me is to silence that voice because I've always had it and I've always talked. And for a while it was clearly understood, but now it's clear that I have nothing of worth to say. So, I have to repress all that, it's not good. – Mireille*

Outside the workplace, broad and uninformed criticism adds to the existing pressure. By dealing with sensitive cases and manifesting the will of governments through the application of policies and ministerial agendas, healthcare social workers reportedly become the target of blame and generalized frustration toward the system not only for service beneficiaries, but for society at large:

> *[…] it increases our fatigue, our burnout, because you arrive here every day and then you hear from the media 'oh they aren't doing this or that' or the big government that says 'oh, we'll be cutting here, we'll be cutting there', it's like, ok, yet we work so hard. It's not like we're here just twiddling our thumbs all day. - Rayne*

Budgetary setbacks are identified by many as the prime, most tangible example of the undervaluation of the social work profession by decisional authorities and the public:

> *In my view, social work or just social services and the people that provide them are not seen as important. And we see it plainly in governmental cuts, font-line staff cuts, font-line cuts. - Martine*

When not at risk of facing layoffs or the erosion of community resources (effectively their tools of practice), clinical social workers report feeling undermined by the limited understanding of administrators, in itself a contributing factor to professional distress:

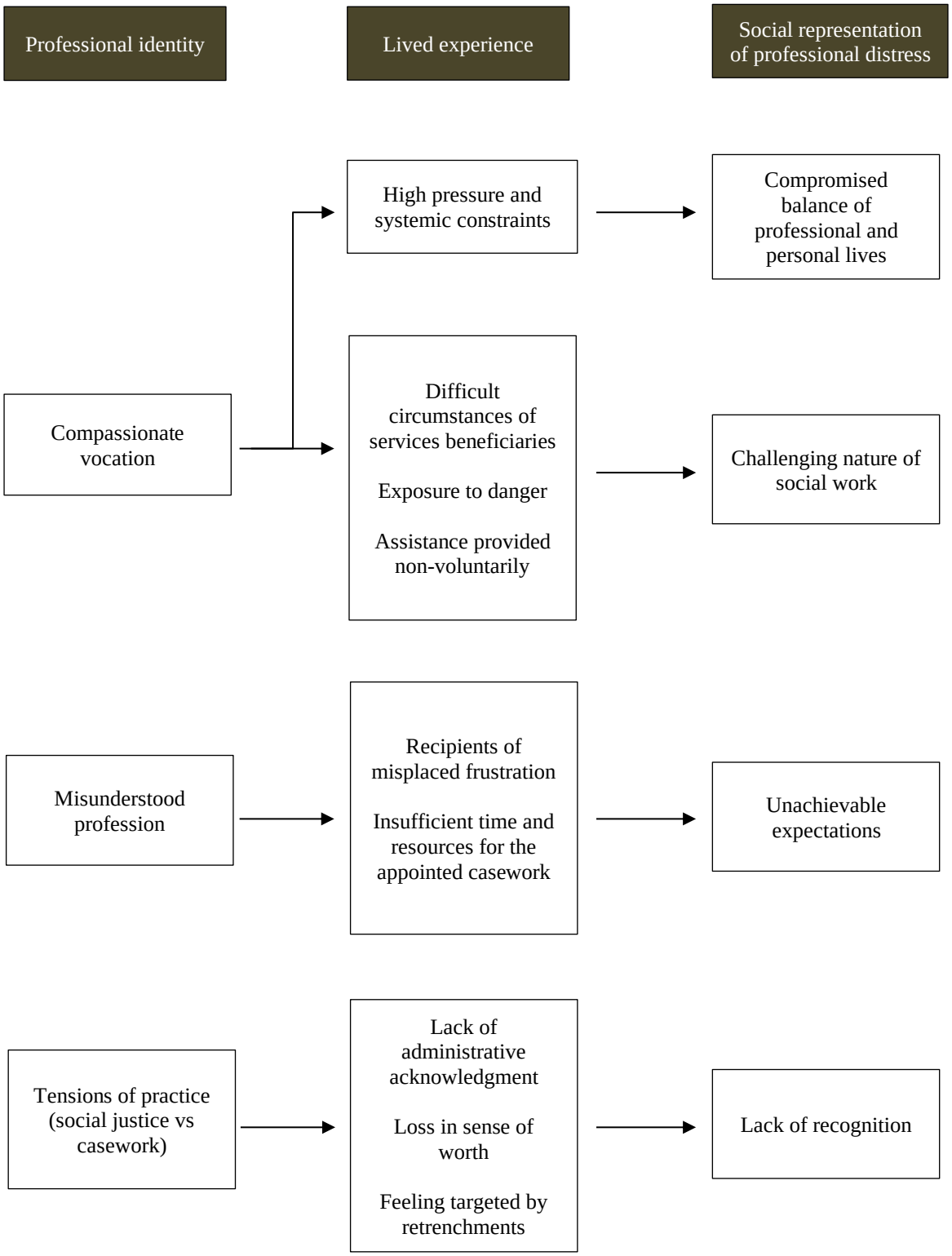
> *Even the supervisor, the director, they have no idea what we're doing and they don't want to know. […] You say you're tired, it's not going well, I can't concentrate, I can't sleep, I dream about work, I have nightmares about work, but yeah, it's okay, it your job. - Monique*

Ultimately, these persisting difficulties appear to lead healthcare social workers themselves to undervalue their profession, internalizing the neglect they experience daily:

> *You know when I talk about the wheel of nonrecognition, our own association doesn't recognize the work, doesn't understand what we do and does nothing about it. - Alexa*

Overall, our results consistently relate the social representation of professional distress in healthcare social workers to matters of experience and identity, establishing the fundamental role of each. The Figure 1 below synthesizes the ties found from our integrated content analysis (Negura, 2006), with contextual links conceptualized by way of a thematic arborisation and validated throughout with basic co-occurrence measures.

Figure 1
Interconnections between professional identity, lived experience and the social representation of professional distress in healthcare social workers



Discussion

After exploring the social representation of professional distress in social workers, our results reveal numerous intimate ties among the circumstances of the distress, social workers' view of their profession and the group's shared experience of mounting disparities between occupational values and workplace norms.

Professional distress: the deeper meaning behind the causes

Let us begin with the leading perceived cause of professional distress identified by our sample: the *compromised balance of professional and personal lives*. From our participants' testimonies, what becomes immediately apparent is that the necessary boundaries between professional and personal lives are described as impinged upon by the organizational constraints of the workplace. Indeed, with limited time and resources and an increasing caseload, healthcare social workers reporting feeling pressured to sacrifice their personal lives to achieve their expected contribution to the team. The encroachment of the occupation on the clinical social workers is such that it is not limited to overtime. It also takes the form of a 'mental invasion', trapping front-line practitioners in emotional prisons of guilt as they discuss assuming the responsibility of an insufficient social infrastructure. Work-related worries and anxieties are said to appear in the forms of dreams, obsessive thoughts and general malaise, effectively depriving the healthcare social workers of well-deserved downtime at home. The mental intrusion of the work-life is a symptom well detailed in the case studies of two healthcare social workers with confirmed diagnoses of professional distress (Ekman & Halpern, 2015). For our participants, it was conceived as an indicator of an imminent psychological breakdown, a sign to step back and solicit support.

The limited acknowledgment allegedly given by administrators may be linked to the perceived professional identity of social workers. Their worries are *to be expected,* as their self-perception is rooted in their devotion to service beneficiaries, believed to be a core value of the social work profession (Stickle, 2016). The intrusion of the workplace into every aspect of the social worker's life is thus perceived as not only normal, it is said to be taken for granted by healthcare institutions as they keep piling workplace obligations despite the high turnover of employees. Consequently, social workers report guilt at leaving their workplace for the day and report the need to coach themselves in order to emotionally disengage for the evening. This is of particular interest, as the emotions of guilt and shame have been more readily studied in child protection workers (Gibson, 2015). However, we would argue from our results that it should be given equal importance in the context of healthcare, as the social representation of professional distress as integrated these emotional tensions with great bearing on the lived experience of clinical social workers.

Professional identity thus bears great significance in the emergence of distress according to our participants, as it helps to explain the psychosocial mechanism facilitating the colonization of personal mental space by professional concerns. Indeed, professionalism is conceptualized by healthcare social workers around their devotion to service beneficiaries. When resources and power are insufficient to accomplish their occupational mission, our participants attempt to diminish their resulting feelings of guilt by drawing on personal resources and time, thereby compromising the sanctity of their personal lives. Here, our results attest to the importance of work life balance in the well-being of clinical social workers and the problems arising when managerial priorities induce compassion fatigue (Thomas, 2013) and professional exhaustion (Lloyd et al., 2002) by relying solely on the individual compassion and devotion of their professionals to provide adequate services (Abramovitz, 2018). When contending with significant pragmatic limitations, this clash between ideal and actual practice comes at the price of the clinical social workers' professional well-being. These findings align closely with research done by Graham and Shier (2014), who argue the importance of both work-life balance and the meaningful outcome of the job in the subjective well-being of social workers.

We may turn to our second important theme, the *challenging nature of social work*, to further investigate the social representation of professional distress through the lens of lived experience. Here, professional identity is even more flagrantly tied to the healthcare social workers' experience of professional distress. Social work is indeed said to be complexified by the very role professionals are made to endorse within healthcare institutions. While social workers' code of ethics demand of them to be the advocates of the marginalized (Canadian Association of Social Workers, 2005), their area of work allows for little opportunity to foster empowerment (Hyslop, 2018; Wilson et al., 2011). Rather, clients are often assigned to them in a non-voluntary manner and are alleged to project their general frustrations of the system onto their caseworker, a symptom of their role of policy implementers or 'street-level bureaucrats' (Lipsky, 1997). This is particularly challenging, as the contrast between the intentions of clinical social workers and the perceived disdain towards their involvement undermines what is said to be the occupation's greatest reward: gratitude.

From our findings on the social representation of professional distress, we further posit that the difficult nature of the profession is exacerbated by the complex needs of service beneficiaries, described to have escalated over the years as retrenchments to the Welfare State have persisted. This observation by our participants is one confirmed by Hick (2014), who attests to the increasing poverty and economic disparity in Canada from national surveys. The requirements placed upon clinical social workers have thus increased whilst their resources have been curtailed by financial cutbacks (Abramovitz, 2018; Baines, 2004). Less equipped to meet clients' demands, our healthcare social workers indicate feeling powerless to execute their mandate. Furthermore, faced with disgruntled service beneficiaries, they conceive of the need to be wary of

misplaced anger, as highly vulnerable individuals are reported to often blame front-line practitioners for institutional shortcomings, a well-known issue of the healthcare work environement (Cotton, 2017). In sum, the constant hovering risk of danger is a reoccurring theme of the front-lines practitioners' representation of professional distress.

Yet, as compassion is central to their professional identity (Lévesque et al., 2019; Stickle, 2016), healthcare social workers describe feeling less troubled by their own compromised safety than they are affected by the suffering of service beneficiaries themselves. The constant exposure to human misery is indeed a constant reality of the occupation, more so under neo-liberal policies (Dominelli, 2002), with our results pointing to the participants' experience of compassion fatigue and at times of vicarious trauma. This supports our initial review of the literature on the systemic determinants of subjective well-being (Abramovitz, 2018; Dominelli, 2002; Lloyd et al., 2002; Phillips, 2019; Roland-Lévy et al., 2014). The accumulation of emotional needs from clients is incorporated by many social workers preventing them to tend to their own state of mind as they prioritize the needs of others even when faced with concrete signs of their personal mental health decline (e.g. insomnia, anxiety, fits of crying, etc.). Faced with allegedly increasing workplace pressures and an eroding quality of life for the underprivileged, healthcare social workers recall the corresponding disregard they anticipate from administrators, a phenomenon denounced by some in the scientific community (Coyle et al., 2005). These circumstances concurrently reinforce their perception of the profession as one of compromise, sacrifice and hardship.

Unachievable expectations, in their own right, echo the leitmotif of healthcare social workers' workplace experience so far: the reported unrealistic management of tasks with dwindling resources to meet the needs of service beneficiaries. This, in turn, increases the guilt felt by clinical social workers who, beyond grappling with constant difficulties in the pursuit of their own mandate, are acutely aware of disappointing those they seek to help. While conscious of the impossibility to meet the expectations placed on them, healthcare social workers are nevertheless deeply affected by the sense that they are unworthy of their profession. Faced with a blow to their self-esteem and shared perception as professionals, our front-line practitioners report one of either two reactions: 1. pushing past their own limitations to please employers and clients alike, even when approaching burnout, or 2. disengaging emotionally from their mandate and clients. This second alternative is akin to the consequences arising when the psychological contract of employment is broken (i.e. when the work expectations fail to apply following changes in obligations or work conditions) (Coyle-Shapiro & Kessler, 2002). The uncovered social representation of professional distress thus not only orient the interpretation and hierarchization of the determinants of professional distress but might also serve to construct them entirely. Our empirical findings ultimately align with Jodelet's (2008) conceptualization of experience as a felt and lived process jointly informing and influenced by representations. Concretely, our findings suggest that the social

representation of professional distress in clinical social workers does shape the subjective well-being of this occupational group.

This brings us to another aspect of the healthcare social workers' account of their distress: *the lack of recognition* they endure. In the particular context of healthcare institutions, clinical social workers indicate feeling rather marginalized from their interdisciplinary colleagues. In interviews, this is attributed to the lower legitimacy thought to be possessed by the social work profession compared to the medical sciences (Beddoe, 2013). Clinical social workers thereby report being undervalued within the team by administrators and patients alike. While patients may forgo them entirely when reflecting on their recovery, the devaluation of social work by administrators is attributed to the choices made when carrying budgetary cutbacks and the consequent precarity of the clinical social workers' employment, itself a confirmed practice (Baines, 2004). Presumed ignorance about the profession, doubled with the alleged disinterest to know more, aggravates the erosion of the healthcare social workers' sense of worth. Some of our participants have even expressed being cognizant of the ways by which this circle of prejudice has been internalized by their occupational group and has further catalyzed the professional distress among them through the depreciation of their deep-seeded purpose. Without condoning the general resignation to a perpetual state of occupational dissatisfaction, our participants foster the critical thought necessary to address the processes at the root of their professional distress. This display of metacognition (Frith, 2012) among healthcare social workers provides great insight into their shared circumstances. These results ultimately reinforce the relevance of a critical approach to social representations research (Howarth, 2006).

Limitations of the study

Before concluding on the implications of our study, it is important to shed light on the limitations of our results. To start, as we have restricted our eligibility criteria to female francophone social workers, we cannot claim that our sample is representative of all Canadian healthcare social workers, even less so of Canadian social workers in other fields of practice. As such, our results ought to be understood with regards to our participants' singular characteristics. We argue that our results remain of interest given the regional diversity of our sample and the female majority of social workers (83%, see Government of Canada (2018)). Additionally, given the number and complexity of the intersecting determinants of the social representation of professional distress, the subjective themes uncovered in the thematic analysis often overlapped and should not be considered in isolation. This rendered the quantitative assessment of each distinct element difficult, as some measures of frequency and recurrence may not reflect the full extent of each element found. This is however an expected outcome of the analysis which aims to reflect the complexity of the issue at hand. The joint elucidation of the social representation of professional distress through identity and lived experience hence constitutes a distinctive

contribution by apprehending the representation as a whole while remaining faithful to its given context. We thus hold that our results are of great interest to the field of academic social work and provide an original understanding of the determinants of professional distress as represented by the healthcare social workers it concerns.

Conclusion

The study of the social representation of professional distress in social workers proved complex and multi-faceted. Our results attest to the fact that professional distress in social workers is not represented as an isolated phenomenon and bears roots in identity and experiential factors concurrently. We found that consensually throughout three Canadian provinces, front-line practitioners identify their current psychosocial and organizational contexts as contributors to their professional distress, a matter alleged to be further compounded by the misrepresentation of their profession. The perceived misrepresentations held by administrators, colleagues and service beneficiaries alike is alleged to cause, according to their social representation, much of the professional distress experienced by social workers, who report a lack of recognition, gratitude and expectations suitable to both their expertise and their practice's realm of feasibility. The established qualities of clinical social workers, specifically their compassionate disposition, devotion and care (Stickle, 2016), is represented by the occupational group as being instrumentalized to achieve managerial targets of cost-efficiency, a matter surveyed and posited recently by Abramovitz (2018). Beyond daily work life, healthcare social workers have integrated the larger systemic trends they have observed to their social representation of distress by reporting the psychological suffering incurred from confronting the declining community resources and tools to advocate on behalf of their service beneficiaries. Finally, the representation of the bleak prospect of their future in healthcare under continuous retrenchments was found to exacerbate the shared experience of distress they commonly face and threaten their sense of purpose within the institution.

The reading made on professional distress is here a cautious one, seeking first to serve as an alternative to strictly psychological individual explanations of distress in social workers. Our findings also provide avenues of reflection for future research on the concurrent determinants of professional distress at varied degrees of influence. Finally, our study sought first and foremost to do justice to our participants and to recognize their adept understanding of their own circumstances and shared battles. As a conclusion to our previous studies, we hope to have adequately drawn ties between professional identity, the shared experience of organizational constraints and professional distress, as the phenomenon deserve to be explored with regards to the representational dynamics at play. With an alleged flawed representation of social work by those around them, front-line practitioners' battle for recognition and a better work life should start by raising awareness about the social worker's mandate and values

while denouncing the impacts of representational conflicts on the entire occupational group.

Study 4

The unsuspected ties between linguistic affiliation and professional distress in healthcare social workers

Francophones in a minority setting: how language shapes institutional relations

In addition to the rich variety of aboriginal languages, two distinct languages have predominantly defined the cultural landscape of Canada: French and English (Landry, Forgues & Traisnel, 2010). Bearing roots in the founding narrative of the country, the constitutive status of the two languages was legitimized in 1982 in article 16 of the Canadian Constitution, deeming them both official languages and protecting the French-speaking minority from the risk of cultural extinction by granting them, in principle, equal rights to French services and resources in every public context (Constitution Act, 1982).

The constitutional rights of Francophones have been implemented with varying degrees of success over the years, and Francophones in minority settings still contend with accessibility challenges to public resources, particularly in the context of healthcare (Bouchard, Colman & Batista, 2018). As our previous research has shown, the very experience of healthcare services may change for Francophones according to linguistic factors, with those services generally being increasingly medical and impersonal in English-speaking settings and more relational and informal in French-speaking contexts (Lévesque et al., 2018). We therefore argue that, depending on the social representations held by services beneficiaries, equity in service access requires not only the existence of bilingual services, but also an active offering of Francophone resources with full awareness of their emotional and symbolic significance.

Francophones in minority settings report feeling in poorer health than Anglophones of the same region, independent of gender or age (Bouchard et al., 2009; Chomienne et al., 2010). This poses a real challenge for the fair provision of healthcare services and emphasizes the pivotal role of Francophone service providers. Indeed, healthcare workers, along with every other government-funded professional, actualize public policy and effectively constitute society's experience of the law (Lipsky, 1997). As such, French-speaking professionals in minority settings bear the responsibility owed not only to their employer but also to the community to which they provide services.

This is particularly true for healthcare social workers, who describe being called to the profession as an act of devotion to their community (Stickle, 2016). When the interests of administration and community are irreconcilable, this dual allegiance does a disservice to the social workers' own well-being in the workplace (Fantus et al., 2017). Further, a social worker's practice is based on their ability to create a therapeutic relation (Sudbery, 2002), which, in turn, relies heavily on their communication skills. Likewise, healthcare service beneficiaries expect to receive quality care with minimal misunderstandings. For them,

limited access to French-speaking professionals correlates with higher risks of medical errors (diagnosis and medication), adverse events, lower healthcare access and higher likelihood of service dissatisfaction (Bowen, 2015). Lastly, linguistic equitability possesses a non-negligible symbolic relevance to the provision of healthcare services. Our results from a previous study suggest that Francophone service beneficiaries seeking assistance for a depressive episode viewed their mother tongue as constitutive of relation-based care (Lévesque et al., 2018).

Within healthcare institutions, the stakes are thus highest for social workers at the service of Francophone communities, as the number-intensive approach to casework proves challenging in the context of a relation-based paradigm of care. With this in mind, we wondered how healthcare social workers who work in providing services to Francophones in minority setting experience their Francophone status and whether it bears any impact on their workplace well-being. This inquiry was pursued also in response to Molgat and Trahan-Perreault (2015) who, while acknowledging the recent diversification of research on Francophone minorities, report a lack of interest in the significance of this linguistic affiliation within institutional social work settings.

We aimed to contribute to the scientific corpus on Francophone specificities in Canada by conducting a larger study on professional distress in healthcare social workers who identify as Francophones in minority settings. Our previous analyses of this larger data set uncovered a complex network of variables in the self-reported distress of front-line professionals. According to our participants, this alarming trend can be traced to, among other factors, widespread financial cutbacks targeting mainly social workers and their community resources, the undervaluation by and ignorance of colleagues, administrators and service beneficiaries alike, the difficulty of balancing busy professional and personal lives and the limited guidelines and preparedness possessed by social workers at the start of their employment.

Exploring our language-specific results became our final priority, as the literature is not clear on whether linguistic affiliation, as opposed to simply a minority status, has a definite negative impact on workplace well-being or more generally on mental health. Gallo et al. (2009) have shown how cultural belonging may protect minority groups against unfavorable health outcomes. An earlier study by Mossakowski (2003) adds credence to this possibility by reporting the mitigating effects of a minority affiliation on depression. More specific to our population, some comparative research on Francophones and Anglophones together did not find significantly worse outcomes for the minority group, with a study by Puchala et al. (2013) relating how little variation in mental health was measured between linguistic groups in both minority and majority settings. Further, a very recent paper by Bouchard et al. (2018) reviewed a nation-wide census and reported little health differences between linguistic groups, regardless of the persistent difficulties in healthcare-service access afflicting minority Francophones.

In terms of their perception of their general state of mental health, inconsistencies were highlighted with respect to the reporting of a major depressive episode over the course of their lives. In fact, 14.3% of Francophones reported suffering from depression, compared to 11.4% of Anglophones (Chomienne et al., 2010). In addition, a study by Savard et al. (2013) reveals how Francophone healthcare professionals in a minority setting are impeded by their own institutions in the creation of social capital for their community and must perform compensatory work to rectify the structural inequities facing their service beneficiaries. In light of these results, we wondered whether the workplace well-being of Francophone professionals in a minority setting was possibly affected by their linguistic identity across two dimensions. Firstly, healthcare social workers may suffer adverse consequences as a result of their linguistic minority status, which could affect their perceived levels of health. Second, the added workload related to linguistic matters (ex: translation) in comparison to their Anglophone counterparts may negatively affect the workplace well-being of Francophone social workers and play a role in the professional-distress epidemic they face (Lloyd et al., 2002).

Overall, it is clear that health disparities exist between minority and majority groups, with the latter favoured most often than not (Angel & Angel, 2006; Na & Hample, 2016; Nelson, 2002). Angel and Angel (2006) suggest that these disparities are actualized by social structures and legitimized through institutional pressures. By exploring the ties between language and professional distress in healthcare social workers, we hope to answer the following research question: How does working as a Francophone healthcare social worker in a minority setting affect those workers' daily professional experience and influence their social representation of professional distress? Our objectives are twofold: 1) determine the role of linguistic affiliation on the social representation of professional distress in social workers and 2) situate the underlying dynamics within the daily context of the healthcare social workers' professional experience.

Lived experience, professional identity and power: understanding them all using the social representations' theory

Our wider research on healthcare social workers focused particularly on their workplace experience and their shared representations of social work and professional distress. It should thus be noted that this article, as a continuation of this broad reflection, contributes to the literature on the subjective experience of health in Francophone minorities. As such, it matters less what objective measures of well-being can be derived from our participants but rather what they, as a group, deemed to be of interest in the conversation around linguistic affiliation and its bearing on psychological distress. To better interpret this narrative, we have situated our research under the theory of social representations, a paradigmatic approach focused on the logic, genesis and interpersonal dynamics of common sense (Rateau & Lo Monaco, 2013). In this framework, social representations constitute a structured realm of knowledge

shared by a group around a specific social object (Abric, 2003). As process of social thinking, they have an instrumental function providing the necessary references to navigate complex cultural and social systems.

For the purpose of this article, we argue that an exploration of the social representation of professional distress may reveal what influence linguistic affiliation may have on workplace experience. Indeed, social representations play a crucial role in the construction of professional identity (Lévesque et al., 2019; Fraysse, 1998). They contextualize, historically anchor and guide practices for a given group (Elejabarrieta, 1994), thereby framing an occupational role. Furthermore, social representations work to legitimize the professional group by contrasting its knowledge base amongst other occupational bodies (Lac et al., 2010).

As social representations are mobilised by dominant groups to organize hierarchies, protocols and the overarching normative structures that define the workplace, they facilitate power relations within institutions (Lorenzi-Cioldi, 2009). Given the minority status of our participants, an exploration of these inner power dynamics is crucial to properly situate their experience of distress in its systemic context. The lived experience (Jodelet, 2012) of clinical social workers will be explored in depth in this article, as it is given meaning by the social representations. By extension, the social workers' lived experience shapes their comprehension of their linguistic affiliation. According to Jodelet (2006), lived experience not only refers to the knowledge surrounding a given circumstance but also further accounts for the subjective feelings that it brings to the surface. The social workers' lived experience is incorporated into their subjective selves, thus shaping their professional identities within a Francophone minority setting (Negura, 2017). Under the theory of social representations, lived experience, power and professional identities are thus strongly interrelated and should be considered jointly in the search for an adequate understanding of a group's shared perspective.

Methodology and analysis: A qualitative assessment of linguistic affiliation

As mentioned previously, the data used for this study was collected in the course of a larger study on the professional distress of social workers in a healthcare setting. Our research recorded the testimonies of 30 Francophone participants from three provinces in Winnipeg (Manitoba), Ottawa (Ontario) and Moncton (New-Brunswick) who had a self-reported experience of professional distress, described to participants as "a notion used to encompass the many forms taken by psychological distress at work, including stress, depression, professional burnout, suffering, etc.".

Of note is that we aimed to interview equal numbers of Francophone participants from each region, as specificities regarding their cultural identity, namely historical differences between Acadians, Franco-Manitobans and Franco-Ontarians, could introduce variability in the interpretations of the workplace experience. By equalizing the inclusion of participants from every background, we sought to explore the common ground between groups. The sample was also exclusive to female social workers, as all voluntary participants were women. The methodological limits the study are discussed further in the article. The demographic characteristics of our participants can be seen below (see Table 1).

Table 1
Distribution of the sample (n=30)

Sociodemographic characteristics		(**n)**
Age	20-25	1
	26-35	15
	36-45	10
	46-55	2
	56-65	2
Municipality	Moncton	10
	Ottawa	10
	Winnipeg	10
Years in current position	0-5	15
	6-10	11
	11-15	4
Workplace setting	Institution	25
	Community	5

Healthcare social workers were voluntarily recruited under the principles of purposive sampling. Eligible participants were retained to maximize the representativeness of the sample in healthcare settings across provinces. The front-line practitioners were contacted by word-of-mouth, administrative initiative and direct contact by the researchers at team meetings. The interviews were held at the participants' convenience and at their place of choosing. Participants were also given the opportunity to choose individual pseudonyms to be quoted in upcoming publications. When none was chosen, the researchers assigned an arbitrary name to ensure confidentiality when citing verbatims. The study received the approval of the University of Ottawa's ethics committee.

The data consists of the transcriptions of 30 semi-directed interviews that lasted between forty-five minutes and one hour, all collected in the summer of 2017. All interviews were conducted in French. While some English was used due to a participant's spontaneous preference, most verbatims had to be translated in their entirety. The original quotes are displayed along the authors' translation within the article to honour the bilingual nature of the research and to avoid the loss of meaning incurred by the translation process (Wong & Poon, 2010). The interview guide was composed of three sections which dealt with distinct aspects of the social workers' social representations: social work as a profession, their experience of organizational constraints and professional distress.

An inductive approach was used in accordance with our descriptive research design. A thematic analysis was performed on the transcripts after they were coded using the NVivo platform, a software designed to facilitate the organisation of qualitative data. Nodes of meaning were coded in accordance with the larger recurring themes and sub-divided with regards to the distinct positionings and elements of significance to which they correlated. The influence of linguistic affiliation on the workplace experience of social workers was discussed mainly from the perspective of professional distress but also through its spontaneous occurrence in the distinct contexts of professional identity and organizational constraints. For the sake of exhaustivity, all relevant responses pertaining to linguistic affiliations were taken into account for the content analysis and are discussed with regards to their place of occurrence in the interviewing process.

Results

Prior to our interviews with healthcare social workers, our literature review had led us to surmise that a minority linguistic affiliation would at the very least worsen their professional distress due to added unofficial duties, namely translation (Lloyd et al., 2002; Savard et al., 2013; Savard et al., 2014). While our results indeed confirm our initial assumptions, we were surprised to discover just how varied and profound these factors that contribute to professional distress could be. Our participants suggested four specific ties to professional distress: professional identity, their experience of stigma, the altered nature of their role and the precarity of their employment. These findings are all conveyed through the lived experience of professional distress and together relate to the manners by which this distress can be exacerbated, be it on an individual level (the personal ability to build a therapeutic relationship) or on a social one (the status of the profession).

Professional identity and language

As expected, working in a second language ties into the experience of professional distress on a logistical level. Social workers report added exhaustion as a result of their constant translation efforts:

Parce que je m'en vas pis j'me dis que j'suis fatigue c'est pas parce que j'ai trop travaillé, c'est parce que mon cerveau travaille à traduire tout ce que j'fais dans la journée […]

When I leave I tell myself I'm really tired and it's not because I worked too much; it's because my brain is so tired from translating everything I do during the day [...] - Laëtitia

That being said, this language barrier does much more than simply complicate the daily provision of services. Our participants have reported the many ways in which working in English might undermine the reliability of their practice and, correspondingly, the integrity of their relations with service beneficiaries:

Mais, ton thought process est en français. C'est tellement plus facile de t'exprimer, d'arriver à connecter les émotions, de reformuler les choses que les patients vivent.

My thought process is in French. It's so much easier to express yourself [in French], to be able to connect with emotions, to reformulate what the patients are living. - Héloïse

Upon exploring this matter further, it becomes apparent that this initial obstacle to the provision of services goes to the core of professional identity. Mental-health-service users in an anterior research on service access described French as "the language of the heart" (Lévesque et al., 2018) and considered it integral to a relation-based practice. While not as precisely articulated by social workers, this sentiment is conveyed by the way participants identify their native language as an integral part of their authentic selves, which, in turn, facilitates a relation-based practice:

Je suis plus moi-même en français. La communication avec l'équipe, je suis juste, bien, je suis meilleure à communiquer en français. Même si je me dis complètement bilingue, on a une différente personnalité, je pense, quand on parle dans une langue qu'on est moins confortable.

I am more myself in French. The communication with the team, I'm just, well, I'm just much better at communicating in French. Even if I consider myself fully bilingual, we have a different personality, I think, when we speak in a language in which we are less comfortable. - Michèle

Quand j'utilise le français, ça va mieux. Ça passe mieux, je suis plus à l'aise, puis je vois que la personne en face de moi est satisfaite aussi. Donc, ça rend la vie plus facile.

> *When I speak French, it's better. It goes better, it gets through better, I'm more at ease and I see that the person in front of me is more satisfied also. So, it makes life easier. - Leti*

Having to perform professional duties in a second language thus threatens to complexify the day-to-day work not only logistically but also emotionally, rendering the social worker less able to be her professional self and foster an authentic therapeutic relationship.

Professional identity is also said to relate to linguistic affiliation in that social workers self-identify as the Francophone community's advocates and endorse the consequent responsibilities assumed by their representative in the healthcare system:

> *Ça fait que nous, on s'assure d'être toujours là pour défendre [nos patients francophones] un peu. On ne parle pas de défense, on parle de représentation, mais bon, on défend un peu les droits et les intérêts de francophones.*

> *We just make sure to always be there to defend them [francophone patients] a bit. We don't speak of defense as much as representation. But yeah, we defend a bit the rights and best interests of francophones. - Sara*

This need for activism in the workplace, while an added responsibility to an already overloaded list of obligations, was never brought up as a negative. On the contrary, given how it tied to the professionals' ethos, linguistic advocacy was mentioned in conjunction only with the benefits to service beneficiaries:

> *Puis, je pense que c'est parce que les gens aussi se sentent ici comme que c'est un hôpital francophone, puis que tout le monde parle en français autour, puis qu'ils sont plus contents de cette réalité. Ça, quand on voit, ils plus contents. On dirait qu'ils sont plus contents de nous voir.*

> *I think that since people feel like this is a francophone hospital, and everybody is talking French around them, well they are happier with that reality. It shows when people are happier. They seem happier to see us. - Fesefel*

While facilitating interventions with Francophone patients, the Francophone linguistic affiliation was named as a disadvantage as well, as Anglophone service beneficiaries were alleged to engage in discriminatory patterns:

Des fois, on a des patients qui ne veulent pas être ici juste parce qu'on est vu comme un hôpital francophone. Ils sont anglophones. Puis, des fois, on l'entend qu'ils ne veulent pas être ici. Tu sais, ils nous appellent des frenchies.

Sometimes we have patients that don't want to be here just because we are a francophone hospital. They are anglophones. And, sometimes, you are told that they don't want to be here because of it. You know, they call us frenchies. - Michèle

At the root of the problem, we find that linguistic affiliation calls into question the validity of the professional mandate on the basis of pre-existing prejudice. This brings us to the next concern raised by healthcare social workers: stigmatization.

Double stigmatisation in the workplace

Our first study revealed how professional identity in healthcare social workers is currently weakened by inner dissensions. Given the lack of consensus on the precise nature of the profession and its controversial position in a medical setting, healthcare social workers are constantly required to prove themselves:

Je suis toujours en train de me prouver.

I'm always proving myself – Leti

Having to advocate for their legitimacy, our participants indicated that linguistic affiliation compounds their struggles for recognition in contrast to their colleagues with greater disciplinary repute like doctors and nurses. Under these circumstances, the Francophone identity is said to act as an additional barrier to interacting with other service providers:

Comme ça, le fait d'être en minorité, ça n'aide pas beaucoup comme ça limite un peu plus nos interventions. Même quand on appelle à une place que c'est seulement anglophone, je pense qu'on est perçu d'une façon différente. Quand tu demandes, puis que tu as un accent, puis j'ai double accent, c'est toujours un peu comme, je pense, c'est un peu limité dans l'accès de services.

It's like, the fact of being a minority, it doesn't really help it limits our interventions. Even when you call a certain place that is only anglophone, I think we are perceived differently. When you make a request and when people hear that you have an accent, and I have a double accent, it's always like, you're more limited in the services you can access. - Fesefel

Further, healthcare social workers experience stigmatization through the inevitable linguistic barriers that impact their relations with colleagues and patients alike. Among healthcare professionals and administrators, a double standard is alleged to plague every aspect of their daily work life:

> *J'verrais jamais ça d'un francophone qui reçoit un email en anglais pis j'en reçois pis j'me dis pas « Oh my God, envoie-moi un courriel en français ». Jamais, jamais jamais jamais j'ai fait ça. Pis j'suis à une institution francophone pis j'pourrais le faire mais voyons, pourquoi qu'elle m'écrit en anglais. Non, elle est plus à l'aise. Fine.*

> *I would never see the same expectations from a francophone that received an email in English. I get them and I never think "Oh my God, just send me an email in French." I would never, ever, ever, ever ask that. I am technically in a francophone institution and I could question why she writes to me in English. No, she's just more at ease. Fine. – Alexa*

In cases of misunderstanding, administrators are also said to side with patients on the basis of language, a symbolically charged choice that undermines the participants and speaks of the weakened status they hold within their institutions:

> *Mais, à un certain moment, il arrive que cette famille-là dit à ma boss qu'ils n'ont pas compris qu'est-ce que j'avais dit. « On n'a pas compris qu'est-ce qu'elle disait, elle ne parle pas anglais ». Puis, ma boss, dès qu'elle sait, elle vient et puis j'ai tort, j'ai mal fait la job. Donc, toutes sortes de choses qui me tombent dessus.*

> *Sometimes, a given family can tell my boss that they didn't understand what I had told them. "We didn't understand what she told us; she doesn't speak English". And then my boss, as soon as she hears that, she comes to me and blames me, tells me I didn't do my job properly. So, all sorts of things end up on my shoulders. - Leti*

Finally, these proficiency standards in both languages are perceived to apply predominantly to social workers, with management operating under a far more lenient decorum:

> *On s'entends-tu que traduire c'est pas un élément facile pis j'vas dire on a un regard où qu'on est des pédagogiques où qu'on corrige, faut avoir une belle position même au niveau de français. Tu sais j'veux dire moi j'ai des superviseurs qui m'écrivent, ça leur a pris 30 secondes à m'écrire avec les mots tous croches pis des fautes partout.*

> *We can agree that translating is not an easy task, and we have to be scholarly, correct ourselves and take care even in French. I mean, I have supervisors that write to me, it takes them 30 seconds and they write with inadequate wording and mistakes everywhere. – Alexa*

An indication of this injustice is the perception that institutions staff English unilingual positions, even if the healthcare facility is mandated to offer bilingual services, for which there is sufficient demand:

> *Y'a des postes unilingues anglophones au département […] Pis moi si y'a des postes unilingues anglophones y devrait en avoir des postes unilingues francophones. On a en masse de dossiers français comme qu'on a en anglais*

> *Well anglophones have unilingual anglophone job postings. […] To me if there are unilingual anglophone jobs there should be some unilingual francophone postings. We have quite enough francophone files, just as many as anglophones ones. - Jordana*

This alleged inequity in protocol brings into question the legitimacy of the linguistic pressures perceived by our Francophone participants. The unilingual administrative hires call into question the organization's commitment to bilingual proficiency. The high expectations set on Francophone social workers appear to serve as additional leverage for management to weigh in on their healthcare social workers' professional lives, either regarding communication standards or, more concerningly, their employment stability.

<u>Francophonie and the precarity of employment in institutional settings</u>

At their extreme, the issues related to the alleged one-sided expectations of linguistic proficiency take the form of additional employment precarity. Beyond the stigmas that surround linguistic affiliation, healthcare social workers report feeling targeted by administrators on the basis of language. Indeed, contrary to their unilingual Anglophone colleagues, Francophone social workers in a minority setting denounce the requirement to prove their proficiency in English as a condition to their employment:

> *Pis t'as des travailleuses sociales dans la Péninsule que ça fait X nombre d'années qui travaillent […]pis là y'ont [l'administration] décidé qui faut faire des tests d'anglais pis y passent pas les tests d'anglais. C'est des travailleuses sociales d'expérience qui se font enlever leur emploi parce qui peuvent pas parler anglais.*

> *You have social workers in the peninsula that have been working for many years […] and then they [the administration] come by and decide to administer English proficiency tests and they don't pass*

the English test. Those are experienced social workers who are losing their jobs because they can't speak English. – Alexa

Power discrepancies between social workers and their institutions are thus reinforced by adding uncertainty to an already precarious line of employment, with social workers being the first target of financial cutbacks and budget restrictions across provinces (Baines, 2004). The perceived lack of such constraints for the linguistic majority is distressing to Francophone social workers in a minority setting, who describe being acutely aware of this double standard:

Intervieweur: Est-ce que ce test de langue-là existe pour les anglophones pour parler français?

Participant : Non. Non, j'pense ça doit exister mais… […] les anglophones bien y'ont des postes unilingues anglophone.

Interviewer: Does this test [English proficiency] exist for the anglophones in French?

Participant: No. No it might exist but… […] Anglophones, they have positions that are unilingual to English. - Jordana

Furthermore, these alleged dismissals on the basis of English proficiency are experienced as a particularly symbolically violent ordeal, with social workers claiming English-proficiency as the institution's priority ahead of their experience and their value as professionals:

Une employée que ça faisait 3 ans qu'elle était au département. Excellente travailleuse comme elle avait du feeback positif des familles, elle parlait en anglais. Elle avait un accent francophone, a venait du nord, qu'était vraiment un thick accent […] les familles la comprenaient. Elle avait des dossiers aussi tant anglophones que francophones mais elle a pas passé son test pis elle a été mis à la porte.

An employee had been in the department for 3 years. Excellent social worker and she got positive feedback from families, spoke English. She had a francophone accent as she came from the North, and it was a rather thick accent […]the families understood her. She had just as many anglophone as francophone files, but she didn't pass her English test and got dismissed. - Jordana

The perceived administration's proneness to value bilingualism above experience and professional worth cripples Francophone social workers' sense of employment security and adds to their subjective distress. In a climate of

uncertainty, our participants feel unable to question the expectations placed on them and the unfairness of the *status quo*:

> *Il faut qu'on s'assure qu'on va aborder les choses d'une façon qui va être acceptée par la grande majorité, qu'on ne va pas bouger trop de roches, mettons, pour ne pas créer une friction ou rien de ça.*
>
> *We have to make sure to bring things up in a way that is going to be accepted by the majority. We don't want to be moving too many rocks, let's just say, or create friction or anything like that. - Sara*

This alleged power discrepancy is of utmost importance to understanding how linguistic affiliation complicates every aspect of the lived experience of healthcare social workers and informs their representation of professional distress. Indeed, employment precarity weighs heavily on our participants' well-being, intensifying the pressures to conform.

Changing the nature of social work

As a result of social workers' perceived employment precarity, our participants report feeling warry of advocating for themselves. Under these circumstances, linguistic affiliation is alleged to unfairly benefit the institution, with tasks outside of the social workers' job description being forced upon them in addition to their regular mandate:

> *Je suis souvent prise à faire de la traduction parce que je suis vraiment bonne dans les deux langues.*
>
> *I'm always stuck doing translating because I'm really good in both languages. – Joëlle*

Translation tasks are far removed from the social workers' actual mandate, which calls into question the integrity of the professional role. Participants' have reported professional boundaries being crossed on the basis of their indispensable translating abilities, while no effort was being made to provide adequate replacement or support:

> *[…] si je parle en français, je prends des notes en français. Puis, là, si je suis en pause, en vacances, si je suis malade, puis quelque chose arrive d'urgence sur mon client avec lequel je parle en français, toutes mes notes sont en français, alors il y a une prochaine étape à prendre ou je reçois un appel lorsque je suis n'importe où sur, « Ok, qu'est-ce qui arrive dans cette famille ? Tu n'as pas traduit tes notes encore. Alors, qu'est-ce qui arrive ? »*

> *[…] if I speak French, all my notes are in French. Then, if I'm on my break or I take some vacation or am sick and something urgent comes up with the francophone client, all my notes are still in French. Then I start getting calls no matter where I am about "Ok, what's going on with this family? You haven't translated the notes yet. So, what is happening?" – Tania*

Far more than a pragmatic issue, the prioritization of translation weakens the professional status of social workers by detracting from their authentic mandate. These added tasks are experienced by social workers as foreign and burdensome, simply added on to the point where some feel compelled to conceal their Francophone identity in order to safeguard their role and their time:

> *Mais, on a tous dit la même chose : aussitôt que tu es bilingue, il n'y a pas juste ton travail, ta liste ordinaire, aussitôt que tu es bilingue, il y a toujours des rajouts. Puis, on n'enlève pas, on rajoute toujours. Puis, ensuite, il y a un sens de pression. Puis, il y en a une qui dit qu'elle refuse de laisser savoir les gens qu'elle parle français maintenant, parce que ce n'est pas juste de toujours avoir des rajouts.*
>
> *But, we all say the same thing: as soon as you are bilingual, there is not just your work, your ordinary list, there are always additional tasks. And, we don't take anything away, we keep piling it on. And then, you feel a pressure. There is one of us that says that she refuses to let people know that she speaks French now, because it's unfair to constantly have added work. - Rayne*

Most damaging to the professional experience of healthcare social workers is the perceived reluctance of the administration to acknowledge the undue work involved with translating duties, allegedly taking for granted that our participants would perform those tasks without additional compensation. This frustration was manifested in terms of the fear of losing their position, thus clearly expressing how this compliance was said to be leveraged through employment precarity:

> *Mais, ça serait une chose si ça serait qu'on changerait juste de poste, mais ce n'est pas ça qu'on rajoute toujours à notre assiette. […] Parce que malgré que j'ai été d'une équipe de cinq à moi, ils ne m'ont pas enlevé de responsabilités, alors... (Rires) Ça fait deux jobs. Je ne veux pas faires les mathématiques, ça décourage.*
>
> *It would be one thing if you were just given a different position […] I went from a team of five to myself alone and they didn't reduce any responsibilities so… (laughter). It makes two jobs. I don't want to do the math, it's discouraging. - Rayne*

Discussion

The representation of professional distress in healthcare social workers has far more intricate ties with linguistic affiliation than initially anticipated. Where we first expected Francophone professionals in a minority setting to report a mild exacerbation of their workplace distress consequent to some added translation tasks (Savard et al., 2014), our results suggest that the Francophone status is in fact a key variable of their lived experience, which involves complex dynamics within their representation of distress. Within our sample, that representation of distress was found to consist of three converging elements: injustice, induced incompetence and powerlessness. The linguistic-minority affiliation was found to be more than a contributor to workplace challenges; in fact, it was a representationally determined social positioning defined by intersubjectively negotiated power relations, all integral to the lived experience of social workers.

Duveen (2013) posits that social identity appears as a function of representation. According to our data, being identified as a Francophone and a social worker triggers a process of identity formation in which the internalized representations of these social groups become intertwined. The professional identity of healthcare social workers, as advocates and representatives of Francophone service beneficiaries in a minority setting, was thus found to be indissociable from their linguistic affiliation, which, in turn, affected their social representation of professional distress in numerous ways. This significance is co-constructed (Moloney & Walker, 2007) and over time *becomes* the content of their social identity (Tajfel and Turner, 1974).

The social representation of distress studied reflects this specific content of the professional identity of Francophone social workers. The injustice, the first transversal element which organizes the discourse of our participants when speaking about their professional distress, echoes the representational mechanisms of power between dominant and dominated group (Lorenzi-Cioldi, 2009). The professional particularities of Francophone social workers in the health sector as an occupational group are underestimated in comparison to the benefit of their linguistic affiliation. This is illustrated through management's alleged insistence on the clinical social workers' execution of language-dependent tasks that are otherwise outside the boundaries of their profession. The perception of that situation as an injustice is further amplified when the translation is added to front-line professionals' daily requirements without compensation or greater employment stability. Furthering this sense of injustice is the fact that second-language proficiency expectations are said to apply differently to Anglophone colleagues and administrators. As a result, social workers report experiencing great frustration at the perception of a double standard from the system they are called upon to support. Most notable here is that the work overload is not central to the representation of professional distress. Rather, it is the unfairness of the demands that defines the social workers' dissatisfaction. Without contradicting past research on excessive workloads (Bouterfas et al., 2016; Safy-Godineau, 2013), the representational angle here

reveals the affective dimension of the lived experience of front-line professionals and allows us to clarify how workplace expectations are articulated in terms of power relationships.

This brings us to the second converging element of the representation of professional distress: induced incompetence. Healthcare social workers first report experiencing the strain of self-doubt from an inability to adequately convey feelings, experiences and counselling to service beneficiaries when practicing in a second language. The task of translation blurs the professional boundaries set by social workers' formal mandates and training. In a profession that actively claims social workers' unique role and legitimacy within the institutional setting (Beddoe, 2013), the redirection of their official role to unassigned tasks jeopardizes the integrity of social workers' professional identity and is experienced as a manifestation of their undervaluation in the workplace. Indeed, this practice serves only to reinforce the front-line professionals' "complementary" role in a healthcare setting and to devalue their genuine responsibilities (Lévesque et al., 2018; Webb, 2016).

Finally, the powerlessness that shapes social workers' representation of professional distress is most strongly correlated with linguistic affiliation through the alleged administrative disregard of front-line professionals' expertise in work-retention practices. Our participants report how their livelihood is made conditional to their ability to maintain inequitable proficiency standards in both official languages (English and French), an expectation not imposed on unilingual Anglophones. Furthermore, both the Anglophone clientele and managers were alleged to trace service dissatisfaction to faults in communication, thereby misappropriating discussions around resource and fund shortages and redirecting them toward individual responsibilities (Baines, 2004). From these experiences, it is made clear that, through rhetorical stratagems, Francophone clinical social workers are continuously kept in asymmetrical relations of power (Foucault, 1975), be it with their employers or with their Anglophone service beneficiaries. Ultimately, this supports a dual stigmatization in the workplace grounded in matters of identity, either from the perspective of the social workers' non-medical background (Beddoe, 2013) or their Francophone linguistic affiliation.

Overall, these results highlight the importance of moral resilience in Francophone clinical social workers. With social identities being internalized through in- and out-group interactions as a result of a representational dynamics (Duveen, 2013), fostering critical thought is key to avoid the involuntary activation of disempowering representational components introduced by dominant groups (Glăveanu, 2009; Lorenzi-Cioldi, 2009). In essence, the social representation of professional distress acts as a polemic representation in the workplace (Lévesque et al., 2019; Gillespie, 2008), contesting the hegemonic representation of administrators as derived from the new public-management ideology (Wilson et al., 2011). Our results concur with prior research by Hyslop (2018), who similarly found that New Zealander healthcare social workers

defied workplace norms through a shared narrative of resistance and human concern.

Methodological limitations

Following the discussion of our results, it is imperative to mitigate the scope of our findings in accordance with their methodological limitations. To start, the data was collected from a gendered, specifically female, sample. This calls into question the representativeness of our sample, even though it is regionally diverse. This particularity may have indeed introduced certain nuances in the social representation of professional distress that we are unable to identify at this time. We remain, however, confident that our analyses have value, even if from a gendered perspective, as the social work profession in Canada remains mostly female (with 83% of Canadian social workers being women) (Government of Canada, 2018). Our analysis of linguistic affiliation through professional distress is additionally limited to the specific experiences of healthcare social workers and may not apply to other contexts of practice such as community work.

Conclusion

This paper aims to contribute to the growing literature on the role of linguistic affiliation for Francophone minorities of Canada. In the particular case of healthcare social workers, we sought to explore the role of language within the representation of professional distress and uncovered many interrelations actualized in the lived experience of front-line professionals. Our results explore how linguistic affiliation relates to the social representation of professional distress on matters of recognition (or lack thereof), discrimination, employment precarity and role boundaries. Linguistic affiliation may at times facilitate the provision of services for the Francophone community. Through their advocacy mandate, social workers are also inspired to perform a more authentic practice defined by its humanity, understanding and societal mission, which is together constitutive the professional role. Simultaneously, social workers' minority linguistic affiliation is alleged to exacerbate their experience of professional distress on the grounds of discrimination, work overload and the disrespect for the nature of their role. Overall, belonging to a minority linguistic group revealed surprisingly complex ties to workplace experience and well-being, thus supporting the significance of linguistic minority studies.

While our analysis echoes our previous findings on professional identity, organizational constraints and professional distress as a whole, we find merit in investigating the specificities of linguistic affiliation as it provides new avenues of reflection around the lived experience of social workers in a healthcare setting. In addition to this study's contribution to the research on Francophone minorities in Canada, we hope that it will serve to encourage further exploration into the role of linguistic affiliation on workplace well-being and to encourage concrete initiatives by healthcare administrators for the sake of the front-line practitioners they employ.

Conclusion

Results overview

Every study presented in this thesis provides a singular outlook to a preponderant, highly complex phenomenon: the professional distress of clinical social workers. While no claim is made towards complete exhaustivity, novel arguments are presented that complement our current understanding of work-related stress in human care workers. As expected, the theory of social representations proved indispensable to achieve the project's aims by considering concurrently matters of identity, experience, perception and communication under a single paradigmatic approach. The sociopolitical context determinant to the workplace environment of clinical social workers was accounted for as the place of emergence of hegemonic discourse (Gillespie, 2008) and situated in contrast with the resistant narrative of our participants. While the interview guide unfolds around three main themes; the representation of social work, the formal training and experience of social workers and their professional distress (with matters of linguistic relevance explored throughout), the healthcare social workers' testimonies aligned under a common sense of resilience, client devotion and advocacy.

An exploration of the social representation of social work first permitted to untangle the NPM reforms' influence on the construction of healthcare social workers' professional identity. Far from a static expression of occupational function, the social representation of social work presents itself in association with the sociopolitical context at hand. While organizational changes alone were unable to remove the symbolic foundation specific to the discipline, the neoliberal work expectations imposed on clinical social workers were revealed to strengthen negative and oftentimes conflicting dynamics within their professional representation (Hyslop, 2018). A structural analysis helped us uncover four pillars constitutive to the professional identity of clinical social workers: 'counselling for support', 'empowerment and respect', 'social justice' and 'compassionate vocation'.

The first element of the social representation of social work, 'counselling for support', was the only recurring consensus of practice not deemed essential to the professional identity of clinical social workers. Rather, as a consequence of their contemporary role in a healthcare setting (Beddoe, 2013; Hyslop, 2018; Roland-Lévy et al., 2014), it is described as a necessary aspect of their discipline, albeit not an integral one on account of its inability to further social change. This contested element of identification was however found to bear an indispensable role in opposing negative peripheral elements of the representation of social work, namely by serving as a contrast to the depreciative perceptions thought to be held among service beneficiaries, interdisciplinary colleagues and administrators. While dissociated from the militant role at the core of social work practice (Payne, 2014), peripheral elements such as 'punisher', 'child snatcher', 'complementary profession' and 'magician' could therefore be disproven by the well accepted component of 'counselling for support'.

The disjointed self-perception of clinical social workers with the alleged view of others was posited to exacerbate professional distress by contributing to feelings of inadequacy and practice dissonance. This was found to be particularly true of the core elements of 'empowerment and respect' and 'social justice', most greatly impacted by the perceived misunderstanding of external actors, namely through an identification with the prejudicial tropes of 'punishers' and 'child snatchers'. Under New Public Management, clinical social workers appear unable to shake their historic affiliation with child protection services and remain employed as agents of control, a role in complete opposition with their idealized self-view. Identity tensions are heightened amongst the occupational group as their 'compassionate vocation' situates them at the service of a misinformed administration and an antagonistic client base. Within a neoliberal climate of employment, social work is alleged to be increasingly restricted by flawed expectations of practice such as casework and bureaucratic tasks alone (Abramovitz, 2018; Phillips, 2019), thereby undervaluing the foundational components of the clinical social workers' professional representation. Self-advocacy and the negotiation of one's place within the institution thus characterizes the daily lives of front-line practitioners who must contend with mutually compounding inner and outer dissensions to their social representation of social work.

Thereafter, achieving the research project's objectives required a qualitative inquiry on the lived experience of clinical social workers, most notably regarding the ways in which their professional experience is influenced by the current organizational constraints of the Canadian healthcare setting. Through a thematic analysis facilitated by the NVivo platform, it was found that clinical social workers reported clear impacts of NPM reforms on both external and internal components of their workplace experience. The systemic constraints described by our participants centered around four intersecting elements: a deficit in resources, a limited time, an excessive amount of work and an unsupportive management, each attested in prior research (Abramovitz, 2018; Phillips, 2019; Roland-Lévy et al., 2014). This quaternary of obstacles was the most prevalent aspect of the professionals' narrative and points to multifaceted issues they face daily. These external pressures were reported to define the lived experience of clinical social workers along with the intersubjective component of paradoxical autonomy.

With regards to the experience of institutional work-life in front-line practitioners, the harm caused by decades of healthcare reforms centred on cost-efficiency alone is substantive. Limited resources, time, workload balance and managerial support resulted in a perceived failure to practice in accordance with the professional representation of social work. The clinical social workers' feelings of adequacy were further eroded by the reported decline in the quality of available services under their subjective standards of practice (Graham & Shier, 2014). Bureaucratization served only to exacerbate these shared occupational conflicts by shifting once more their genuine client-centred priorities to managerial ones (Chow et al., 2019). The necessity of task-

documentation for the clinical social workers' own funding within the establishment (Burton & van der Broek, 2009) is ultimately reinforcing their sense of precariousness as under-recognized members of the team. Under the front-line practitioners' interpretative lens, this outsider status is only corroborated by the disconnect between managerial expectations and their own (Coyle et al., 2005), said to be a result of the difference between a medical and humanistic stance and a cause for the lack of interest perceived in administrators.

The exploration of the shared conflicts experienced by healthcare social workers called for the formulation of a critical outlook. Indeed, we argue that their persisting professional distress could not be limited to individual concerns alone as it dually highlights an administrative agenda. In essence, the testimonies of clinical social workers condemn the climate of self-sacrifice actively fostered by the workplace, wherein meeting expectations requires the sacrifice of their well-being through their overinvolvement to compensate for a flawed environment of practice (Abramovitz, 2018). Undervaluing social workers also work in the institution's favour as front-line practitioners, in a bid for recognition, do more with less.

In the lived experience of clinical social workers, such concerns are enmeshed with their shared representation of the paradoxical autonomy under which they are required to operate. More workplace autonomy was found to be decidedly negative, contrasting previous research and models on occupational well-being (Karasek and Theorell, 1990; Papathanassoglou et al., 2012). In a poorly understood profession however, role boundaries are often crossed by colleagues and administrators taking advantage of the margin provided by a discretionary autonomy. In a climate of deferred responsibility, autonomy equates with greater accountability, compounding workplace difficulties by exposing healthcare social workers to increased risks of litigation. Finally, the autonomy bestowed on clinical social workers is not unconditional and requires the partial abdication of their genuine priorities of practice in favour of institutional values. The latter are absolute, in spite of a lack of guidelines dearly needed to alleviate the weight shouldered by clinical social workers, who must dually please their employers without clear indications on how to perform their duties.

With a clearer understanding of clinical social workers' professional identity and lived experience in a Canadian healthcare setting, the specific nature of their professional distress was subsequently explored in relation to its previously established representational determinants. For our participants, professional distress was perceived as stemming directly from a compromised balance between their professional and personal lives (Graham & Shier, 2014). Clinical social workers report feeling trapped in a mental prison, whereby work-related anxieties persist due to their inability to complete satisfactory work in the context of NPM reforms. These stressors were found to be consolidated by their professional identity, as the devotional core of social work (Stickle, 2016) compels front-line professionals to drain their personal resource for the sake of their service beneficiaries. The challenging nature of the profession is further mobilized to rationalize the experience of professional distress as an

inevitability, given that institutional functions situate social workers in conflict with clients, leaving limited opportunities for empowerment (Wilson et al., 2011). Overall, what is apparent of the social representation of professional distress in clinical social workers pertains to its construction around the service beneficiaries' unmet needs and the compassionate toll endured under institutional constraints (Jessen, 2015). Unrealistic expectations by administrative authorities combined with a lack of disciplinary recognition leave healthcare social workers with an eroded sense of self-worth in an ever-demanding workplace.

Understanding professional distress ultimately leads us to a final inquiry on the impact of linguistic affiliation on the lived experience of clinical social workers. We thus shifted our focus to the role of linguistic affiliation on the social representation of professional distress and its importance in shaping the shared experience of workplace dissatisfaction. Our results attested to the impact of a minority identity on the lived experience of clinical social workers. On the one hand, being a francophone social worker was reported to facilitate a more authentic practice, the exercise of advocacy for a marginalized community and the defense of francophone rights in light of dwindling resources. This allegiance, however, was also found to come at further cost to the legitimacy and credibility of front-line professionals. Outside the threat to the integrity of the relation-based care when practicing in a second language, anglophone patients were said to reproduce discriminatory patterns and sometimes reject the help of professionals on the primary basis of language. Disheartening under any circumstances, this disrespect was alleged to be most distressing when managers formalized it by blaming the social workers themselves for the patients' dissatisfaction. Linguistic affiliation could thus be instrumentalized to discredit social workers in general and call into question the legitimacy of their contribution. This ties into the social representation of professional distress by echoing the lack of recognition experienced by social workers, contributing further to their workplace dissatisfaction.

The most telling indication of the embedment of linguistic identity in the social representation of professional distress can be found in the social workers' perceived need to negate their linguistic affiliation upon experiencing its disadvantages in the workplace. While relatively uncommon, this extreme measure is best understood in the context of the alleged precarity incurred from identifying as a francophone in a minority setting. In the instances of logistical or symbolic discrimination, the power held by the administration is best manifested by the English proficiency standards said to be imposed exclusively upon francophones. Those standards allegedly lead to the prioritization of English proficiency above what matters most to social workers: their experience and professional worth. Through linguistic affiliation, we find that the representation of professional distress ties into the respect front-line professionals strive to receive and the stability they earn through their hard work. The fact that their livelihood can be threatened by their minority status and consequent obligation to prove their linguistic abilities shakes the foundation of social workers' daily well-being and professional interrelations, while

simultaneously bringing into question the system's compliance with francophones' constitutional rights.

Implications for policy and research

Research-wise, our four studies lend credence to the intersubjective nature of professional distress in clinical social workers. This thesis's main contribution can be summed up as helping to deepen our understanding of healthcare social workers' endemic plight in the workplace beyond individual considerations. Indeed, psychological factors such as stress management deficiencies or limited resilience have been historically bolstered by institutional administrators as the main factors to explain professional distress (Collins, 2015; Wilberforce et al., 2014; Kinman & Grant, 2011; Rothmann & Cooper, 2008). By situating NPM reforms as the ideological context of emergence of the shared professional representations of clinical social workers, this thesis provides a critical stance to contest individual accountability alone and reflect on the crucial role of systemic imbalances, power relations and implicit ideology in defining the lived experience of front-line practitioners.

This broader contextualization served to anchor professional distress in a sociopolitical reading. While vital to a critical research project, it further permitted the identification of NPM reforms as a relevant component of the daily experience of clinical social workers. The systemic ties uncovered among each study constitute a fundamental aspect of social work inquiries and serve as a testament to the relevance of social representations theory in intervention research (Negura, 2016). Given the multidisciplinary nature of academic social work, the Moscovician paradigm, much like the conceptual tools provided by Goffman and Foucault (Garneau & Namian, 2017), provide theoretical and methodological avenues unbound by arbitrary disciplinary frontiers (Garnier, 2000). As a whole, mobilizing social representation approaches for empirical purposes allowed the joint consideration of identity, language and lived experience. This thesis thereby lends itself as an additional example to the applicability of the theory of social representations in the field of social work while contributing to the expansion of its use in a North American context.

The use of the theory of social representations indeed proved crucial in bringing to light the diversity of meanings and dynamics constructed around clinical social work by its professionals (Negura & Lavoie, 2016b). The paradigm therefore facilitated the exploration of proximal, yet distinct themes subsumed by the social representation of professional distress in healthcare social workers, thereby permitting the unveiling of a closely interrelated web of meanings in the context of professional practice. Moreover, the detailed analysis of the professional representation of clinical social workers effectively brought into view the complex vectors of influence underlying the creation of their occupational identity. Our results suggest that the front-line practitioners' knowledge base which constructs the core of their self-perception is indeed more than a simple product of their formal expertise. We posit that it is a consequence

of the ubiquitous social cues that they receive from outside influences, which, in turn, situate their place in society and within the institution. These conclusions align with those of Bataille (1997) on the emergence of a professional identity and reinforce the claim made by social representations' scholars on the importance of considering the dialogical relationship of individual and collective influences for an adequate appreciation of ordinary epistemologies and practices (Clémence, Apostolidis & Dany, 2016). Coherently, the theory of social representations places emphasis on the organizational culture under which social workers practice. It does so without losing sight of the singular ethos of this occupational group. This proved key in properly understanding professional distress, influenced by both their occupational and linguistic identity. Overall, our research strategy harnessed a representational approach in an effort to account for the shared meanings attributed to professional practice and its importance to the clinical social workers' workplace well-being (Clot & Litim, 2006). Together, the four studies comprised in this thesis are a testament to the flexibility, versatility and relevance of the theory of social representations for empirical research in the workplace.

By untangling the intersubjective appreciation of professional distress in clinical social workers, this research project ultimately contributed to the limited body of data on the well-being of francophone minorities in Canada by providing explanations as to the contradicting results found in previous studies. While some authors report the lack of significant differences in the physical and mental health of anglophones and francophones (Bouchard et al., 2018; Puchala et al., 2013), others attest to the significance of the linguistic minority affiliation in their subjective health (Chomienne, 2010; Bouchard et al., 2009). From our own results, we may posit that this subjective appreciation of health explains the discrepancies in the literature by pointing to a neglected aspect of work-related stress statistics. In purely correlational research, linguistic factors are oversimplified and therefore overlooked as a contributor to workplace dissatisfaction, ultimately leading to inadequate surveys of the determinants of professional distress. Within this research, language had to be explored narratively in the context of lived experience and was hardly identified as the cause of workplace stress outright given its complex ties to the phenomenon. Representational links between linguistic affiliation and professional distress emerged gradually as the professional representations of clinical social workers were uncovered and explored thematically.

Beyond simply contributing to our knowledge base, these findings invite the reconsideration of policies around francophone rights in Canada. Indeed, the right to bilingual services might be granted constitutionally, but a subjective investigation into the working lives of clinical social workers underline the gap between the public protections in place and the remaining issues lacking any resolution. On the basis of these results, we ought to ensure not only the equitable accessibility to bilingual services, but also the fair compensation and recognition of bilingual workers. For francophone clinical social workers, this would also alleviate the bid for recognition towards administrators and reinforce their value

in the workplace, thereby countering many of the representational factors contributing to their professional distress.

Apart from linguistic considerations, this thesis' findings call for the reconsideration of standard institutional protocol in favor of front-line practitioners' well-being. For instance, clinical social workers' input could be considered before major retrenchments or restructuration with employment security in mind. This would safeguard them daily from undue anxiety while anticipating the next budgetary cuts and dismissals. Clearer expectations and litigation protection should also be implemented to foster institutional solidarity. At the very least, administrators could account for more than individual psychological determinants in the prevention of worker exhaustion. Ultimately, the greatest changes would need to take place at a ministerial level, whereby through more centralized models of care, resource limitations could enter into managerial discussions and be addressed directly. Changes of this nature would surely transform the reality of healthcare social workers' practice and facilitate the execution of their mandate. We posit that this renewed ability to achieve disciplinary goals would translate in an increased sense of competency and purpose which would ultimately play a vital role in diminishing clinical social workers' rates of professional distress.

While a useful first step in advocating for the betterment of workplace conditions for healthcare social workers, this research project does come with certain methodological limitations which would warrant further study. A more representative sample considering anglophone, men and social workers from the territories and Western provinces (such as British Columbia and Alberta), would provide a clearer overview of the common problems of healthcare social workers across the nation. Comparative results could also be drawn between groups to determine their significance in the lived experience of front-line practitioners. Arguably, the perspective of administrators and interdisciplinary colleagues could also be taken into account in order to determine the adequation of the social workers alleged self-perception in others and the actual representation of clinical social workers in other healthcare professionals.

Additionally, it is important to note that our results may only reflect the state of the professional representations of clinical social workers at the point and time of our data collection. While some degree of long-term issues, such as building tensions and chronic fatigue, were taken into account through the testimonies of our participants, a longitudinal design would have surely helped in exploring the measurable impact of NPM reforms. Indeed, had social representations been revisited in front-line practitioners at key moments in time (ex: following the implementation of a new reform) throughout the last decade, the precise effect of organizational changes could have been paralleled with the nature of the representations found and their gradual transformations. Further avenues of research could look into mobilizing such a design to explore more profoundly the vital impact of the institutional environment on professional distress.

Final remarks

This thesis was an ambitious one, seeking to explore jointly matters of identity, experience and language under the theory of social representations to demystify professional distress in clinical social workers. Overall, these goals were achieved through four distinct studies of mixed conceptual heritage. While bearing numerous implications for research and policy, data alone cannot do justice to the amazing resilience, devotion and heart of our participants. It should never be forgotten that the window our interviews provide into the lived experience of healthcare social workers offers but a glimpse of its total reality, evermore complex and nuanced than what could be discussed here. It is a true privilege to be granted an opportunity to share our participants' stories, struggles and hopes. We may only hope that this thesis serves to inspire many to pursue social work research and appreciate its value in the healthcare setting.

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Introduction

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Appendices

Contract Agreement
about the Intellectual Property Right (I.P.R.)

The Social Representations and Communication Research Centre and Multimedia Lab's policy on **IPR issues** is in accordance with European Commission recommendations on the management of intellectual property in knowledge transfer activities and the **Code of Practice for Universities and other public research organisations**. This IPR contract is an integral part of the *Research Trainee Agreement* as clear statement about IPR issues, including protection to background or foreground for carrying out the project, to be signed by the Early Stage Researcher (ESR) recruited. In particular, to prevent any potential tension about *Intellectual Property Right* connected to the involvement of the ESR and co-supervisors on top of previous multiyear work conducted by the project leader (prof. A.S. de Rosa) and by offering the access to its related tools and data sources (meta-analysis grid, SoReCom "A.S. de Rosa" @-library, multi-media documentation etc. not yet published or open-access), the *Research Trainee Agreement* includes this clear statement about IPR issues to be signed by the ESR since the beginning of his/her enrolment. This contract will also make clear that the secondment period at the co-supervisor's institution for complementary training does not grant any right to the co-supervisor to access to the project leader's (prof. A.S. de Rosa) data and tools that aren't yet published (including the web tools with restricted access) or to automatically participate in the scientific publications related to the core of this individual research project (whether it be a publication of the sole project leader or a joint publication of the project leader with the ESR).

Moreover, both research trainees and trainers must ensure that the research conducted is relevant to society and does not duplicate research previously conducted elsewhere, avoid plagiarism of any kind and respect the principles of intellectual property and data ownership in all circumstances, including in collaboration on research programs led by tutors, other researchers and research trainees**.** The ESR must abide by the principle of intellectual property and joint data ownership since the research is carried out in collaboration with a supervisor and/or other researchers. In accordance with European Commission recommendations on the management of intellectual property in knowledge transfer activities and the Code of Practice for Universities and other public research organisations [Brussels, 10.4.2008 C (2008)1329] and some of the basic IPR principles of the European Charter for Researcher (http://ec.europa.eu/euraxess/index.cfm/rights/europeanCharter):

a) "Researcher should recognise the limitations to this freedom that could arise as a result of particular research circumstances (including supervision/guidance/management) or operational constraints, e.g. for

budgetary or infrastructural reasons or, especially in the industrial sector, for reasons of intellectual property protection. Such limitations should not, however, contravene recognised ethical principles and practices, to which researchers have to adhere."

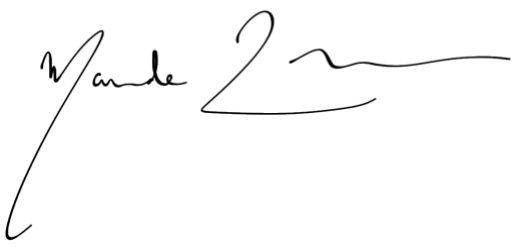
b) "Researchers at all levels must be familiar with the national, sectoral or institutional regulations governing training and/or working conditions. This includes Intellectual Property Rights regulations, and the requirements and conditions of any sponsor or funders, independently of the nature of their contract. Researchers should adhere to such regulations by delivering the required results (e.g. thesis, publications, patents, reports, new products development, etc) as set out in the terms and conditions of the contract or equivalent document."

c) "Employers and/or funders should therefore develop strategies, practices and procedures to provide researchers, including those at the beginning of their research careers, with the necessary framework conditions so that they can enjoy the right to be recognised and listed and/or quoted, in the context of their actual contributions, as co-authors of papers, patents, etc, or to publish their own research results independently from their supervisors)". In particular:

- Given that the project creator and leader of the Meta-theoretical Analysis of the Social Representations Literature will contribute substantially to a trainee's individual research project by assisting in the formulation of hypotheses, providing tools on top of previous multiyear work and by offering the access to data sources (meta-analysis grid, SoReCom "A.S. de Rosa" @- Library, multi-media documentation etc. not yet published or open-access), also providing human/technical resources, etc., the project leader name (A.S. de Rosa) should appear in any publications or conference papers or any other sort of dissemination of the research.
- Therefore the research trainee will be collaborating on the project aimed at the Meta-theoretical Analysis of the Social Representations Literature and the development of SoReCom "A.S. de Rosa" @- Library already created and implemented by the SoReCom project leader A.S. de Rosa, and will understand that as creator of the study, the research supervisors and project leader is the owner of the intellectual property rights for the entire research programme. As for any research he/she may develop under the research director's lead and supervision, the research trainee commits to participate in the research in accordance with the time and modalities established by the research director and not to divulge or publish in any way or form (including via Internet) anything concerning the study without the express permission of the research director. With his/her written permission and upon approval of the text, conference papers, publications or any other sort of dissemination of the research can be released jointly, respecting the research director's (A.S. de Rosa) intellectual property rights as the primary author.

Date: October 12th, 2017

Signature of the research trainee



Montfort hospital ethical committee approval

745-A, suite 102 ch. Montréal Rd, Ottawa, ON K1K 0T1
Tél./Tel.: 613-746-4621 Téléc./Fax: 613-746-4111
hopitalmontfort.com

Hôpital Montfort

Un hôpital d'enseignement affilié à l'Université d'Ottawa

A teaching hospital affiliated with the University of Ottawa

Avis d'approbation éthique
Comité d'éthique de la recherche (CÉR) de l'Hôpital Montfort

Le 4 avril 2017

Chercheur principal :

Professeur Lilian Negura
Université d'Ottawa
lilian.negura@uottawa.ca

Co-chercheurs

Charles Gaucher
Université de Moncton
charles.gaucher@umonctonc.ca

Florette Giasson
Université de Saint-Boniface
fgiasson@ustboniface.mb.ca

Titre du projet : « La détresse professionnelle chez les travailleuses sociales francophones œuvrant dans le domaine de la santé en Ontario, Manitoba et Nouveau-Brunswick. »

Numéro du dossier : LN-01-02-17

Date de début : 4 avril 2017

Date de fin : 3 avril 2018

En conformité avec la dernière édition de l'Énoncé de politique des trois conseils — Éthique de la recherche avec des êtres humains (ÉPTC 2), je confirme que le Comité d'éthique de la recherche (CÉR) de l'Hôpital Montfort a évalué et **approuvé votre projet de recherche** et les documents suivants pour les dates de début et de fin mentionnées ci-dessus :

- Protocole de recherche, version 2016
- Affiche de recrutement (FR et EN)
- Formulaire de consentement (FR), version datée du 31 mars 2017
- Grille d'entrevue (FR)
- Questionnaire Échelle de détresse psychologique Kessler (FR), version datée du 31 janvier 2017

Le CÉR de l'Hôpital Montfort est constitué et exerce ses activités d'une manière conforme à la Norme nationale du Canada visant la surveillance de l'éthique de recherches comportant des essais cliniques biomédicaux de l'Office des normes générales du Canada, aux Bonnes pratiques cliniques : directives consolidées, du Conseil international sur l'harmonisation des exigences techniques relatives à l'homologation des produits pharmaceutiques à usage humain (CIH-BPC E6), à la Partie C, Titre 5, du Règlement sur les aliments et drogues et aux règlements applicables, à la partie 4 du Règlement sur les produits de santé naturels; à la partie 3 du Règlement sur les instruments médicaux, au « *Code of Federal Regulations* » des États-Unis, à la Loi ontarienne de 2004 sur la protection des renseignements personnels sur la santé, de même qu'aux lois et règlements applicables en Ontario.

Le protocole de l'étude ne peut être modifié sans une approbation préalable du CÉR sauf s'il est question de la sécurité immédiate des participants. Le chercheur doit, avant toute utilisation, soumettre pour évaluation et approbation toutes les modifications au protocole et à la documentation destinée aux participants, par exemple, formulaire de consentement et aux outils de recrutement. Vous devez aussi aviser le CÉR immédiatement de tout événement indésirable ou nouvelle information pouvant augmenter le risque ou modifier le cours du projet de recherche.

Veuillez-nous acheminer **quatre semaines avant la date d'échéance de cet avis d'approbation**, un rapport d'étape annuel et le cas échéant une demande de renouvellement du certificat d'approbation éthique de l'étude. Vous pouvez en tout temps soumettre un formulaire de fin d'étude et y joindre un rapport final.

Si vous avez des questions, vous pouvez communiquer avec le Bureau d'éthique de la recherche (BÉR) de l'Hôpital Montfort au 613-746-4621, poste 2221 ou par courriel à ethique@montfort.on.ca.

Richard Carpentier

Richard Carpentier, Ph. D.
Président du Comité d'éthique de la recherche — Hôpital Montfort

University of Ottawa ethical committee approval

Numéro de dossier: 10-16-01 **Date (mm/jj/aaaa):** 01/12/2017

Université d'Ottawa University of Ottawa
Bureau d'éthique et d'intégrité de la recherche Office of Research Ethics and Integrity

Certificat d'approbation éthique

CÉR Sciences sociales et humanités

Chercheur principal / Superviseur / Co-chercheur(s) / Étudiant(s)

Prénom	Nom de famille	Affiliation	Rôle
Lilian	Negura	Sciences sociales / Service social	Chercheur principal
Charles	Gaucher	Sciences sociales / Université de Moncton	Co-chercheur
Florette	Giasson	Sciences sociales / Université de St-Boniface	Co-chercheuse

Numéro du dossier: 10-16-01

Type du projet: Professeur

Titre: La détresse professionnelle chez les travailleuses sociales francophones œuvrant dans le domaine de la santé en Ontario, Manitoba et Nouveau Brunswick

Date d'approbation (mm/jj/aaaa)	Date d'expiration (mm/jj/aaaa)
01/12/2017	01/11/2018

Conditions Spéciales / Commentaires:
Le présent certificat est valide pour la recherche menée hors de l'Hôpital Montfort et des institutions de soins de santé au Nouveau-Brunswick et au Manitoba.

550, rue Cumberland 550 Cumberland Street
Ottawa (Ontario) K1N 6N5 Canada Ottawa, Ontario K1N 6N5 Canada
(613) 562-5387 • Téléc./Fax (613) 562-5338
http://www.recherche.uottawa.ca/deontologie/ http://www.research.uottawa.ca/ethics/index.html

Numéro de dossier: 10-16-01 **Date (mm/jj/aaaa):** 01/12/2017

Université d'Ottawa University of Ottawa
Bureau d'éthique et d'intégrité de la recherche Office of Research Ethics and Integrity

La présente confirme que le Comité d'éthique de la recherche (CER) de l'Université d'Ottawa identifié ci-dessus, opérant conformément à l'Énoncé de politique des Trois conseils et toutes autres lois et tous règlements applicables de l'Ontario, a examiné et approuvé la demande d'approbation éthique du projet de recherche ci-nommé. L'approbation est valide pour la durée indiquée plus haut et est sujette aux conditions énumérées dans la section intitulée "Conditions Spéciales / Commentaires".

Lors de l'étude, le protocole ne peut être modifié sans approbation préalable écrite du CER sauf si le participant doit être retiré en raison d'un danger immédiat ou s'il s'agit d'un changement ayant trait à des éléments administratifs ou logistiques de l'étude comme par exemple un changement de numéro de téléphone. Les chercheurs doivent aviser le CER dans les plus brefs délais de tout changement pouvant augmenter le niveau de risque aux participants ou affecter considérablement le déroulement du projet. Ils devront aussi rapporter tout évènement imprévu et / ou dommageable et devront soumettre toutes les nouvelles informations pouvant nuire à la conduite du projet et/ou à la sécurité des participants. Toutes modifications apportées au projet, aux lettres d'information / formulaires de consentement ainsi qu'aux documents de recrutement doivent être soumises pour approbation à ce Service en utilisant le document intitulé "Modification au projet de recherche" au: http://recherche.uottawa.ca/deontologie/submissions-and-reviews.

Veuillez soumettre un rapport annuel au responsable de l'éthique de la recherche, quatre semaines avant la date d'échéance indiquée afin de fermer le dossier ou demander un renouvellement de l'approbation éthique. Le document nécessaire est disponible en ligne au:
http://recherche.uottawa.ca/deontologie/submissions-and-reviews.

Pour toutes questions, vous pouvez communiquer avec le bureau d'éthique en composant le poste 5387 ou en nous contactant par courriel à: ethique@uOttawa.ca.

Germain Zongo
Responsable de l'éthique de la recherche
Pour Barbara Graves, Présidente du CÉR en Sciences sociales et humanités

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Ottawa (Ontario) K1N 6N5 Canada Ottawa, Ontario K1N 6N5 Canada
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http://www.recherche.uottawa.ca/deontologie/ http://www.research.uottawa.ca/ethics/index.html

St-Boniface University ethical committee approval

Université de
Saint-Boniface
Bureau de la recherche
200, avenue de la Cathédrale
Winnipeg (Manitoba) R2H 0H7
Téléphone : 1 (204) 237 1818, poste 467

Le 17 mars 2017

Florette Giasson
École de travail social
FÉÉP
INTRA

Dossier	ETH 2017 17 mars Dossier UO 10-16-01 – le 1er novembre 2018 - 2020
Chercheur principal	Lilian Negura Université d'Ottawa
Cochercheurs	Florette Giasson
Titre :	La détresse professionnelle chez les travailleuses sociales francophones œuvrant dans le domaine de la santé en Ontario, au Manitoba et au Nouveau-Brunswick
Dates	Du 1er février 2017 au 1er janvier 2020
Demande de prolongation :	Le 1er novembre 2018
Rapports	Un rapport annuel Un rapport final au terme du projet

Madame,

Le Comité d'éthique de la recherche a pris connaissance des modifications apportées au projet et il juge la demande conforme aux attentes en matière d'éthique de la recherche.

Veuillez noter les exigences en matière de rapport.

Je vous prie d'agréer l'expression de mes sentiments distingués.

Président par intérim, CÉR

Antoine Cantin-Brault, Ph.D.

Moncton university ethical committee approval

UNIVERSITÉ DE MONCTON
EDMUNDSTON MONCTON SHIPPAGAN

Faculté des études supérieures et de la recherche (FESR)

Le 3 mars 2017

PAR COURRIEL

Monsieur Lilian Negura
Professeur
École de service social
Faculté des sciences sociales

Monsieur Negura,

Je souhaite vous informer que le Comité d'éthique de la recherche avec les êtres humains de l'Université de Moncton a examiné votre demande d'approbation éthique pour votre projet de recherche intitulé *La détresse professionnelle chez les travailleuses sociales francophones œuvrant dans le domaine de la santé en Ontario* (n° de dossier **1617-050**) et a conclu que la recherche proposée était conforme aux normes éthiques des conseils nationaux de recherche.

Je vous prie d'aviser le comité d'éthique de la fin de votre projet. À cet effet, veuillez consulter le site Web de l'Université de Moncton à l'adresse http://www.umoncton.ca/fesr/cer afin de récupérer le formulaire CER-105. Je vous rappelle que la période de validité de la présente approbation éthique est d'une année, laquelle se termine le **1 mars 2018**. Le cas échéant, vous pourrez présenter une demande de renouvellement d'approbation éthique en soumettant à la FESR le formulaire CER-102 dûment rempli et accompagné des compléments d'information nécessaires. Pour toute modification que vous souhaiterez apporter à votre projet de recherche, vous devrez soumettre une demande de modification d'approbation éthique à l'aide du formulaire CER-103.

En vous souhaitant bon succès dans votre recherche, je vous prie de recevoir, Monsieur Negura, mes plus cordiales salutations.

Le vice-doyen,

François Vigneau
FV/mc

p. j.
c. c. Monsieur Charles Gaucher, président, Comité d'éthique de la recherche avec les êtres humains

Campus d'Edmundston
165, boulevard Hébert
Edmundston, NB E3V 2S8

Campus de Moncton
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Moncton, NB E1A 3E9

Campus de Shippagan
218, boulevard J.-D.-Gauthier
Shippagan, NB E8S 1P6

Interview guide

Grille d'entrevue

<u>Accueil et présentation de la recherche</u>

- Remerciements pour la participation de la répondante
- Présentation des objectifs de la recherche
- Insister sur l'expérience et la parole du répondant
- Nous ne sommes pas là pour les évaluer ou les juger
- Confidentialité assurée et enregistrement sur support magnétique
- Questions éventuelles

« Quand je vous ai appelé, je vous ai dit que la discussion portera sur la détresse professionnelle chez les t.s.. Avant de commencer notre discussion, nous devons concrétiser la manière dont VOUS définissez le travail social. Il ne s'agit pas de donner la définition OFFICIELLE du travail social, où comment le travail social est décrit dans les formations que vous suivez, mais de faire connaître votre propre vision du travail social. Je vous prie donc avant de commencer l'entrevue proprement dite de répondre à quelques questions d'introduction. »

(Interviewer : poser les questions et noter les réponses du répondant dans le guide. Important : ne pas donner le guide pour compléter au répondant)

1. La vision du travail social

Selon vous, quels mots ou expressions vous viennent à l'esprit quand vous pensez au « travail social » comme profession ? (*Intervieweur : obtenir au minimum 3 mots et au maximum 8 mots)*

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

Est-ce que pour vous (chaque mot) c'est positif, négatif ou neutre pour relater votre vision du travail social. *(Intervieweur : inscrire dans le côté droit de chaque mot le signe —, + ou = en fonction des réponses du répondant)*

Indiquez les 2 mots qui caractérisent le mieux le travail social selon vous. *(Intervieweur : souligner les mots indiqués par le répondant)*

- Si vous faites une activité professionnelle dans la journée qui n'est pas /le premier mot/, cette activité serait-elle encore du travail social pour vous?
- Si vous faites une activité professionnelle dans la journée qui n'est pas /le deuxième mot/, cette activité serait-elle encore du travail social pour vous?

Expliquer en quoi chacun de ces mots (tous les mots, pas juste les deux mots) est relié ou associé au travail social selon vous? *(Interviewer : s'assurer que le répondant explique chacun des mots qu'il a identifiés au point a)*

Pourriez-vous me dire en une phrase ce que représente le travail social pour vous?

Quelles sont POUR VOUS les valeurs que tout t.s. doit adopter pour être un bon professionnel ?
Selon vous, quels sont les comportements qu'une personne doit absolument adopter en tant que ts?
Selon vous, quels sont les comportements qu'une t.s. ne doit en aucun cas adopter ?
Est-ce que vous avez une bonne opinion du t.s. comme profession, en général ?
Quelle est, selon vous, l'image des t.s. dans la société en général ?

- chez les patients ?
- chez les collègues de travail (d'autres professions : médecins, infirmières, etc.) ?
- chez l'administration ?

2. Formation et expérience du travail social

Quelle est votre formation professionnelle en travail social ?
Quelle était la vision du travail social qui vous a été enseignée pendant votre formation initiale ?
Est-ce que cette vision correspond à la réalité sur le terrain ? à la pratique professionnelle de tous les jours ?
Avez-vous eu de formations offertes ou exigées par l'employeur ? Est-ce que ces formations sont utiles pour votre pratique professionnelle ? En quoi sont-elles utiles ?
Est-ce que ces formations projettent une vision différente du travail social que celle que vous a été enseignée durant votre formation initiale ? Si oui, comment procédez-vous pour faire face dans votre pratique professionnelle avec ces différentes visions du travail social ? Expliquer votre réponse.

Comment les tâches d'une journée normale de travail vous sont-elles attribuées ? Que faites-vous pour bien réussir votre travail ?

Quelles sont les instances (l'employeur, l'Ordre professionnel, etc.) qui sont les plus responsables de la régulation du travail social dans votre organisation ?
Ya-t-il de documents qui prescrivent votre activité professionnelle ? Comment ces régulations de ces différentes instances affectent-elles réellement votre

travail avec les personnes ? Dans quelle mesure adaptez-vous votre travail à ces prescriptions ?

Quel est le rôle de votre gestionnaire ? Quelles sont les exigences de la gestion concernant votre travail ? Comment faites-vous pour répondre à ces exigences ?

Quelles sont les contraintes de votre travail ? Comment vous adaptez-vous aux contraintes de votre activité professionnelle ?

À quel point utilisez-vous le français dans votre travail ? Est-ce que ce fait (l'utilisation du français) change la façon dont vous faites votre travail ? De quelle manière ? Comment faites-vous pour réussir à offrir les meilleurs services en français dans un contexte anglophone majoritaire ?

Quels sont les aspects du travail social qui vous motivent de faire ce métier ? Qu'est-ce que vous aimez particulièrement dans votre profession ? Comment voyez-vous cette profession dans l'idéal ?

3. La détresse professionnelle des t.s.
Maintenant j'aimerais continuer avec le sujet principal de notre discussion. Vous avez accepté de participer à cette entrevue parce que vous avez eu une expérience de détresse en lien avec l'exercice de votre travail. La détresse professionnelle est ici un concept que nous utilisons pour identifier les multiples formes prises par la détresse psychologique au travail (stress, dépression, épuisement professionnel, souffrance).

Pourriez-vous nous donner plus de détails de cette expérience de détresse ?

Comment expliquez-vous cette expérience ou ces expériences en particulier ?

Pensez-vous que d'autres t.s. ont eu des expériences de détresse similaires ?

Comment expliquez-vous la détresse professionnelle des t.s. d'une manière générale ? Quelles sont les causes, selon vous, de ces manifestations ? Y a-t-il des instances (t.s., patients, l'employeur, l'Ordre, le gouvernement, etc.) plus responsables que d'autres de cette situation ?

Vous m'avez parlé des causes, mais y a-t-il de solutions à cette détresse ? Quelles sont les solutions pour ce problème de la détresse professionnelle chez les t.s. ?

Pensez-vous que le contexte spécifique des t.s. francophones en contexte minoritaire apporte de nuances spécifiques à la manifestation et aux causes de la détresse professionnelle des t.s. ? Quelles sont ces nuances ? Expliquez votre position.

Est-ce que le fait que le travail social est une profession majoritairement féminine affecte les manifestations de la détresse professionnelle des t.s. ? De quelle manière ? Expliquez votre position.

Clôture de l'entrevue

- Questions, oublis
- Remerciements
- Retour sur le déroulement de l'entrevue *(Interviewer : s'intéresser à l'appréciation du déroulement de l'entrevue et non à une synthèse de celle-ci)*

(Intervieweur : remplissez la fiche signalétique après avoir terminé l'entrevue. N'oubliez jamais de mettre le code de l'entrevue comme nom du fichier d'enregistrement et d'inscrire ce code sur les questionnaires. Le code de l'entrevue est constitué d'une lettre qui représente la ville où se déroule l'entrevue et un numéro qui indique l'ordre de réalisation de l'entrevue. Par exemple, la deuxième entrevue effectuée à Ottawa doit être codée : O2)