THE EXPERIENCES OF AND RESPONSES TO COMPASSION FATIGUE AMONGST SOCIAL WORKERS EMPLOYED IN GOVERNMENT HOSPITALS

by

Sebedi Clement Motshana

Submitted in accordance with the requirements for the degree of

MASTER OF SOCIAL WORK

AT THE UNIVERSITY OF SOUTH AFRICA

Supervisor

Prof HM Williams

JANUARY 2023

DECLARATION

Name: Sebedi Clement Motshana

Student number: 40915662

Degree: Master of Social Work

Title: **THE EXPERIENCES OF AND RESPONSES TO COMPASSION FATIGUE AMONGST SOCIAL WORKERS EMPLOYED IN GOVERNMENT HOSPITALS**

I declare that the above dissertation is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references.

I further declare that I submitted the dissertation to originality checking software and that it falls within the accepted requirements for originality.

I further declare that I have not previously submitted this work, or part of it, for examination at Unisa for another qualification or at any other higher education institution.

27 January 2023

ACKNOWLEDGEMENT

I would like to extend my sincere gratitude and appreciation as follows:

- The Almighty God for giving me wisdom, strength and courage to study even during trying times.
- Sincere gratitude to my supervisor Professor Marili Williams for your patience, guidance, unremitting support and words of positive encouragement.
- My work supervisor Moepeng Mokhine for your understanding and support.
- I am extremely grateful to the National Health Research Database for granting me permission to access the hospitals.
- Much appreciation to the management of the hospitals for allowing me to enter the gates of the hospitals to access the social workers even during the difficult era of COVID-19.
- Special gratitude to the social workers working in these hospitals, for openly welcoming me into your lives and allowing me to interview you. Without you my study would not have been feasible, I am humbled by your gesture.
- Special acknowledgement to my friend Jack Legodi for encouraging and motivating me to further my studies, much appreciation "*spaapa*".
- Special thanks to my mother, Sewele Florina Motshana, being the rock you are and my pillar of strength.
- Much appreciation to Dikeledi and Cleopas Thindisa for being the brother and sister that I never had, I am thankful and blessed by your presence in my life.
- Much appreciation to the editor, Mrs Kim Smit, for editing my work so it is polished and understandable.
- Special acknowledgement to Ms Margaret Grobbelaar for your tireless efforts in helping me to analyse the research findings and to develop the themes.
- Lastly, I wish to acknowledge my fellow research student, Lindiwe Botha, for always pushing me to study hard and for the academic advice you provided when I got stuck.

DEDICATION

This dissertation is dedicated to:

- My late father, Hendrick Mathukhu Motshana, I wish you were here to enjoy this moment with me.

- My late sister, Suzan Ntilane Motshana, I wish you were here to cherish this moment with me.

ABSTRACT

Social workers working in government hospitals are tasked to render social work support services to patients and their families within a multidisciplinary team approach, however, there is a lack of research evidence about these social workers' experiences of, and responses to, compassion fatigue. Alongside this qualitative study, the researcher wanted to explore and describe these government hospital social workers' experiences and responses to compassion fatigue. Exploratory, descriptive, and contextual research strategies were applied against a phenomenological research design background. A sample of government hospital social workers in Gauteng was selected using the purposive sampling technique. Data was collected using semi-structured interviews with questions contained in an interview guide. The data was analysed using the eight steps of Tesch (in Creswell, 2014), and Lincoln and Guba's evaluative criteria (Lincoln & Guba, 1985) were applied for data verification. Ethical considerations such as informed consent, confidentiality, anonymity, privacy, beneficence and management of information were adhered to throughout the research process. The contribution that this study makes includes bridging the gap caused by the scarcity of literature on the experiences of social workers with regard to compassion fatigue and how they deal with it. The results of this study will encourage hospital social workers to recognise compassion fatigue and have measures in place to deal with it so that they can better their lives. The awareness created by the findings of this study will also boost the service delivery offered to patients because social workers who can recognise and deal with compassion fatigue will be able to provide a better quality service. Finally; the study will guide managers and supervisors to recognise compassion fatigue and the importance of supporting social workers in dealing with compassion fatigue.

Keywords: Compassion fatigue, hospital social work, hospital social worker, medical social worker, government hospitals, public hospital, resilience and experiences of social workers.

KAKARETŠO

Badirelaleago bao ba šomago maokelong a mmušo ba filwe mošomo wa go aba ditirelo tša thekgo ya mošomo wa tša leago go balwetši le malapa a bona, ka dihlopha tša ditsebi tša mafapha a leago a go fapana. Le ge go le bjalo, go na le tlhaelo ya dinyakišišo mabapi le maitemogelo le ditlamorago tša go lapa kudu mmeleng le monaganong ga badirelaleago. Ka go šomiša mokgwa wa nyakišišo wa khwalithethifi, monyakišiši o laeditše le go hlaloša maitemogelo le ditlamorago tša go lapa kudu ga badirelaleago ba maokelo a mmušo. Datha ya nyakišišo ye e fihleletšwe ka mokgwa wa dipoledišano, ditlhokomedišišo le tshekatsheko. Badirelaleago ba go šoma maokelong a mmušo ka Gauteng ba kgethilwe ka go šomiša thekniki ya go sampola gomme datha ya kgoboketšwa ka mokgwa wa dipoledišano tša go se rulaganywe ka dipotšišo tšeo di lego ka gare ga tokomane ya go tlhahla dipoledišano. Datha e sekasekilwe ka go šomiša dikgato tše seswai tša motlolo wa Tesch (Creswell 2014), gomme mmotlolo wa Guba (Krefting 1990) wa šomišwa go netefatša datha. Maitshwaro a go dira nyakišišo bjalo ka go hwetša tumelelo, go botega, go se tšweletše maina a batšeakarolo, go laetša kwelobohloko le taolo ya tshedimošo a ile a obamelwa mo nyakišišong. Thesese ya nyakišišo ye e thiba sekgoba seo se hlotšwego ke tlhaelo ya dingwalo ka ga maitemogelo a badirelaleago mabapi le go lapa kudu mmmeleng le monaganong mošomong le ka moo ba šomanago le se, dipoelo tša nyakišišo ye di tla tliša lesedi le go hlohleletša badirelaleago ba maokelong go lemoga go lapa kudu mošomong le go bea dikgato tša go šomana le maemo a go kaonafatša maphelo a bona, gape bolemogi bjo bo hlotšwego ke diphihlelelo tša nyakišišo ye bo tla godiša kabo ya ditirelo go balwetši ka lebaka la gore badirelaleago bao ba kgonago go lemoga le go kgona go šoma maemong a ba ka kgona go aba tirelo ya boleng bjo bokaone gomme mafelelong ba thuša go abelana ka tsebo ye le balaodi le balekodi gore ba lemoge go lapa kudu mošomong le bohlokwa bja go thekga badirelaleago go šomana le go lapa kudu mmmeleng le mogopolong mošomong.

Mantšu a bohlokwa: boemo bja go lapa kudu mmeleng le monaganong/molapomogolo, go lapa kudu ka maokelong, mošomo wa go direla leago bookelong, modirelaleago wa bookelong, modiredileago wa tša maphelo, bookelo bja mmušo goba bja phoraebete, kgotlelelo le maitemogelo a badirelaleago.

LIST OF ACRONYMS AND ABBREVIATIONS

AIDS:	Acquired Immune Deficiency Syndrome
ARV:	Antiretroviral
BO:	Burnout
CCMT:	Comprehensive Care and Management Treatment
CF:	Compassion Fatigue
COE:	Chief Executive Officer
DSD:	Department of Social Development
HIV:	Human Immunodeficiency Virus
ID:	Identity Document
IFSW:	International Federation of Social Workers
IT:	Information Technology
NASW:	National Association of Social Workers
NGO:	Non-Governmental Organisations
NPO:	Non-Profit Organisation
NHRD:	National Health Research Database
SACSSP:	South African Council for Social Service Professionals
SANCA:	South African National Council on Alcoholism and Drug Dependence
SASSA:	South African Social Security Agency
SARS:	South African Revenue Service
SW:	Social Work
STS:	Secondary Traumatic Stress
TB:	Tuberculosis
USA:	United State of America
UNISA:	University of South Africa
VT:	Vicarious Traumatisation

LIST OF TABLES

LIST OF SKETCHES

TABLE OF CONTENTS

CHAPTER 1 OVERVIEW OF THE STUDY

1.1 INTRODUCTION

This chapter presents the general orientation to the study on compassion fatigue amongst social workers employed in government hospitals. The chapter also provide the background regarding social work practice, the history of hospital social work, the various roles of hospital social workers. It furthermore outlines the problem formulation, the rationale for conducting the research study and what the researcher aimed to achieve with the study. In this chapter, the background of the study is also provided. It further presents the theoretical framework underpinning the study.

1.2 BACKGROUND OF THE STUDY

1.2.1 Existence of social work practice

Social work is practised cross the world, and consists of various career paths and environments for social workers to work in. Authors like Salsberg, Quigley, Mehfoud, Acquaviva, Wyche and Silwa (2017:5), Roh, Moon, Yang and Jung (2016:44), Mwansa and Kreitzer (2012:9) point to the fact that on continents such as Africa, the United States of America (USA), and Europe, as well as in countries like Denmark, Norway, and New Zealand, social workers are employed in government, private and non-government sectors. Below is a brief history of hospital social work. Although history of social work is briefly discussed below, it will be further discussed into detail in chapter two.

1.2.2 History of hospital social work

Internationally, social workers doing hospital social work are placed in different workplaces. For example, in the United States of America (USA), social workers work in hospitals, patients' homes, hospices and nursing facilities (Gunderman, 2018:1) and likewise in countries such as Australia, Denmark, Norway and New Zealand (Harslof, Nielsen & Feiring, 2017:585; Giles, 2016:27; Cleak & Turczynski, 2014:200). A study that was conducted to probe the prevalence of compassion fatigue amongst social workers working at a hospice in the USA, found that hospice social workers experience compassion fatigue. The study recommends compassion satisfaction as a possible mechanism to protect social workers (Pelon, 2017:134-150). Another study was done in the USA on compassion fatigue among social workers based at a defence hospital and found that social workers experience compassion fatigue (Beder, 2012:1-17). Since the studies mentioned above were conducted overseas, the findings of these studies differ significantly from the researcher's study because the challenges and circumstances experienced by these countries are not similar to the ones

the researcher studied. The studies mentioned above also lack indigenous elements. In addition, the studies prove that compassion fatigue exists among hospital social workers but do not focus on how hospital social workers respond to compassion fatigue. The researcher's study is unique as the focus is on how hospital social workers respond to compassion fatigue. In African countries, like South Africa, social workers are employed in various sectors, for example:

- Child protection services both government departments and non-governmental organisations (Truter & Fouché, 2019:137),
- South African Police Services, South African National Defence Force, Department of Correctional Services (Masson, 2019:57),
- the Department of Social Development (Kheswa, 2019:1), and
- government hospitals (Matsea, 2017:370).

The practice of social work is regarded as an occupation which carries out tasks using prolific methods to advance social justice with a focus on the rights of the ones they serve precisely to benefit the disempowered and underprivileged people (Mwansa & Kreitzer, 2012:2). In South Africa, social workers render services to all people, irrespective of the person's status in the community in terms of race, nationality, gender, social status, or religion (Warria, 2016:18).

Hospital social work is also practised in South Africa. It is known as medical social work, hospital social work, or public social work (Hassan, 2016:495). Another known acceptable term for hospital social work is health care social work or clinical health care social work (Dziegilewski & Holliman, 2020:47).

In addition, in South Africa ,there is a regulation awaiting ministerial approval pertaining to regulations relating to the requirements and conditions for registration of a speciality in social work in health care which defines a social worker in health care as someone who is qualified as a social worker, have speciality in terms of abilities, knowledge ,level of experience, and someone who possess a particular specialised training in relation to social work in health care (Regulations relating to the requirements and conditions for registration of a speciality in social work in health care, 2020:Regulation 11116, Vol 659(43343).

The regulation furthermore list conditions in which South African Council for Social Service Professions can register a person for a speciality in social work in health care as listed below (Regulations relating to the requirements and conditions for registration of a speciality in social work in health care, 2020: Regulation 11116, Vol 659(43343).

- The applicant must submit proof of qualification as a social worker as stipulated by the act and have paid all required fees as stipulated by the act.
- Should have submitted proof that he/she complies with the following requirements; masters' degree in social work appropriate to a speciality in social work in health care, plus two years of relevant evidence based practical knowledge and experience within the scope of social work in health care, or post graduate certificate or diploma appropriate to a speciality in social work in health care, plus three years of relevant evidence based practical knowledge and experience within the scope of social work in health care, or bachelor's degree in social work, plus the completion of accredited short course in social work in health care recognised and approved by the Council, on recommendation of the Professional Board for Social Work, with four years of relevant evidence based practical knowledge and experience within the scope of social work in health care, or bachelor's degree in social work, with five years of relevant evidence based practical knowledge and experience within the scope of social work in health care.
- If a social worker applies and does not meet the requirements, he or she can apply for a review and sit for an examination.

Hospital, medical or public social work aims to promote the psychosocial wellbeing of people, either individuals or households, by helping them with the required aid so that they are able to handle their long-term, severe or incurable illnesses (Roh et al., 2016:44).

1.2.3 Roles of hospital social workers

In hospitals, social workers adopt different roles and serve as important multidisciplinary team members addressing the different psychosocial needs of the patients being treated. Hospital social workers have countless specific duties and tasks in which they are often seen as a link between clients (patients), their families and other professionals who work both inside and outside hospitals (Pockett & Beddoe, 2017:132).

While other medical professionals deal with their patients' physical health on an individual basis, social workers also involve the families of patients and their communities. Medical social workers make sure that the psychological needs of individuals and their families are attended to, not only during their hospital stay but also beyond being discharged (Gunderman, 2018:1). Various authors agree that social workers based in hospitals render psychosocial support, help patients deal with illnesses, provide counselling to patients, and advocate the rights of patients (Kaplan & Berkman, 2016:114; Roh et al., 2016:44). It is also critical to understand that as they deal with sensitive and traumatic cases, social workers end up

carrying a heavy burden. Scientific proof of compassion fatigue shows that professionals who spearhead and play critical roles in assisting people with trauma are in great danger of suffering the consequences of compassion fatigue (Craig & Sprang, 2010:320). Similarly, Doel (2012:56) supports this by saying that professionals who play a crucial role in treating patients with trauma or work mostly near traumatised patients are likely to be traumatised themselves.

In addition, Roles of hospital social work are stated by Schenk, Mbedzi, Qalinge, Schultz, Sekudu, and Sesoko (2015:203) as follows:

- Giving help to clients and members of their household.
- They don't work alone but rely strongly on working relationships with other qualified personnel, such as doctors and nurses, to provide holistic services to a patient.
- Help clients and their family members to be able to adjust to their changed living conditions.

In hospitals, social workers are based in different wards such as oncology wards, renal wards, medical wards, paediatric wards, Covid-19 wards, or any other ward in the hospital (Harvey & Jones, 2022:2671; Cuatero & Campos-Vidal, 2019:274; Manning, 2022:298; Seekles & Ormandy, 2022:5; Kurevakwesu, 2021:708; Yi, Kim, Akter, Molloy, Kim & Frazier, 2018:667). In addition, Cordoba (2020:4-5) state that hospital social workers operate in different wards or units inside hospitals such as emergency units, high care units, children wards, labour ward, cancer ward, kidney ward, medical ward, psychiatric ward, crisis centres and palliative care wards.

Since government hospitals' social workers serve clients who need emotional and social support in their everyday lives, it is essential for the social workers to empathetically understand the clients' suffering as if it were their own.

A report by Statistics South Africa (2018) confirms that the province with the largest population in South Africa is Gauteng, with an estimated 14.7+ million people, which equates to 25.4% of the country's entire population. Keeping this fact in mind, it is understood that government hospitals in Gauteng serve many patients daily, and it can be expected that the demands for, and the types of, service delivery requirements provided by hospital social workers can influence their (hospital social workers') capacity to maintain healthy personal psychosocial functioning.

Several research studies prove that hospital social workers are affected by compassion fatigue (Fox,2019:1-9; Kreitzer,Brintnell & Austin,2020:1942-1960; Ostadhashemi, Arshi, Khalvati, Eghlima, & Khankeh, 2019:1871-1877 & Yi, Kim, Choi, Droubay, & Kim, 2019:970-987).

Compassion fatigue is caused by the social worker's concern to try to understand the patient's conditions from their frame of reference. Compassion fatigue is an intrinsic effect that is caused by caring with kindness and feeling sympathy and pity for patients who are traumatised (Portnoy, 2011:48).

The hospital context in which social workers operate in, comes with its own challenges, and make social workers more vulnerable to compassion fatigue. The following authors outline challenges of hospital social workers (Daphna-Tekoah, 2021:247; Cuatero & Campos-Vidal, 2019:274; Heenan & Birrell, 2019:1745; Limon, 2018:23):

- Patients undergoing emotional pain.
- The fact that most of their patients die regularly.
- Having to serve so many patients because of too much workload.
- Other professionals in the hospital context not clearly understanding the roles of hospital social workers.

As stated by Yi et al., (2018:671) working in wards such as oncology wards where patients die most of the time because of cancer make social workers more vulnerable to compassion fatigue. Another factor that makes hospital social workers more vulnerable to compassion fatigue is because the context which they work in, they are exposed to lot of patients who are going through trauma and pain (Todaro-Franceshi (2019:5). In addition, since they experience lots of patients dying and see lots of patients who are going through some pain, as a result they are more susceptible to compassion fatigue because they use lots of empathy by showing care to their patients together with their families (Dubois & Mistretta, 2020:65).

1.3 PROBLEM FORMULATION AND PROBLEM STATEMENT

The problem statement is the foundation of what the researcher intends to research. This is confirmed by Grant and Osanloo (2014:18). They state that a problem statement is characterised by the source of the problem of study and also other underlying factors that might be associated with or encompass the problem. This is supported by Krathwohl (2009:83), who states that identifying a research problem underpins the direction of a research study since the research problem paves the way for a study.

Social workers employed by Gauteng government hospitals render daily services to many patients and their families. The researcher was concerned by the paucity of research conducted to investigate the experiences and responses of hospital social workers concerning compassion fatigue.

The problem is as follows: there is a dearth of research which focuses on the experiences of, and response to, compassion fatigue by government hospital social workers, specifically in Gauteng.

Other research was found to focus on the following:

- In Durban, KwazuluNatal, research was conducted about compassion fatigue amongst nurses (Wentzel & Brysiewicz, 2018:82-86).
- In the North West province a research study concentrated on the level of job satisfaction and general needs of social workers (Calitz, Roux & Strydom 2014:153-169).
- Another study done in Gauteng probed palliative caregivers' experiences of compassion fatigue within the Tshwane district, with a specific focus on the hospice at Bophelong Community Health Care Centre in Mamelodi (Maja, 2016:-1-130).

By exploring government hospital social workers' experiences of, and responses to, compassion fatigue the researcher wanted to amplify the current scientific body of knowledge.

1.4 RATIONALE FOR THE STUDY

The concept of "rationale" in research refers to motivating why a proposed topic should be researched. It includes the researcher's personal reasons and motivations for why it is essential to spend time investigating a subject matter (Rojon & Saunders, 2012:55; Plooy-Cilliers, Davis & Bezuidenhout, 2014:93).

The researcher's chosen topic is informed by his direct interaction with social workers in government hospitals in Gauteng who display characteristics of compassion fatigue. Part of the researcher's daily work activities is the referral of cases to hospital social workers. He occasionally engages with Gauteng government hospital social workers in meetings. Hearing Gauteng government social workers verbalise their challenges that seemed to have characteristics of compassion fatigue, increased the desire of the researcher to study the proposed research problem.

Compassion fatigue is a condition which comes as a result of being exposed to traumatized people or people who are having stress and it can start slow until becoming serious (Parker,

2020:177). In addition, compassion fatigue affects social workers holistically meaning that all their aspect of life and when social workers are affected by compassion fatigue, their ability to care diminish (Yi et al., 2018:668). Ainsworth and Sgorbini (2010:21) describe compassion fatigue symptoms as continuously stressed feelings, anxiety, hopelessness, frequent mood changes, and a persistent negative attitude. Failure to concentrate, doubting oneself, feeling sorrow for oneself, distrusting people, having prolonged stress, and deterioration in job performance are unpleasant consequences of compassion fatigue (Ainsworth & Sgorbini, 2010:21).

Even though the mentioned studies researched compassion fatigue to some extent, very few focused on government hospital social workers' experiences of, and responses to, compassion fatigue. In addition, some of the studies followed a quantitative approach. This resulted in the researcher developing an interest in exploring how these hospital social workers experience and respond to compassion fatigue.

The rationale for selecting the abovementioned research topic was also informed by the reality that not a lot is known about the subject matter the researcher wants to investigate, and the researcher was concerned about the social workers' wellbeing and was keen to explore their experiences of, and responses to, compassion fatigue.

1.5 THEORETICAL FRAMEWORK

A theoretical framework is important in research studies because it provides a guideline for studying a problem and helps the researcher to support the findings by using work that already exists to agree or disagree with the findings. A basis for every investigation or inquiry where knowledge is built and established is referred to as a theoretical framework (Grant & Osanloo, 2014:12). Similarly, Maree and Van der Westhuizen (2009:17) state that a theoretical framework is essential to pinpoint or locate a research study or to try out a theory that is already available. Feist and Feist (2008:40) also state that a theory is a set of assumptions.

1.5.1 Resilience theory

Resilience can be perceived as a trait certain people have to cope well with the challenges they experience here and now, and it can also serve as a form of preventative measure to deal with future challenges that may affect them (Grant & Kinman, 2014:20). For this research, the researcher followed the resilience theory to contextualise hospital social workers' experiences of, and responses to, compassion fatigue in Gauteng. It is a

phenomenon that places tremendous pressure on many social workers, yet they are still expected to produce quality work even under such severe circumstances.

In addition, Gilligan (cited by Turner, 2017:441) states that, when associated with social work, resiliency can be recognised as performing stronger and healthier even during hardships. Another way to define resilience is to say that resilient people possess an ultimate aptitude to recover and bounce back from hardships and difficulties in life (Truebridge, 2014:12). Resilience entails the ability to accommodate adverse and unwanted life events and have the qualities to defeat those hard times and calamities that might emerge as a result of suffering or emotional wounds (Van Wormer, Sudduth & Jackson, 2011:413). Based on the definitions of resilience theory, it is evident that human beings can be resilient even during trials and tribulations. Whitney (2017:26) asserts the following regarding resilience:

- Alternatively, resilience bolsters the strengths perspective. The theory of resilience comes from the notion that everyone possesses the internal intelligence to develop and learn from life events.
- In order to make use of these abilities to thrive, even during difficulties, people need to embrace a resilient mentality.
- Resilience shifts people's negative mindset to a positive mindset and confronts difficulties, to make meaning.

Resilient individuals have confidence when in control and have a different perspective towards stress. In addition, to them experiencing stress, they feel they are given a chance to embrace bad experiences and turn them into new opportunities for learning and development. In this research study, it is critical to understand resilience and compassion fatigue amongst government hospital social workers, so that appropriate practical suggestions can be made to enhance the existing support mechanisms for Gauteng hospital social workers in dealing with the high demands of their work. For this research, the researcher wanted to understand the capacity and abilities of social workers through their experiences and responses to compassion fatigue whilst working in government hospitals. The researcher also wanted to further explore what social workers expect to deliver even though they are experiencing compassion fatigue. In addition, the researcher wanted to understand how hospital social workers rebound from trauma and stress caused by their patients and how they have learned to act professionally.

The resilience theory enabled the researcher to identify the capabilities of participants that make them strong irrespective of the challenges they face in everyday life. It also assisted

the researcher in understanding that even though participants face difficulties due to their work, they still try harder to deliver quality results. As stated by Kent, Davis and Reich (2014:87), resilient people still exercise normal behaviour and are moderately affected by any stressful life circumstances they come across. The researcher also wanted to learn more about factors enhancing hospital social workers' resilience. A study done by Cleveland, Warhurts and Legood (2019:1442-1444) regarding social workers' resilience reported the following as factors that enhanced their resilience:

- Help that emanates from fellow colleagues and supervisors.
- Team dynamics, which may include their title role and the setting in which they operate.
- Ensuring that they are always acting in a professional manner, by maintaining a level of emotional distance between themselves and both fellow colleagues and patients, and also by attending capacity building coaching classes in order to amplify their professionalism when it comes to their emotions.

Masson (2019:7) concurs and adds the following factors that contribute to resilience:

- personality,
- characteristics or attributes,
- spiritual beliefs,
- professional empowerment,
- acceptance of self and others, and
- support from work, religious and cultural communities.

In addition, Rose and Palattiyil (2020:25) state that some of the components that add to an individual's resilience may include aspects such as knowing oneself, tremendous self-esteem, humour and a positive self-concept.

Being resilient means that hospital social workers understand that challenges will always be there but they ensure that even during difficult times they bounce back and provide quality services to their patients. As stated by Rose and Palattiyil (2020:24-25) being optimistic, hopeful about the future, having the ability to accommodate to unfavourable situations that might be caused by trauma, and accepting one's impediments, are what make people more resilient. Kapoulitsas and Corcoran (2015:89) concur and add that one of the perceived crucial roles of resilience is helping people to cope with stress.

The resilience theory enabled the researcher to understand that every human being has the ability to cope with strenuous situations. Grant and Kinman (2014:18) summarise the characteristics of resilient people as follows:

- Hardiness
- Self-efficacy and self esteem
- Self-awareness
- Emotional literacy (the ability to attend to, recognise and regulate moods in the self and in others)
- A positive self-concept and a strong sense of identity
- A high degree of autonomy
- The ability to set limits
- Openness to experiences and the ability to learn from an experience
- Advanced social skills and the social confidence to develop supportive relationships.
- Flexibility and adaptability in the use of coping strategies.
- Creative problem-solving and planning skills
- Well-developed critical thinking abilities
- The capacity to identify and draw on internal and external resources
- Resourcefulness and successful adaptation to change
- Enthusiasm, optimism and hope - an orientation towards the future
- Persistence in the face of challenges and setbacks - the ability to recover rapidly
- A sense of mastery and purpose
- A sense of coherence - the capacity to derive meaning from difficulties and challenges

The abovementioned characteristics show that for social workers to be resilient, they need to possess certain characteristics. The researcher approached this research study aiming to explore and understand those resilient characteristics which social workers possess.

The researcher also wanted to explore how the hospitals in which the participants work contribute towards the resilience of participants.

1.6 RESEARCH QUESTION, GOAL AND OBJECTIVES

1.6.1 Research question

The research question forms the basis, and serves as a guideline, for the complete research process that will be followed. A research question constitutes the face of every inquiry that any scholar wants to probe (Miles, Huberman & Saldana, 2014:25). Various authors also

state that research questions form a mind map of any research the researcher aims to answer regarding specific research (Tracy, 2013:15; Harding, 2018:287).

By having a research question, the researcher will have direction and focus in conducting the research (Matthews & Ross 2010:57; Bryman, 2012:9; Maree, 2016:3). The findings of a research study need to be able to give answers to the research question. The research question for this study is: “What are the hospital social workers’ experiences of, and responses to, compassion fatigue whilst working in Gauteng government hospitals?”

1.6.2 Research goal

A research goal is the specific aim or purpose that the researcher wants to attain and should lead to the satisfactory completion of the study. The goal is based on the research question and indicates the needed result that the researcher would like to achieve with the research study (Waller, Blaikie & Priest, 2019:68; Farquharson & Dempsey, 2016:19; Regoniel, 2014). The following is the researcher’s research goal for this research study: “To develop an in-depth understanding of hospital social workers’ experiences of, and responses to, compassion fatigue whilst working in Gauteng government hospitals.”

1.6.3 Research objectives

The research objectives include the steps and activities that the researcher will follow to reach the goal of the research. The objectives enabled the researcher to ensure that all the steps of the complete research process are followed in a scientific manner. Research objectives are described by Kumar (2014:69) as steps which the researcher puts in place to achieve a research inquiry. Various authors confirm that objectives are plans and steps which the researcher will take to reach the aim of their research (Kumar, 2019:485; Walliman, 2016:34; Carey, 2012:24).

The following objectives were developed to assist in attaining the goal of the research study:

- To explore social workers’ experiences of, and responses to, compassion fatigue whilst working in government hospitals in Gauteng.
- To describe hospital social workers’ experiences of, and responses to, compassion fatigue whilst working in government hospitals in Gauteng.
- To report the findings, draw conclusions and make recommendations in relation to hospital social workers’ experiences of, and responses to, compassion fatigue whilst working in government hospitals in Gauteng.

Now that the research questions, goal and objectives for the research study have been established, the relevant key concepts need to be defined and explained within the context of this particular research.

1.7 CLARIFICATION OF KEY CONCEPTS

Compassion fatigue. Parker (2020:177) asserts that compassion fatigue refers to a reaction that is experienced by people who are exposed to patients who suffer from stress or emotional wounds. It is regarded as tension that increases over time as a result of wanting to relieve patients from their emotional wounds and feelings of failure, and not being able to do so. Such helpers often blame themselves and regard themselves as in competent (Lee et al., 2018:768-769). In this research study, the researcher focused on hospital social workers' feelings regarding their work, how their interaction with their clients affects them, how trying to be in the shoes of their clients and trying to feel their clients pain affects them, how seeing their clients not improving affects them and how they deal with the negative effects caused by assisting in traumatic and stressful situations.

Experiences is "the knowledge and skill that you have gained through doing something over a period of time" (Turnbull & Hornby, 2013: sv "experience"). "Experience is an event that affects you in some way" (Waite & Hawker, 2009: sv "experience"). In this research study, the researcher concentrated on the experiences of social workers employed in hospitals and how they confront compassion fatigue.

Resilience refers to being able to cope with the misfortunes of life in a positive way (Turner, 2017:441). Another way to define resilience is to simply say that "resilience is the self-righting and transcending capacity within all youth, adults, organisations, and communities to spring back, rebound, and successfully adapt in the face of trauma, adversity, and/or everyday stress" (Truebridge, 2014:12). For this research study, the researcher focused on how hospital social workers bounce back from compassion fatigue in order to be able to balance their work and personal life and serve their communities.

To **respond** means "to do something as a reaction to something that somebody has said or done" (Turnbull & Hornby, 2013: sv "respond") or to "say or do something in reply or as a reaction" (Waite & Hawker, 2009:790: sv "respond"). For this study, the researcher focused on the coping strategies hospital workers use in response to the stress caused by compassion fatigue.

"**Social work** is a practice-based profession and an academic discipline that promotes **social** change and development, **social** cohesion and the empowerment and

liberation of people." (IFSW definition of social work). For this research study the researcher is referring to a profession that strives to better the lives of the people and empower people to change their lives.

Government is "a particular system or method of controlling a country" (Turnbull & Hornby, 2013: sv "government"). It can also be defined as "the system by which a state, or community is governed" (Waite & Hawker, 2009: sv "government"). For this research study, the researcher focused on South African government hospitals in Gauteng.

A **hospital** is "a large building where people who are ill/sick or injured are given medical treatment and care" (Turnbull & Hornby, 2013: sv "hospital"). Similarly, Van Rensburg (2012:535) defines hospitals as "health care institutions that have organised medical and other professional staff as well as inpatient facilities that deliver medical, nursing and related services 24 hours per day, seven days per week". For this research study, only Gauteng provincial hospitals were included where patients are attended to by health care professionals such as medical doctors, nurses, psychiatrists, social workers, and psychologists.

A hospital social worker/ medical social worker refers to a social worker employed in hospitals to render social work services to patients who are admitted to hospitals (Dziegielewski & Holliman, 2020:44; Parveen, 2017:21). In this research study, the researcher refers to those professionals with a degree in social work, registered with South African Council for Social Services Professions, and appointed as a practicing social worker in a Gauteng government hospital.

"**Government hospital or public** hospital includes those owned by federal, state, and local governments" (Kinsey, 2010, sv "government hospital").

For the purpose of this research study a government hospital was any hospital that is for the public, owned by the South African government and receives funds from government of South Africa for its operations, and operates in Gauteng.

1.8 CONTENT OF THE RESEARCH REPORT

This research study is split into five chapters as outlined below:

In Chapter One, an introduction and general orientation to the research study about hospital social workers' experiences of, and responses to, compassion fatigue whilst working in government hospitals was provided. This introduction focuses on introducing and formulating the research problem, the problem statement, the study rationale, elucidation of key concepts, and the content of this research report.

Chapter Two focuses on the literature study and a theoretical discussion about hospital social workers' experiences of, and responses to, compassion fatigue whilst working in government hospitals.

Chapter three covers the details of how research methods are utilised. In addition, research methodology, approach of the research and the design of the research are also thoroughly explained.

Chapter four provides an exposition of the research findings as well as themes.

Chapter five lays out a comprehensive discussion of the conclusions and research recommendations. In this chapter; the main aspects of the study, the end results of the study as well as the goal of the study are outlined. In addition, this chapter also summarises the value of the research, the limitations and areas for future research.

1.9 SUMMARY OF THE CHAPTER

This chapter covered the general introduction, goals of the research, objectives of the research, research methodology, ethical considerations, the clarification of key concepts and the dissemination of research results. The next chapter will discuss the literature review.

CHAPTER 2 LITERATURE REVIEW

2.1 INTRODUCTION

Chapter two is a literature review which will encompass a comprehensive summary of previous studies conducted by various researchers on compassion fatigue. The purpose of this chapter is to review previous literature on the following; the history of hospital social work, the overall description of compassion fatigue as compared to other similar terms such as vicarious trauma and secondary traumatic stress, compassion satisfaction, causes of compassion fatigue, signs of compassion fatigue, roles of hospital social workers, challenges of hospital social workers, the effects of compassion fatigue on personal and professional lives and how it affects service delivery, hospital social workers strategies to deal with compassion fatigue, and lastly, the role of managers or supervisors in ameliorating compassion fatigue among hospital social workers.

Efron and Ravid (2019:2) outlines a literature review as follows:

- A literature review is a well-structured writing regarding a particular subject.
- It contains information whereby researchers scrutinise, assess, and integrate conclusions of research done by academics with regards to a targeted topic.
- During a literature review, a researcher should be able to provide a very clear detailed, extensive, insightful position regarding a topic by comparing its status with the previous findings of research studies.
- A researcher must be able to provide insight and an opinion pertaining to a particular subject.
- A literature review compares various findings of research, affirms the present literature and demonstrates what needs to take place in order to improve the current knowledge of a particular subject matter.

Hempel (2020:3) concur with Efron and Ravid by stating that a literature review:

- Is a critique summary of a research which is available regarding a particular research field.
- Is a summary of the research that already exists regarding a research inquiry.
- Paves the way towards creating conditions for new research.
- Points out key gaps regarding knowledge that is already available regarding a particular topic.

Based on the above statements, it is clear that a literature review is a summary of the findings of research that was conducted previously by different authors researching similar topics. In addition, the researcher agrees that a literature review also entails comparing the findings of previous research with the current research together with identification of gaps in terms of knowledge.

2.2 HISTORY OF HOSPITAL SOCIAL WORK

Hospital social work is an ancient discipline which can be traced back to the early 18th century. As stated by Gehlert (2019:6-7) and Gehlert and Browne (2012:6) that in England, London City, the first social worker named Mary Stewart known as *'a hospital amoner'* was employed to work in a hospital called Royal Free Hospital in 1895.

In the USA the first social worker hired by Dr Richard Cabot to work in a hospital in 1905 was Garnet Pelton at Massachusetts General Hospital and began her hospital duties on the second of October 1905 (Gehlert, 2019:3&7; Parveen, 2017:26-27; Gehlert & Browne, 2012:6-7). After six months, Pelton resigned because of tuberculosis and Dr Richard Cabot hired Ida Cannon as replacement in 1906 who worked as the hospital social worker for forty years (Gehlert, 2019:3,7-8; Gehlert & Browne, 2012:7). Dr Richard Cabot, a pioneer of hospital social work believed that to treat the illness of patients, it is also important to take to considerations their social living circumstances (Gehlert, 2019:8-9).

In Ireland the inception of medical social work can be traced back to 1918 in Adelaide hospital in Dublin (Parveen, 2017:25).

While in south Africa, the first hospital social workers can be traced back to the early 1940's. This is supported by the findings of the national health services commission report of 1944 which reported that in South Africa, two hospital social workers were hired in Groote Schuur, Cape Town and in Pretoria (Pillay, 1994:39).

The early role of hospital social workers as depicted by (Ab, 2004:10; Gehlert, 2019:10; Ruth & Marshall, 2017:239) was to:

- Conduct patient assessment and associate patients with medication.
- For translation purposes.
- Make available detailed information regarding the psychological and social wellbeing of patients.
- Link between a hospital and communities.
- Conduct community awareness to prevent repeat of disease.

The introduction of social work in hospitals was not easy and even the pioneer of hospital social work Dr Richard Cabot experienced challenges, such as lack of support from colleagues and hospital management to a point of using his own money to pay first salary of the hospital social worker he hired (Gehlert, 2019:11; Ruth & Marshall, 2017:5237; Ab, 2004:9).

It was only supported and valued when it was evident that hospital social workers play a significant role in identifying the social or background cause of illnesses, the fact that social work services enabled hospitals to save money because of their ability to investigate the social background of illnesses where illness start and this helped patient avoiding repeatedly getting sick with the same illness (Gehlert, 2019:11; Ruth & Marshall, 2017:5237).

Social work is practiced all over the world and its nature is so diverse that social workers are employed in many different places of work to render social work services. Internationally, social workers doing hospital social work are placed in different workplaces. In some continents, for instance in America, medical social workers work in clients' homes, hospitals and nursing homes (Gunderman, 2018:1).Several studies conducted with social workers in the following countries demonstrates that different countries in the world employ social workers in hospitals and concur with the above statement (Fox, 2019) [in Australia]; Fronek, Briggs, Kim, Han, Val, Kim & McAuliffe, 2017; Yi et al., 2019 [in Korea and Australia]). In South Africa, social workers are employed by the Department of Health which places them in hospitals. Schenk et al., (2015:203) state that even though the main focal point for this department is to provide assistance with regard to psychological and physical welfare it also focuses on providing limited social work services.

Hospital social work is a discipline of social work that is practiced by social workers who are employed to practice in hospitals. In previous years, it was described as the supply of social assistance in a health care environment, while presently it is defined as the provision of social assistance not only in hospitals but in other associated health care environments (Dziegielewski & Holliman, 2020:44).

Hospital social work is sometimes referred to as medical social work. According to Parveen (2017:21) medical social work is another field of social work and at times terms such as clinical social work, hospital social work or health care social work are used interchangeably to refer to this sub-discipline of social work. Hospital social work is also sometimes called clinical social work or medical social work. In support of the above statement, Dziegielewski and Holliman (2020:36) argue that in a medical environment, clinical social work is most often

called medical social work. Based on the abovementioned different names for hospital social work, the researcher is of the view that the above names; hospital social work, medical social work and clinical social work can be used interchangeably.

2.3 TYPES AND FUNCTIONS OF GOVERNMENT HOSPITALS

In the South African hospital sector, there are different types of government hospitals. According to the South African Department of Health Government Policy on the management of hospitals, Government gazette No 35101, notices (2012:3), the following are categories of public hospitals:

(a) district hospital;

(b) regional hospital;

(c) tertiary hospital;

(d) central hospital; and

(e) specialised hospital.

The abovementioned categories of hospitals render difference services to the public. The following are functions and operations of South African public hospitals as indicated by the South African Department of Health Government Policy on the management of hospitals, Government gazette No 35101 notices (2012:4-6):

2.3.1 District hospitals

District hospitals are categorised into small, medium and large district hospitals with the following number of beds:

(a) small district hospitals with no less than 50 beds and no more than 150 beds;

(b) medium size district hospitals with more than 150 beds and no more than 300 beds; and

(c) large district hospitals with no less than 300 beds and no more than 600 beds.

(2) A district hospital must

(a) serve a defined population within a health district and support primary health care;

(b) provide a district hospital package of care on a 24-hour basis;

(c) have general practitioners and clinical nurse practitioners' primary health services;

(d) provide services that include in-patient, ambulatory health services as well as emergency health services; and

(e) where practical, provide training for health care service providers.

(3) A district hospital receives outreach and support from general specialists based at regional hospitals.

(4) A district hospital may only provide the following specialist services

(a) paediatric health services;

(b) obstetrics and gynaecology;

(c) internal medicine;

(d) general surgery;

(e) family physician.

2.3.2 Regional hospitals

(1) A regional hospital must, on a 24-hour basis, provide

(a) health services in the fields of internal medicine, paediatrics, obstetrics and gynaecology, and general surgery;

(b) health services in at least one of the following specialties

(i) orthopaedic surgery;

(ii) psychiatry;

(iii) anaesthetics;

(iv) diagnostic radiology;

(c) trauma and emergency services;

(d) short-term ventilation in a critical care unit;

(e) services to a defined regional drainage population, limited to provincial boundaries and receive referrals from several district hospitals; and

(f) where practical, provide training for health care service providers

(2) A regional hospital receives outreach and support from tertiary hospitals.

(3) A regional hospital has between 200 and 800 beds.

2.3.3 Tertiary hospitals

A tertiary hospital:

(a) provides specialist level services provided by regional hospitals;

(b) provides sub-specialties of specialties referred to in paragraph (a);

(c) provides intensive care services under the supervision of a specialist or specialist intensivist;

(d) may provide training for health care service providers;

(e) receives referrals from regional hospitals not limited to provincial boundaries; and

(f) has between 400 and 800 beds.

2.3.4 Central Hospitals

A central hospital:

(a) must provide tertiary hospital services and central referral services and may provide national referral services;

(b) must provide training of health care providers;

(c) must conduct research;

(d) receives patients referred to it from more than one province;

(e) must be attached to a medical school as the main teaching platform; and

(f) must have a maximum of 1200 beds.

(2) Central referral services are provided in highly specialised units, require unique, highly skilled, and scarce personnel and at a small number of sites nationwide.

(3} National referral services

(a} refer to super-specialised national referral units; and

(b) represent extremely specialised and expensive services (e.g. heart and lung transplant, bone marrow transplant, liver transplant, cochlear implants).

2.3.5 Specialised hospitals

A specialised hospital

(a) provides specialised health services like psychiatric services, tuberculosis services, infectious diseases and rehabilitation services; and

(b) has a maximum of 600 beds.

2.4 THE ROLE OF HOSPITAL SOCIAL WORKERS

Hospital social workers around the world render different services and play a variety of roles. According to Fronek et al., (2017:672) in South Korea, a social worker's duties include making decisions for patients, most specifically those who are underprivileged and qualify for assistance. While in the United Kingdom (UK), according to Heenan and Birrell (2019:1744), one of the key roles of social workers is normally to be at the forefront for making arrangements prior to the release of patients. Importantly, they are the primary point of contact for the service user, working with them from admission to discharge and often continuing through to community care.

2.4.1 Hospital social workers in multidisciplinary teams

In hospitals social workers adopt different roles and serve as important multidisciplinary team members, addressing the different psychosocial needs of the patients being treated. Social workers in hospitals work in a team in collaboration with different types of professionals to provide holistic services to patients. Hospital social workers usually find themselves working within a team of academics coming from different fields, like medicine, nurses, those who work with the human physique, and those who assist patients with talking challenges and relaxation activities (Parveen, 2017:21).

Below is a table outlining four types of teamwork in health settings as discussed by Dziegielewski and Holliman (2020:33):

Table 2.1: Types of teams in hospital settings

MULTIDISCIPLINARY TEAMS	INTERDISCIPLINARY TEAMS	TRANSDISCIPLINARY TEAMS	PAN DISCIPLINARY TEAMS
-Consist of a batch of qualified personnel, providing services independently but collaborating with other professionals	-Consist of a batch of health care professionals, providing services interdependently by collaborating with other health care professionals and	-Consist of a batch of qualified health care personnel, together with the patient and a group of people who are a pillar of support for the patient,	-A batch of qualified health care personnel working in a specialised environment where they perceive themselves as equal.

to achieve a common goal. -Information is shared formally to help patients.	relying on each other to provide a service towards patients. -Sharing of information is done formally and informally.	working together to help the patient.	-All the members of this team have expertise in a particular subject area.

Social workers in hospitals work as independent personnel, and also as part of multidisciplinary teams where they work with other professionals such as doctors, nurses, dieticians and occupational therapists to ensure that the patient's needs are covered as a whole. Dziegilewski and Holiman (2020:108) support the latter by stating that a multidisciplinary team consists of various qualified personnel from the welfare sector which comprises of doctors, hospital social workers, therapists, and other health professionals who can provide help to the clients and members of their families.

Information about the diagnoses of the patients is shared with members of the multidisciplinary team so that they can execute their roles based on their functions and expertise. The better way to define multidisciplinary is by splitting it to its two words of origin, which are ''multi' and ''discipline'' whereby multi plainly signifies a collective of various qualified personnel and discipline denotes the sector in which they work (Dziegilewski & Holliman, 2020:108). Various authors (Albrithen & Yalli, 2016:130; Parveen, 2017:21) agree with Dziegiewski and Holliman (2020:108) by stating that multidisciplinary teams are made up of various qualified medical personnel, such as nursing personnel, physicians, physiotherapists, dieticians, speech therapists, occupational therapists and pharmacists.

2.4.2 Work as allied workers/ secondary services

The role of hospital social workers is not considered essential, as it is regarded as a support service to essential hospital personnel such as nurses and doctors. Furthermore, they are seen as allied workers. Dziegilewski and Holliman (2020:53) validate this by alluding that allied health professionals comprise of qualified personnel who work in any health or medical setting, and this may include medical social workers, psychologist, dieticians, and optometrists, and the reason why doctors and nurses are not seen as allied workers is because they provide a much needed crucial service in health care settings.

According to Heenan and Birrell (2019:49) social workers, working in collaboration with a group of other professionals, are often a minority group, and might even end up disadvantaged by virtue of being the minority. The researcher agrees with Heenan and Birrell (2019:49), because he thinks being an allied worker or secondary service in a workplace has its own challenges that may lead to not being prioritised compared to essential workers, and this can also lead to them being last personnel when the tools of the trade are allocated since priority lies with essential workers, such as doctors and nurses.

2.4.3 Works in various wards

In hospitals, social workers are placed in different wards.

- Oncology wards

Patients who are living with cancer are placed in oncology wards and are often facing many challenges resulting from the nature of their disease. Social workers are therefore needed to ameliorate the pain and challenges cancer patients are faced with. Being diagnosed with and treated for cancer is highly stressful and potentially traumatic for children and families.

Working with cancer patients, or in particular patients who are living with life threatening diseases, has a negative effect on the wellbeing of social workers. This notion is highlighted by Yi et al., (2018:667) who state that it is not only the family of children diagnosed with cancer that undergo psychological stress, even oncology social workers experience psychological stress because they need to provide support every step of the way to the sick children and their families.

- Paediatric ward

In hospitals, social workers are also found in children's wards to provide support for children who have challenges and who are ill. Cuatero and Campos-Vidal (2019:274) explain that common challenges that hospital social workers face regularly include attending to patients who are not treated well, patients who have psychological dilemmas, patients who are suffering emotionally and patients who have being abused when they were younger.

- Renal ward/unit

Hospital social workers are also placed in renal wards to educate patients together with their families about the disease and provide counselling (Gehlert & Browne, 2012:480). A study done by Berzoff, Kitsen, Klingensmith and Cohen (2020:7) which focused on advanced care planning for renal social workers shows that hospital social workers in renal wards are expected to provide advanced care to patients who are experiencing kidney failure. Seekles

and Ormandy (2022:5) concur and state that in renal unit/wards, hospital social workers play variety of roles such as follows:

- Educating patients on how to take care of themselves and the machines they use.
- Improving state of living conditions of patients in relation to their treatment.
- Providing patients with supports throughout their illness.
- Providing families of patients with support if the patients die.

- Medical wards

Even in medical wards, social workers are placed to provide support towards patients who are nearing their end of life (Manning, 2022:298).

- Covid-19 wards

The Covid-19 pandemic also gave birth to a new hospital ward called Covid-19 wards and has seen social workers having a role to play in those wards. During the Covid-19 era, lots of social workers has been allocated a role to conduct bereavement counselling inside Covid-19 wards for those families who lost their loved ones (Fox, McIlveen & Murphy, 2021:133-134). Kurevakwesu (2021:708) concur and state that during Covid-19 pandemic, there was too much overpopulation inside hospitals and hospital social workers had to see lots of patients.

- High care unit/Intensive care unit

Inside the intensive care unit, hospital social workers also have a role to play which is to update families of patients regarding patients who are not responsive to treatment to create connection between the patient and their families at home by updating them about the status of the patient (Manning, 2022:298 & Parveen, 2017:115). Fox et al., (2021:135) concur by stating that during Covid-19 pandemic, the role of social workers was to use creative ways in a form of nonverbal communication either by using pictures or letters rather than talking to ensure that there is communication between the patient who is dying and his or her family to communicate last messages and goodbyes.

- Any hospital wards

Almost in every hospital ward, hospital social workers have a role to play because almost in any ward, the chance of a patient dying is present, then the role of a social worker to provide bereavement counselling is always needed. In hospitals, social worker's role is to facilitate a

process of making sure that dying patients can communicate last messages to their loved ones and families are able to communicate last messages to dying family members (Fox et al., 2021:135). Harvey and Jones (2022:2671) concur with their study done on social workers working in different hospitals serving different wards such as protection of children, working with elders and disable people.

2.4.4 Assessing the needs of patients

Heenan and Birrell (2019:49) postulate that assessing what the patients and the families require in terms of their welfare and the type of social care they need, is the responsibilities of medical social workers employed in hospitals that deal with critical cases. This is also supported by Parveen (2017:83) who outlines some of the roles of medical social workers in hospitals as providing counselling, defending the rights of patients, helping patients with legal matters, evaluation of patients, and assisting patients who experience money problems The researcher agrees with both statements since assessment is a tenet in social work practice, to be able to identify the needs of the patients, and concomitantly solicit information. Identifying the needs of the patients therefore allows the social workers to ascertain the type of action plan needed to assist the patients. In addition, it assists social workers to garner pertinent information that will assist the social worker to best attend to patients.

2.4.5 Attending psychosocial need of patients and their families

The role of social workers in general, and in a hospital setting specifically, is different from other professions, such as doctors and nurses, in the way that social workers go to the extent of involving the families of patients as part of a treatment plan. Unlike doctors and nurses who only treat the patient alone. The role of hospital social workers is defined by Pockett and Beddoe (2017:132) as hospital social workers having a variety of responsibilities such as linking patients with their family and further qualified people who will assist them with the provision of services either in the hospital or outside the hospital.

2.4.6 Educate patients about illnesses they are diagnosed with

Medical social workers play a significant role in ensuring that patients better understand the type of illnesses they are diagnosed with so that they are able to live positively with their diagnoses. This role assuages and buffers the pain that patients go through after being diagnosed with a life threatening disease. Heenan and Birrell (2019:1742) delineate the role of medical social workers as follows:

- Help patients and their family members accept their illness, the effect of the illness upon their lives, to understand the type of treatment needed and provide other needed resources that can help patients to live positively while living with chronic illnesses.
- When assisting a patient, medical social workers attend to the the patient in totality, the patient's needs, his or her desires, together with the needs and desires of the patient's families.
- Ensure that patients receive better services inside hospitals and ensure that when patients are discharged, they are ready to face the outside environment.

2.4.7 Discharge planning

One of the key roles of clinical social workers is discharge planning. As stated by Parveen (2017:101), making arrangements for the release of patients and assisting patients with matters associated with adapting to the sickness they are diagnosed with, are some of the duties of hospital social workers. Heenan and Birrell (2019:1748) agree with Parveen by stating the following:

- Although the role of discharging patients is a shared role among different professionals employed in hospitals, social worker takes a leading role.
- Hospital social workers ensure that before a patient is released, he or she is ready to be released. In addition, the patients' health and comfort becomes a priority and guides whether the patient is ready to be discharged or not.

The researcher supports the view that discharge planning must be carried out by social workers, since social workers work with the entire family of the patient and this ensures that the patient will be in good hands when discharged, with people who understand the nature of the patient's illness. This will also ensure that there is tremendous support and patient's needs are attended to. Furthermore, Heenan and Birrell (2019:1742) mention that one of the key responsibilities of hospital social workers is to make arrangements for the release of patients.

To encapsulate the roles of hospital social workers, below is a table of different roles of hospital social workers as mentioned by Dziegielewski and Holliman (2020:57) ;

Table 2.2: Roles of hospital social workers

SERVICE	DESCRIPTION
Case finding and outreach	To find patients and help them to receive the services they require

Preservice and planning	To find patients who need services, assist them together with their families plan and receive the welfare services they need.
Assessment	After identifying patients who require services, they help to pick up what is bothering them and what is making them sick.
Concrete service profession	They help when the patients are admitted and with discharge planning, and ensure that patients receive the services they need, even after they have been discharged.
Psychological evaluations	They assist in collecting information so that they are able to draft a psychosocial report.
Identification of goals and objectives	They assist patients to identify their aims by addressing their welfare challenges.
Direct clinical counselling	Provide counselling to patients to ensure that service users together with their families can face their challenges and are able to deal with them.
Assistance with short-or long-term planning	Help service users to plan for what services are needed now, what will be needed in the future and what their welfare standing will be in the future.
Information and health education	Educate service users and their families regarding what they need to know in relation to their welfare.
Assistance with wellness training	Help service users with planning to ensure that service users' wellbeing becomes better through a holistic approach.
Referral services	They give services users information about the kinds of services they can receive and if there is a need they link the patients with those services.
Patient advocacy	Advise policy makers to draft policies that will be in the best interests of service users.

The role of hospital social workers was outlined in detail and now the researcher will discuss compassion fatigue.

2.5 COMPASSION FATIGUE

In this section the researcher will elucidate on literature that was reviewed in relation to compassion fatigue. Compassion fatigue will be compared with compassion satisfaction, secondary traumatic disorder, vicarious trauma and burnout.

Yi et al*.,* (2018:668) describe compassion fatigue as:

- A condition in which a medical social worker's ability to show care and empathy is reduced, and they are no longer able to carry the pain of patients who have undergone emotionally wounding experiences.
- It does not only affect the emotions of professional carers, but it can also affect their behaviour, their logic and their physical health.

Various authors (Galletta, Larkin, Sardo , Campagna, Finco & Aloja, 2020:2; Parker, 2020:177; Portoghese, Cavanagh et al., 2020:640; Todaro-Franceschi, 2019:5; Hansen, Eklund, Hallen, Bjurhager, Norrstrom, Viman & Stocks, 2018:632; Brill & Nahmani, 2017:12; Figley & Ludick, 2017:574) concur that compassion fatigue is a response that results from working with patients who are traumatised with a need to assuage the pain that they are going through, in return it affects health care workers' emotional, mental, physical, psychological, and social wellbeing. In addition, they further state that compassion fatigue results from using empathy in order to ease the pain of patients and to try to understand the circumstances the patients find themselves in as if it was their own, thus resulting in health care worker's capacity to care diminishing or disappearing. The researcher further agrees that compassion fatigue is a type of stress that is caused by caring for patients by way of showing understanding for the pain they are feeling, that in return, affects counsellors holistically in the long run if it is not identified early and dealt with. The researcher furthermore states that compassion fatigue is caused by the social worker's concern to try to understand the client's conditions from the client's frame of reference.

Compassion fatigue is also related to other terms such as vicarious trauma and secondary traumatic disorder. Below is a table outlining similarities and disparities between secondary traumatic disorder, vicarious trauma, compassion fatigue and burnout (Imes, Omilion-Hodges & Hester, 2021:202; Cavanagh et al., 2020:640,659; Dubois & Mistretta, 2020:42,43,65; Parker, 2020:176,177; Portoghese et al., 2020:2; Fox, 2019:1; Todaro-Franceschi, 2019:515,84; Yi et al., 2018:668; Figley & Ludick, 2017:573,581; Figley, 1995:5,78,151,210):

Table 2.3: Comparison between secondary traumatic stress, vicarious trauma, compassion fatigue and burnout

SECONDARY-TRAUMATIC STRESS DISORDER	VICARIOUS TRAUMA	COMPASSION FATIGUE	BURNOUT
• Is when the stress that is caused by traumatic experiences becomes serious. • The results that are seen in professionals who help patients who have experienced trauma. • Caused when professionals know a person who is undergoing or has undergone trauma. • Proximity to traumatised people affects professionals and causes stress. • A stage when the behaviour	• Manifests in professionals who are caring for patients who have been traumatised. • Affects professionals who use empathy when helping patients. • The great extent to which professionals use empathy when working with patients makes professionals more susceptible to vicarious trauma. • If professionals encounter negative feelings that are not paid attention to, they will end up experiencing compassion fatigue.	• Is a result of taking care of patients who are sick or who are experiencing or have experienced trauma. • Occurs when people experience pain which they refrain from dealing with. • Other terms to refer to compassion fatigue are secondary traumatic stress and vicarious trauma. • Occurs when professionals are exposed to, and interact with, patients who are experiencing suffering or pain. • Can also include how professionals respond after	• Is a result of being unhappy in a work environment. • Several factors may cause burnout, such as relationships with colleagues, too much work, unsatisfactory pay, and lack of benefits. • May be a result of a person's inability to fit well into a working environment. • Professionals may start treating patients badly and their ability to care may even diminish. • Can affect the holistic functioning of people. • Not associated with caring for patients experiencing trauma. • Emerges as a result of job-related circumstances. •

and emotions of professionals changes. • A kind of stress that results from assisting someone who is undergoing trauma. • Also known as compassion fatigue or vicarious traumatisation.	• When professionals work with patients who are experiencing trauma. • It affects the holistic functioning of people. • It is caused when professionals continuously encounter patients who experience trauma. • Vicarious trauma and compassion fatigue are caused by working in a setting in which the core function is to use empathy to service users who have undergone trauma.	being exposed to traumatic cases. • Affects the holistic functioning of people. • Can even negatively affect the ability of professionals to show empathy and decrease their ability to be considerate towards patients experiencing pain and trauma.	

Based on the above comparison, the researcher is of the view that; post-traumatic stress disorder, vicarious trauma and compassion fatigue share similar characteristics, such as; close contact or proximity to traumatised patients, hearing other people's trauma, using empathy and witnessing the suffering of others. In addition, the researcher is of the view that the three terms can be used interchangeably since they all come about as a result of a direct caring relationship between social workers and patients who have experienced trauma.

Although burnout shares some certain commonalities with the three terms because it results in professionals becoming uncaring and can be caused by workload, the conspicuous

difference is that burnout results mostly because of the pressure of the working environment, salary, workload, and culture of the organisation and is not associated with working with traumatised patients. In addition, burnout is not associated with the use of empathy.

Since government hospital social workers serve patients who need emotional and social support in their everyday lives, it is very important for the social workers to be diligent in their duty and try and feel the pain of the clients as if it was their own. This makes social workers more susceptible to compassion fatigue.

Compassion fatigue can occur in different phases and Coles (2017:11-12) explains the phases as follows:

1. Zealot: The caregiver is motivated by idealism and ready to serve and problem solve, wants to contribute and to make a difference, volunteers to help and is full of energy and enthusiasm.

2. Irritability: The caregiver begins to cut corners, avoid client contact, mock peers and clients, denigrate his or her own efforts at wellness, lose concentration and focus; and distance oneself from others.

3. Withdrawal: The caregiver loses patience with clients, becomes defensive, neglects self and others, is chronically fatigued, loses hope, views self as a victim and isolates self.

4. Zombie: The caregiver views others as incompetent or ignorant; loses patience, sense of humour, and zest for life; dislikes others; and becomes easily enraged.

5. Pathology and victimisation or maturation and renewal: This is a stage whereby the carer decides whether to become a victim or becomes renewed. Being a victim happens if cares does not take any measures. Maturation and renewal are possible only when the caregiver acknowledges the symptoms of compassion fatigue and takes direct action to overcome it. If the caregiver chooses pathology and victimisation, he or she becomes overwhelmed and may leave the profession or develop somatic illness. On the other hand, if the caregiver chooses maturation and renewal, he or she becomes stronger, more resilient and transformed.

Not all hospital social workers are prone to compassion fatigue, and there are number of reasons why some social workers are more prone and susceptible to compassion fatigue than the others. As cited by Figley (1995:15-16) the table below depicts reasons why trauma workers are especially vulnerable to compassion fatigue:

Table 2.4: Reasons why trauma workers are especially vulnerable to compassion fatigue

• Since professionals who work with traumatised people use empathy to enable them to provide adequate support, this makes them susceptible to compassion fatigue since the use of empathy make professionals vulnerable to compassion fatigue. • Professionals who have experienced trauma in their own lives are more vulnerable to compassion fatigue especially if they work with patients who are undergoing similar trauma. • If professionals have experienced trauma which they did not deal with properly, this can be invoked by the traumatic experiences of patients. • If the professionals work with children who are undergoing trauma, this may remind the professionals about their own traumatic childhood experiences.

Hospital social workers may experience the same stressors that lead to compassion fatigue but may respond differently. Both individual and environmental factors contribute to how professionals who experience trauma mediate it. According to Figley (1995:95-96) those factors are as follows:

- Personal factors include internal power which might include higher self-esteem, longer work experience, being highly educated, low education, whether individuals have experienced trauma before which may lead to countertransference, being lonely, not satisfied personally and not satisfied professionally.
- Environmental factors include workplace support, personal support, relationships with colleagues, feeling judged by colleagues, death of close people, society's economic circumstances, and political environment.

The description of compassion fatigue lead the researcher to discuss the signs of compassion fatigue.

2.5.1 Signs of compassion fatigue

Compassion fatigue can be identified by number of signs or symptoms. Below is a list of typical signs of compassion fatigue and burnout as stated by Todaro-Franceshi (2019:89-90):

Typical Signs of compassion fatigue and burnout:

Behaviour changes

Not being able to be stable thus affecting empathy

Severe feelings of unhappiness

Being angry

Extreme blame

Easily irritated

Chronic lateness

Spending too much time working and becoming overloaded

Exaggerated startle response

Starting to experience issues with focus and lose concentration easily

Start abusing drugs

Overeating and loss of appetite

Starting to have difficulty with sleeping

Becoming absent from work and faking sickness

Feelings

Having a sore heart

Feelings of being a loser who never achieved anything

Loss of purpose

Becomes difficult to be happy

Self-esteem decreases

Setting impractical goals

Loss of hope and becoming helpless

Becoming numb

Having an empty heart

Starting to lose interest and detach from regular activities

Becoming delusional

Physical changes

Long term tiredness that is extreme and can even affect emotions

Always experiencing a headache

Gastrointestinal complaints

Abnormal blood pressure

Experiencing heart problems

Feeling bodily pains

Always sick

Inability to focus

Feeling anxious

2.5.2 Compassion satisfaction

Although compassion fatigue is a negative consequence of caring, there is a positive consequence of caring which can also serve as a morale booster for hospital social workers, namely compassion satisfaction. Compassion satisfaction is a fulfilment attained by social workers as a result of being able to provide proper assistance for patients (Cherny, Fallon, Kaasa, Portenoy & Currow 2018:253). Various authors (Cuartero & Campos-Vidal, 2019:276; Hunt, Danieffe & Gooney, 2019:2; Hansen et al., 2018:632; Brill & Nahmani, 2017:18; Figley & Ludick, 2017:581) concur with the above statement by stating that compassion satisfaction is the pleasure or joy that counsellors get from making a difference in the lives of the patients they serve. They further state that this inspires and provides strength and sense of courage for counsellors.

The findings of a research study done in the United States of America (USA) to explore the prevalence of compassion fatigue among hospice social workers, discovered the reality of compassion fatigue among hospice social workers and that one of the mechanisms to survive compassion fatigue was associated with improved compassion satisfaction (Pelon, 2017:134-150).

Another study, which was conducted on nurses by Barmawi, Subih, Salameh, Sayyah, Shoqirat, and Jebbeh (2019:6), states that better coping strategies among the nurses were associated with better levels of compassion satisfaction. Even though the similarities between the abovementioned studies and the researcher's current study are that it is on compassion fatigue, the weaknesses or limitations are the fact that it was not done on hospital social workers or in South Africa.

Compassion satisfaction was described as a positive result of caring and helping. In summary, based on above statements, compassion satisfaction is the inverse of compassion fatigue. The topic that follows will discuss the causes of compassion fatigue among hospital social workers.

2.6 CAUSES OF COMPASSION FATIGUE AMONG HOSPITAL SOCIAL WORKERS

This section will outline the literature review on the causes of compassion fatigue among hospital social workers. Taking care of patients who are emotionally wounded causes social workers to become prone to compassion fatigue and working in a hospital worsens their susceptibility (Mcmahon, 2021:1).

2.6.1 Many ugly situations/ deaths

Several studies conducted on the causes of compassion fatigue mention that working with people who are nearing dying can cause compassion fatigue. A study done on nurses by Todaro-Franceshi (2019:85&88) describes how assisting patients who are experiencing trauma and patients who are likely to die gives rise to compassion fatigue.

Another research study has been done about compassion fatigue and nurses in Durban, South Africa (Wentzel & Brysiewicz, 2018:82-86) and the findings of the study was that nurses experience compassion fatigue as a result of dealing with traumatic clients and death. Although the researcher agrees with both the statements working with too much dying can be a cause of compassion fatigue, the limitation of both abovementioned studies is that it was done on nurses, not social workers. In addition, the researcher is of the view that there are a lot of disparities between social workers and nurses. The only notable strength of the above studies compared to the current studying is the fact that it was on compassion fatigue. In contrast a different study, which is a personal narrative by Fox (2019:3), shows that the author of the narrative, after many years of working with the dying, developed expertise in death and dying. Meaning that he developed resilience in order to deal positively with the dying. This shows that working with the dying all the time does not necessarily lead to the development of compassion fatigue. A notable limitation of this narrative research is the fact that it only includes the experiences of one social worker, and it was done in Australia not South Africa.

Hospital social workers, or social workers in general, deal with death as the nature of their job but are not given an opportunity or allowed to grieve or mourn the deaths of their patients such as in normal relationship circumstances. According to the classical work by Doka (1989:3) there are situations whereby lay people or professionals experience death of people close to them but are not allowed to grieve according to the norms of society or policies at work and that phenomenon is called disenfranchised grief. Disenfranchised grief is furthermore described by Doka (1989:40) as follows:

- Disenfranchised grief is a type of grief that is not recognised by the community and social workers cannot show pain openly if they have lost their patients.
- The phenomenon of disenfranchised grief emanates from the community principles of grief. These principles stipulate who is qualified to mourn who, the place where grief is permissible and the duration of grieving.
- Even in the workplace there are policies regarding grief whereby the policies stipulate the following: number of days which workers qualify to take leave for grieving and workers are only allowed to take grieving leave for immediate family members.

- These grieving rules are not a true reflection of the nature of the closeness of relationships and therefore sometimes they seem unfair towards professionals working with people and how the deaths of their patients affect them.

Doka (1989:5) continues by stating that one of the reasons that cause disenfranchised grief is because a relationship between a professional and patient is only regarded as professional relationship, therefore if a patient passes on, professionals are not allowed to grieve even though the passing of patients might affect them negatively. As stated by Doka (1989:5) professionals develop long-term relationships with their patients, however societal rules and workplace policies do not encourage or support them in their grief for their patients in the same way their families grieve.

In a qualitative study done by Yi et al., (2018:671) aimed at understanding the experience of compassion fatigue among 27 paediatric oncology social workers it was found that it was difficult for the social workers to avoid attachment to their patients, especially when witnessing a recurrence of cancer, the death of a patient, or a parent's anguish caused by a child's death. This study has similar attributes and is close to what the researcher is studying (qualitative study on compassion fatigue among hospital social workers), it was not done in South Africa and also the method of data collection was a focus group not individual interviews. This shows a gap since the study was not conducted in South Africa and lacks indigenous elements of a South African context.

2.6.2 High caseloads and focus is on quantity

In a study conducted by Yi et al., (2018:674) on paediatric oncology social workers' experiences of compassion fatigue, excessive workload was one of the contributing factors which caused compassion fatigue. The other findings of the study were as follows:

- High caseload and a shortage of social workers were the major reasons that the social workers experienced strain and frustration.
- Shortage of social workers caused serious strain and made social workers feel suffocated by the work.

2.6.3 Exposure to emotional cases

A study was conducted on compassion satisfaction and compassion fatigue among medical social workers in Korea by Yi et al., (2019:971) and discovered that qualified personnel who work in different caring sectors might show signs of compassion fatigue when attending to the needs of patients who are emotionally wounded or patients who have physical illnesses. Although the study has similarities with the researcher's current stud in terms of compassion

fatigue among medical social workers, its limitation is the fact that it was conducted in Korea so it cannot be compared with s South African social work context since the countries are not the same.

Another study, which was conducted on social workers in Spain by Cuartero and Campos-Vidal (2019:274), found that when social workers understand the overall circumstances of their patients, together with helping patients deal with their pain can result in social workers experiencing stress and pain. This study cannot be compared with the current study since it was done in Spain and focused on private and state sectors and not hospitals.

In contrast, another study conducted on nurses by Todaro-Franceshi (2019:5), agrees with the above authors that compassion fatigue normally appears as a result of taking care of patients who experience psychological pain or trauma. Figley (1995:1) shares the sentiments of the above authors by stating that providing compassionate services towards patients who are going through some pain results in negative consequences for professionals who in return may experience the same pain which their patients are going through and lose their own sense through the process.

The above statement is also supported by Figley and Ludick (2017:588) who state that being regularly exposed to patients who are hurting or working with professionals who are mental exhausted affects hospital social workers negatively.

2.6.4 Lack of resources

A lack of resources can also be a contributing factor to causing compassion fatigue. A study conducted on oncology social workers' experiences of compassion fatigue by Yi et al., (2018:674) reported that in the setting where these paediatric oncology social workers were employed, many did not have a private office space, and the following was also found:

- In the environment where those social workers were employed, they shared offices therefore did not have privacy.
- Since there is no privacy because of office sharing, there is no confidentiality which contributes to them not being able to perform certain tasks
- The issue of sharing offices was also seen to be the root cause of why other professionals didn't value them much.

2.6.5 Lack of support, recognition and understanding of social workers' roles

Since social workers work in multidisciplinary teams, sometimes they do not get enough support, their roles are misunderstood and they lack recognition. A study conducted by Yi et

al., (2018:671&674) on the experiences of compassion fatigue among oncology social workers reported the following:

- Environmental circumstances involved psychologically draining relationships with other professionals and other professionals not valuing or acknowledging their roles.
- The majority of social workers shared that more often they experienced situations whereby they felt they were not being valued by the families of the service users and medical professionals.
- The social workers experienced a feeling of not being valued by professionals who worked as medical personnel since they did not understand their responsibilities, did not give them support and thus left them frustrated.

Figley and Ludick (2017:583) concur with the statement and mention that working in an unhealthy setting affects relations between colleagues and the team spirit becomes weak. They further state that the elements that are lacking in a toxic work environment are a sense of trust, optimism, and mutual support among and between staff members.

2.6.6 Working with others with the same problems as their own

It is of paramount importance for social workers to deal with their own personal issues so that the challenges of their patients do not provoke old unhealed wounds. This is called countertransference. Figley (1995:9-11) describes countertransference as follows:

- Countertransference is accompanied by a psychological response from a professional to a patient.
- It happens when a patient is experiencing a painful situation that has similarly happened to a professional previously and the professional has not dealt with it fully.
- Countertransference may happen either in a way that the professional is aware or unaware and it must be avoided because it can affect the counselling process.

2.6.7 Working with other people

In a study done on university students in courses or programmes in nursing or behavioural science by Hansen et al., (2018:632) it was identified that by having contact with other people and working with people, the students developed compassion fatigue. Although the study was not conducted on hospital social workers, the researcher is of the view that compassion fatigue results from having contact with other people.

2.6.8 Burnout

A systematic review was conducted on 71 previous articles on compassion fatigue in health care practitioners by Cavanagh et al., (2020:640&643) and reported that burnout is one of the elements that contributes towards the emergence of compassion fatigue which might be the result of working long hours and may affect social workers' abilities to show compassion. Even though this review contains a well detailed discussion since it covered a number of studies, it has some limitations because it was done in rich countries, information was not collected from participants but second-hand from other studies and those studies did not only include social workers but other professions (Cavanagh et al., 2020:640&643).

2.6.9 Use of empathy and need to care

According to Figley (1995:95) when someone experiences trauma, it leaves anyone who is close to that person compelled to show empathy and this can have long-term consequences, such as becoming exhausted. Hunt et al., (2019:6) concur with Figley by stating that using empathy is crucial when dealing with patients who are undergoing pain but using too much empathy can cause professionals to experience fatigue. The researcher agrees with both statements and argues that the use of empathy is a tenet of social work and working with traumatised patients. The researcher argues further that using empathy assures the patients that the social workers understand what they are going through but in return it jeopardises the wellbeing of the social workers.

Todaro-Franceshi (2019:83) is of the view that being a passionate care giver makes professionals working in caring professions more susceptible to compassion fatigue, puts them under pressure and paves the way for further emotional pain to occur. Different authors, such as Cavanagh et al., (2020:658); Dubois and Mistretta (2020:65); Hunt et al., (2019:2); Figley and Ludick (2017:581); Figley (1995:1) concur that those who show caring and empathy are more susceptible to compassion fatigue .

Another author has a different view and describes the term ‘’the saviour syndrome’’ which is thought to cause compassion fatigue because professionals must understand that their role is to help and not to save or rescue their patients (Cherny et al., 2018:253). The researcher believes that if social workers understand that they can only do certain things for their patients, then they can avoid being affected by saviour syndrome.

Figley (1995:15) is of the view that only social workers who are not using empathy and avoiding working with patients experiencing trauma, are the ones who can avoid compassion fatigue. It is conspicuous that as long as social workers are exposed to traumatised patients

and respond by doing their work in a diligent manner, including using empathy, they cannot avoid compassion fatigue.

2.6.10 Taking work home

According to Figley (1995:192) working from home and committing to lots of tasks may cause compassion fatigue. The researcher agrees and believes that social workers must leave their work tasks at work and be able to draw a line between work and home to avoid compassion fatigue.

The above section outlined the causes of compassion fatigue, it is of outmost important to discuss the effects of compassion fatigue on a personal and professional level and how it affects service delivery.

2.7 EFFECTS OF COMPASSION FATIGUE ON PERSONAL AND PROFFESSIONAL LIFE AND SERVICE DELIVERY

Compassion fatigue may affect different aspects of the lives of hospital social workers. As Figley (1995:87,179) outlines:

- It can affect both the professional and personal lives of people working with traumatic cases.
- Professionals who do not pay attention to the effects of compassion fatigue can harm themselves, people close to them and even their patients.
- It can make professionals become unnecessarily sensitive in their own lives.

Based on the above statement, it remains clear that compassion fatigue can affect social workers' personal and professional lives and therefore it is necessary for social workers to always be ready to deal with compassion fatigue.

Cherny et al., (2018:252) share the same sentiments by indicating that compassion fatigue can have detrimental effects on the holistic functionality of a human being, and can affect emotions, logic, personal health and can even relationships.

2.7.1 Personal effects of compassion fatigue to hospital social workers

2.7.1.1 Becomes irritable/ angry/moody

According to Brown, Ong, Mathers and Decker (2017:120) compassion fatigue may have an influence on whether hospital social workers will become satisfied and happy and may even result in social workers suffering individual pain.

2.7.1.2 Feels fearful/alert

In a study conducted by Brill and Nahmani (2017:19) it was discovered that, based on the fact that the therapists carried on with their work, experiencing situations where their patients experienced suffering, this ended up creating a situation where the therapists experienced serious stress issues such as;

- Having signs of fear.
- Inability to eat.
- Starting to see the world differently, which also led to having challenges regarding relations.
- No longer wanted to socialise.
- No longer trusting themselves, in terms of if they would be able to provide proper services towards patients.

This view is also supported by Dubois and Mistretta (2020:67) who state that a variety of feelings such as anxiety, sadness and depression can be induced by compassion fatigue. The researcher agrees with both the above statements and states that compassion fatigue affects the emotions and changes social workers' feelings negatively.

2.7.1.3 Feels hopeless, tired, pessimistic or numb

Parker (2020:175) notes that when professionals feel overburdened by occupational duties, they may feel fatigued all day and to lessen the fatigue they may want to boost their energy by drinking lots of coffee which in the long run might induce sleeping disorders. Conversely, a different study done by Denne, Stevenson and Petty (2019:2) on understanding how social worker compassion fatigue and years of experience shape custodial decisions, identified that the highest prevalent sign of compassion fatigue comprised of shutting out one's own feelings which involved behaviour where social workers isolated themselves and started to forget their patients . In contrast, another study done by Yi et al., (2018:671) on paediatric oncology social workers experiences of compassion fatigue, discovered that social workers' extensive experience of patients' pain which they could not lessen, made them lose hope and become weak. From all the abovementioned studies it is clear that compassion fatigue may leave social workers overwhelmed, tired, affect their sleep, numb, helpless and hopeless.

2.7.1.4 Has physical symptoms

According to the results of the study done by Yi et al., (2018:675) it was discovered that due to compassion fatigue, some social workers became physically and emotionally exhausted to the extent that their health was jeopardised. The researcher agrees with this finding and is of

the view that if compassion fatigue is not identified and dealt with, it can even affect the health of social workers.

2.7.1.5 Family is affected/takes work home

Compassion fatigue does not only affect social workers who are directly involved with traumatised patients, but it also affects their families and loved ones. As outlined by Figley (1995:1-2;88,140) compassion fatigue can affect the families and loved ones of social workers in the following way:

- Based on the severity of a patient's trauma, professionals may start showing the same characteristics as their patients.
- Professionals may start having unwanted thoughts that may affect their families.
- Their normal interactions with people might change.
- They may withdraw from regular activities or people close to them.

Another study by Yi et al., (2018:675) concurs with Figley by outlining the following:

- Members of the social workers' households were able to identify the emotional pain the social worker went through.
- Even the social workers themselves realised compassion fatigue affected their family relationships because they started being inattentive and ignorant of the needs of others to the point that their families were left with feelings of abandonment.

2.7.1.6 Affect sleep

According to Figley and Ludick (2017:587), when professionals experience compassion fatigue, they may have insomnia, in addition the relationships they have with their families and the patients may be negatively affected. Todaro-Franceshi (2019:68) concurs with the above statement by stating that work- related stress can cause insomnia, and when professionals start experiencing insomnia, they need to realise they are deeply affected by work-related stress. Figley (1995:185) in addition states that feeling exhausted, decreases mental functionality, nervous functioning, and becoming easily annoyed may be a result of not sleeping enough. Enough sleep is important for the health of social workers. From the above statements it is clear that social worker's personal lives can be affected by compassion fatigue in such a way that their sleeping patterns are affected and in the long run it affects how they relate to the patients they serve.

2.7.1.7 Feel unsecure and uncertain

In a study done on paediatric oncology social workers' experiences of compassion fatigue by Yi et al. (2018:675) it was identified that compassion fatigue affected their emotions and behaviour to the extent that they started doubting themselves to the point that there was an immediate emergence of throwing tantrums. Figley (1995:184) encapsulates and elucidates the impact of secondary traumatic stress in the table below:

Table 2.5: Impact of secondary traumatic stress

COGNITIVE	EMOTIONS	BEHAVIOUR	SPIRITUALITY	INTERPERSONAL	PHYSICAL
Decreased concentration Confused Self-esteem affected Always thinking about trauma Lack of interest Being confused Thinking about self-hurt or hurting other people Doubting self.	Helpless Anxious Guilty feeling Irritated Shutdown Feeling numb Feeling fearful Feeling sad Depressed Oversensitive	Lack of patience Easily irritated Mood swings Disturbed sleeping Eating disorders Substance and drug abuse Hurting one-self.	See life as useless Not satisfied about anything Losing hope Wrath toward God Having doubts about religion.	Lose appetite for sex Not trusting anyone Always wanting to be alone Parenting is affected negatively Feeling lonely	Sweats Heart problems Breath affected Painful body Feeling dizzy Week immune system.

2.7.2 Professional effects of compassion fatigue on hospital social workers

As stated by Yi et al., (2018:674) when experiencing compassion fatigue, social worker's professional work rate, their household, and their emotional and physical health can be negatively impacted. In addition, Figley (1995:2) states that qualified personnel whose duty it is to assist patients who are experiencing emotional pain, end up experiencing emotional pain themselves because they are exposed to that pain. Conversely, Fox (2019:1-9) states that in the welfare setting, compassion fatigue not only affects social workers but other welfare personnel as well, however a lot has been written on compassion fatigue and how it affects other professionals but very little has been written on how it affects social workers. Although much has been written on understanding the phenomenon of compassion fatigue and vicarious trauma in the helping professions, there is not enough literature available on how

this phenomenon impacts social workers in their everyday lives, how the organisations that employ these practitioners are impacted, or indeed how the clients, patients or their families experience these clinicians. The abovementioned statement shows a paucity of literature on how compassion fatigue affects hospital social workers.

2.7.2.1 Empathy, energy or motivation diminishes

Dubois and Mistretta (2020:60) delineate that when compassion fatigue emerges, it can manifest in numerous forms such as feeling hopeless, a decline in showing care and concern, production at work deteriorates, resentment towards one's chosen occupation, and one may start breaking rules and lose the ability to regulate one's own emotions.

Various authors (Cuartero & Campos-Vidal, 2019:275; Yi et al., 2018:668) concur with Dubois and Mistretta (2020:60) by stating that compassion fatigue reduces the capacity of professionals to empathise, reduces their sense of professionalism, reduces their capacity to bear the suffering of patients, reduces their capacity to connect with patients, and has a negative impact on the therapeutic relations with patients. In addition, findings of a personal narrative study by Fox (2019:1-9) delineate the following:

- The author started to choose which activities he wanted to be part of, and detached himself from clinical opportunities, service users and his family.
- Lost interest at work, just did work for the sake of doing it, wanted to finish work fast, not doing quality work, asked closed questions instead of open questioning to grab enough information and was not connecting with patients.
- He was not attentive to patients since he did not want to feel their pain and felt overwhelmed with pressure.
- He was exhausted to the point that he was no longer empathetic towards patients.

The researcher agrees with the authors above and states that compassion fatigue causes social workers to have apathy and lose touch with empathy, which is a salient tenet of social work.

2.7.2.2 Doesn't want to/cannot work

According to Cherny et al., (2018:253), when the psychological power grows, social workers who are experiencing compassion fatigue may slowly withdraw from their duties. In addition, Yi et al. (2018:668) state that a rise in sick leave, reduced work rate and higher turnover can reduce occupational performance.

2.7.2.3 Affects case evaluation

Denne et al., (2019:3) postulate that compassion fatigue has an influence on how social workers assess their patients to the point that it can directly affect patients' lives.

2.7.2.4 Affects work relationships

The findings of a personal narrative by Fox (2019:84) show that the social worker was disconnecting from colleagues and disengaging from the workplace. This shows that compassion fatigue does not only affect social workers but also the relationships they have at work.

2.7.2.5 Inability to be compassionate and caring

According to Brown et al., (2017:120), incapacity to be caring when attending patients and personal pain are some of the dangers linked with compassion fatigue. Cavanagh et al., (2020:660) share the same sentiments by stating that even though other phenomenon, such as burnout, affect mostly social workers, compassion fatigue affects mostly service users since it causes social workers to start caring less as a result of being continuously exposed to trauma cases.

2.7.2.6 Affects sympathy and attentiveness

The results of a study by Yi et al., (2028:675) outlined the following as impacts of compassion fatigue to oncology social workers:

- Reduced capability to show empathy, ignoring the needs of the service users together with their families, and becoming less attentive thus in return caused social workers to blame themselves for providing poor services.
- By experiencing the abovementioned, the social workers started experiencing compassion fatigue which resulted in them becoming disinterested and unwilling to go the extra mile when doing their jobs.

In summary, the table below, as cited in Figley (1995:191), depicts how compassion fatigue affects social workers professionally:

Table 2.5: Professional effects of compassion fatigue

PERFORMING OF WORK DUTIES	MORALE	INTERPERSONAL	BEHAVIOUR
• Diminished quality and quantity • Shortage of motivation • Avoiding certain work duties • Many mistakes • Being obsessed.	• Diminished confidence • No longer interested • Disappointment • Bad attitude • Feeling discouraged • Ungratefulness • Feeling incomplete.	• Isolating oneself from fellow workers • Lack of patience • Quality of relations diminish • Communication affected badly • Fight with fellow workers.	• Always away from work • Feeling extremely tired • Easily irritated • Late to work • Becoming reckless • Work abnormally • Always changing jobs.

2.7.3 Impact of compassion fatigue on service delivery

Postulated by Dziegielewski and Holliman (2020:322) continuous subjection to stressful cases and the necessity for the social work profession in terms of listening empathetically, may also influence the services provided to patients. In addition, Cuartero and Campos-Vidal (2019:286) state that in order to contribute to the betterment of services offered to patients and give them joy, it is vital to protect the wellbeing of social workers. Based on the above statements, the researcher is of the view that compassion fatigue has detrimental effects on the quality of service delivered by hospital social workers, and it is imperative to ensure that the wellbeing of hospital social workers is in the right state to be able to be equal to the task. Having discussed the impact of compassion fatigue, it is equally important to discuss strategies to deal with compassion fatigue.

2.8 HOSPITAL SOCIAL WORKERS STRATEGIES TO DEAL WITH COMPASSION FATIGUE

Compassion fatigue is endemic to social workers since their line of work includes dealing with cases such as trauma, working with people who have lost hope and even working with death or dying. Being a social worker is traumatic and frustrating in nature (Parker 2020:172). This is supported by Figley and Ludick (2017:588) who state that being compassionate and empathetic comes with consequences and a price to pay but the price can be manageable. Todaro-Franceshi (2019:93) states that being conscious of one's actions when performing daily activities might assist social workers to heal the pain caused by compassion fatigue. In

addition, Figley (1995:189) further indicates that professionals must trust in the people who they can turn to when they feel overburdened and If they feel overstressed or when they do not feel any better they must seek help with an understanding that seeking help is not a sign of weakness but a sign of strength.

According to Cuartero and Campos-Vidal (2019:276) compassion fatigue is inherent in the profession of comforting people, thus it inevitably affect someone whose profession it is to comfort people, but there are activities and measures that social workers can put in place to lessen its impact. The researcher share same sentiments and believe that a professional life of a social worker consist of regular encounter of trauma, pain and therefore social workers must always have tools to cope with compassion fatigue.

2.8.1 Uses alcohol

Some social workers use alcohol or drugs to deal with the pressure of working with traumatic patients. Parker (2020:175) assert that when people are experiencing stress, they may end up abusing alcohol or other drugs and this can even affect their health. Todaro-Franceshi (2019:91) also agrees with Parker by stating that if drugs are misused and there is evidence of an eating disorder as a result of a certain encounter, it can be seen as a remedy for individuals to heal.

2.8.2 Takes time off/ gives time off

Taking time off when reaching the stage of fatigue, ameliorates the impact of compassion fatigue. Figley (1995:170) postulates that compassion fatigue becomes worse if professionals do not take time off, thus in turn affecting the profession and the organisations they represent and can even affect the health of service users. In addition, a study conducted by Yi et al., (2018:675) on paediatric oncology social workers experiences of compassion fatigue, concurs and found that one of the strategies employed by social workers when they realised that they were fatigued was to take a day off or leave work early.

2.8.3 Talks with/ debriefs/ educates colleagues

According to Dziegielewski and Holliman (2020:322) social workers who work with patients who are undergoing painful situations need to have a source of support, either from a colleague, family members or they can even consult a professional who specialises in counselling.

Figley (1995:168, 193&194) concurs with Dziegielewski and Holliman by outlining the following:

- Having support provides professionals with a safe place to talk about how stressful situations at work affect someone's personal life.
- Support among colleagues is reciprocal, meaning that one can provide or receive support.
- Having support from a colleague can help to deal with stress immediately rather than having to wait until it becomes worse.
- Support from a colleague can help to identify if one is disorientating from patients.
- It also provides colleagues with opportunities to learn better approaches to overcome stressful situations from each other.

From the above descriptions it is clear that getting support from peers and colleagues is a fundamental strategy to deal with compassion fatigue. In a study conducted on moral distress as experienced by hospital social workers in Korea and Australia by Fronek et al., (2017:678), the hospital social workers consulted with their colleagues and the support they received was a key method utilised to manage compassion fatigue. In addition, talking among colleagues promote learning coping mechanisms which promote resilience (Collins, 2017:15).

2.8.4 Activities/hobbies and trips

Figley (1995:141,166,186) delineate the following regarding hobbies:

- It is important to have bodily activities such as been massaged, regular exercise and dance.
- Living a balanced life through eating healthy, exercising, playing and resting adequately.
- Keeping contact with nature, such as going to parks, hiking, or going on camps.
- Going on vacations.
- Engaging in creative work, such as getting involved in creative arts such as drawing, writing, engaging in drama, cooking, taking pictures, or paint work.

Various authors (Dziegielewski & Holliman, 2020:322; Fox, 2019:4) concur with Figley by postulating that employing different types of coping mechanisms such as engaging in sports, exercise, laughter, expressive writing and doing research assist in building resilience and dealing with compassion fatigue.

2.8.5 Self-care

Social workers are selfless and diligent individuals. Moreover, if caring is done in an altruistic way it can have damaging effects on social workers. Parker (2020:173) delineates the following regarding self-care:

- Social workers cannot perform their duties adequately and handle the everyday stress caused by workplace difficulties if their psychological and mental health is exposed and vulnerable.
- When social workers take care of their wellbeing, they can reflect and are able to make right decisions.
- Charity begins at home. Before social workers are able to care for other people, they need to take care of themselves first.

Various authors, (Mcmahon, 2021:2; Cuartero & Campos-Vidal, 2019:284&286; Brown et al., 2017:127; Figley & Ludick, 2017:585; Figley, 1995:94); concur by stating the following:

- Taking time for self-exploration and attending to personal needs is important
- Engaging in self-care practice regularly, self-regulation, eating healthy and mindfulness diminishes compassion fatigue and improves the work environment and has a positive impact on patients.

In addition, a study done by Collins (2017:11) on resilience of social workers, reported that self-care is important towards advancing resilience.

2.8.6 Is honest with self/resilient

Figley (1995:188-196) states that professionals must be honest with themselves, know their weakness and strengths, and ask for help when they need it.

Conversely, Mcmahon (2021:1) postulates the following regarding resilience:

- Resilience does not make social workers immune to stressful situations but forms a protective layer to deal with stress positively.
- Even though some factors make people more vulnerable to compassion fatigue than others, previous research has proved that resilience plays a key role in dealing with the difficulties of life in a positive manner.
- When people are resilient, they see adversities as opportunities to learn and grow.

Figley and Ludick (2017:587) concur with Mcmahon by adding that professionals can activate self-resilience when they start to accept and realise that showing empathy to other people

can bring stress. Being resilient involve lots of protective mechanisms and self-acceptance is one of them (Bolton, Praetorius & Smith-Osborne, 2016:174). Based on different views of the above statements, the researcher is of the view that accepting failure and seeking help is not a sign of weakness. It is very important for social workers to conduct introspection and have the ability to know when they need help and, in addition, being resilient is a fundamental factor which can assist social workers in dealing with compassion fatigue.

2.8.7 Does extra things

To be able to deal with compassion fatigue positively, social workers must have extra things that they do to cope with the pressure from compassion fatigue. Figley (1995:166&185) postulates the following:

- When professionals lead lives that are satisfying, they are able to deal with vicarious trauma. This includes balancing work, having extramural activities and resting enough.
- Personal nurturing such as warm baths, body massage, exercising, wearing nice clothes and buying things that makes one happy.
- Professionals must attend to what their bodies require, so that they will be able to identify if they are tired or even consult from other professionals to get help.

2.8.8 Does not take on others' problems/accept death

It is important for social workers to understand their role in the helping profession and to accept when things turn ugly for their patients. As stated by Figley (1995:36), professionals must accept that death is inevitable, and understand that they are vulnerable and have limitations, because failure to accept death may result in them becoming devastated and uncaring.

2.8.9 Relies on faith/social work training

It is evident that the majority of people, when facing adversities in life, lean on spirituality to ameliorate the impacts of the adversities they are facing. As stated by Figley (1995:167) losing meaning in life is an indication of vicarious traumatisation, therefore activities such as yoga, meditating and establishing spirituality can relieve the loss of meaning. Dziegielewski and Holliman (2020:308) concur with Figley by stating that when social workers are undergoing difficulties, they may use their spirituality to feel a connection with the people around them. In addition, a study done by Alex (2010:428) reported that leaning on faith and spirituality during difficult times enhance resilience.

2.8.10 Relies on theory and supervision/consultation

The results of a study conducted on hospital social workers in Korea and Australia by Fronek et al., (2017:679) showed that in all cases, social workers reported consultation with colleagues or professional supervision as the greatest sources of support when dealing with complex ethical challenges and moral conflicts that induced moral distress.

Figley (1995:139,167,168,194) concurs with Fronek et al. by denoting the following:

- Constant supervision can help professionals to deal with compassion fatigue.
- Constant supervision is part of self-care, and it helps professionals to stick to professional ethics.
- Supervision must be conducted in a conducive environment that promotes sharing and it can be done by a colleague.
- Supervision must not only focus on challenges but also the success stories.
- Supervision is for everyone irrespective of how long professionals have been in the field.

In addition, a study done on social workers resilience reported that supervision was a mechanism that strengthened social worker's abilities for becoming resilient (Collins, 2017:11).

Figley (1995:173,174) further differentiates vicarious traumatisation from ordinary supervision by delineating the following:

- A vicarious-traumatisation consultation differs from therapy supervision and individual psychotherapy in that it specifically focuses on the question of how trauma therapy is affecting the therapist.
- It provides a forum in which the therapist can understand his or her unique responses to survivor clients and the issues they present. In such consultations, we talk more about cases than one would in one's personal psychotherapy, and we talk more about the therapist's personal issues and history than one would in therapy supervision. The survivor therapist may use this as a place in which to discuss how his or her own abuse history interacts with the work.
- In this forum, the therapist is likely to focus on the effects of his or her abuse history on him- or herself as a therapist rather than to discuss the details of the abuse as he or she might in personal psychotherapy.

Based on the above statement, the researcher is of the view that it is important for social work supervisors to be able to recognise and identify the signs of compassion fatigue in their social workers in order to be able to provide supervision that will enable social workers to deal with the impact of trauma resulting from their line of work.

In addition, Figley (1995:140) states that not only should professionals be supervised individually but also in a group format, because it promotes the sharing of ideas, a supportive environment, and other professionals will be able to see that they are not alone and be able to learn the best practices from colleagues. The researcher agrees with Figley and is of the view that group supervision or case conference assists social workers with debriefing, sharing of good practice, and it serves as an encouragement and makes social workers aware that they are not alone.

2.8.11 Have balance

Figley (1995:140,141,168,190) outlines the following regarding balance:

- It is important for professionals to find a balance between their personal and professional lives because when they are balanced, they are able to provide quality services to patients.
- Balance means that professionals need to be able to identify when their work affects them negatively and be able to slow down by taking frequent breaks to rest.
- Balancing can also entail professionals reducing the number of patients or sessions they see on a regular basis.

The researcher agrees that it is important to have balance, however this might be impossible for social workers based on the kind pf pressure they work under since they have high workloads, work with multidisciplinary teams and there is pressure to see patients immediately or to discharge patients.

2.8.12 Have boundaries

Figley (1995:190,192) describes the following regarding boundaries:

- It is crucial for professionals to be able to set boundaries which forms part of taking care of oneself.
- Various aspects where professionals can set boundaries include time boundaries, overwork, professional boundaries and personal boundaries.
- With time boundaries, professionals must respect their time and their patient’s time.

- Professionals must avoid having too many responsibilities, being overworked, and taking their work home with them.
- Professional boundaries mean that the relationship between a patient and therapist must be strictly professional, and therapists must avoid taking the stress that patients are undergoing personally.
- Personal boundaries involve the ability of a professional to respect the helping relationship by avoiding sharing too much of their personal life with patients**.**

Dziegielewski and Holliman (2020:322) concur with Figley by stating that social workers must accept the fact that they are people, similar to anyone else, they have feelings and must learn to set boundaries between their personal and professional lives.

This can further be compared with the results of a study done on oncology social workers' experiences of compassion fatigue (Yi et al., 2018:675-680) which indicate the following:

- One of the strategies that social workers used to deal with compassion fatigue was to set personal and professional boundaries.
- Setting boundaries meant that the social workers ensured that they did not take what their patients were going through personally but made sure that whatever painful experiences patients shared did not affect them.
- Boundaries were also set between them and their colleagues so that they clearly understood their roles.

Based on the abovementioned statements, the researcher shares the same sentiments that setting boundaries is crucial in social work and social workers must learn to draw a line between their personal and professional relationships to be able to handle compassion fatigue positively.

2.8.13 Caring for pets

According to Figley (1995:186) taking care of animals, or even flowers, at home can provide professionals with the consolation they need. The researcher also shares the sentiment that pets can rejuvenate the energy of social workers and having a pet can help social workers to deal with compassion fatigue.

2.8.14 Stick to ethics

The results of a study conducted by Fronek et al., (2017:679) on moral distress as experienced by hospital social workers in Korea and Australia reported that there were three elements that gave social workers strength when encountering difficulties; those elements

were the social work professional code of ethics, their commitment to the profession and their social work training which helped to prepare them to be resilient. The researcher is of the same view and think that if code of conduct of social workers is fairly followed, social workers can effectively be able to cope with compassion fatigue.

In summary, Todaro-Franceshi (2019:94 & 95) elucidates strategies to deal with compassion fatigue as follows:

- May attend debriefing sessions.
- May take leave and go on a holiday.
- May consult the employee wellness programme.
- May ask to be shifted to a different department where they do not experience a lot of patient death.
- Must take into consideration their own wellbeing and sleeping patterns and avoid abusing drugs.
- Must take into consideration social interactions.
- Social workers must check whether the connection between themselves and their patients, people they love, and colleague is not affected.
- Normalise expressing feelings.
- Practicing yoga, reading books and listening to music.
- Focus energy on activities that bring happiness.

In addition, Figley (1995:186,187) shares the skills that help to enhance the prevention of Secondary traumatic stress which include;

- Assertiveness training: learn and practice the skills associated with having the belief and self-coincidence to stand up for oneself or to say “no” when necessary.
- Stress reduction: learn comprehensive techniques that have proven effective in reducing the physical and mental effects of stress.
- Interpersonal communication: learn about your personal communication style and how interpersonal interactions can be improved to enhance social or collegial support.
- Cognitive restructuring: evaluate how you view your situation and the world and learn more effective problem-solving strategies.
- Community organising: learn how to be an effective organiser in order to be more successful and satisfied in social action.
- Time management: learn techniques to effectively set priorities and organise your time in a productive manner.

Furthermore, Todaro-Francesshi (2019:94-95) shares and expands the steps to deal with compassion fatigue as follows:

Table 2.7: Steps to deal with compassion fatigue

Step 1 Acknowledge feelings (or a wound that needs healing)	Bearing witness to one's own feelings, especially suffering, is difficult but necessary in order to enhance professional quality of life and heal from compassion fatigue. • How do you feel when you are going to work? • Are you looking forward to work or are you dreading it? • Do you feel tired? If you have identified that you are compassion fatigued, you need to explore possible turning points and try to establish what factors in your work may have contributed to it.
Step 2 Recognise choices and take purposeful action	Depending upon your unique situation, there are any number of choices and actions that can be taken. Here are some suggestions of choices you can make; • You can request critical incident stress debriefing. • You can schedule some vacation time. • You can see a grief counsellor. • You can seek employee assistance. • You can request a transfer to a different area where dying and death occur less frequently.
Step 3 Turn outward toward self and others	Step outside of yourself, turn toward yourself; look objectively at how you are caring for yourself. • Do you make time for the important things? • What are the important things for you? Consider your general health status, along with eating, sleeping, and maybe substance abuse patterns. • How are you interacting with others? • Are you able to connect with your patients, loved ones, and co-workers? Seek support from friends and family - connect with them, talk about your feelings. Some of the things you can do to reconnect with your own needs and with others include

	participating in meditation and yoga, attending specialised retreats and in-service education programmes, and using employee assistance support services. Turn towards the things that make you smile – both big and small. It could be family, friends, pets, nature – a butterfly, or if you prefer, music, art, a good book, a good movie - make time for the fun things.

This section shed light on the strategies that can be used to deal with compassion fatigue. The next section will discuss what managers or supervisors can do to assist hospital social workers who are experiencing compassion fatigue.

2.9 WHAT MANAGERS OR SUPERVISORS CAN DO TO ASSIST HOSPITAL SOCIAL WORKERS WHO ARE EXPERIENCING COMPASSION FATIGUE

2.9.1 Supervision/ debriefing sessions

Figley (1995:172,173) describes supervision as follows:

- Supervision must be conducted in a conducive environment which encourages supervisees to feel free to share about work challenges.
- Supervision must promote an environment whereby supervisees are encouraged to share about challenges they encounter at work and how these challenges have affected them personally.
- Supervisors must not use information shared by supervisees during supervision as weaknesses against them when conducting performance assessments.
- Supervision must cover case discussions, as well as the supervisee's previous trauma which they have not dealt with and compassion fatigue.
- Group supervision is also useful to deal with compassion fatigue.

The researcher agrees with Figley that a conducive environment must be created by supervisors for social workers to feel free to offload their burdens. Ultimately, supervision can be done either individually or in a group context. In addition, boundaries must be drawn by managers or supervisors when conducting supervision in a way that what social workers share during supervision cannot be used against them during staff or job performance evaluation.

In addition, a study done on self-care behaviours and their relationship with satisfaction and compassion fatigue levels among social workers by Cuartero and Campos-Vidal (2019:284) reported the following:

- Supervision is not taken seriously and does not take place regularly as it should.
- Even though supervision does not take place as often as it should, social workers leaned on support from colleagues and shared challenges with them.
- The findings of that study showed the importance of providing supervision regularly to support social workers.

Based on the above study, it is clear that supervision is important, must be done frequently and challenges that pose a risk to supervision must be eliminated.

2.9.2 More resources

Figley (1995:170, 235) argues that organisations should provide opportunities for regular supervision, consultation, and case discussion for clinicians, they should provide resources for, and active encouragement of, professional development activities such as continuing education. He further states that resources refer to such tangible aid as financial aid, increased flexibility in the work schedule or time off from the job, changes in duty assignment, and generally staying abreast of the needs of traumatised workers. Based on professional experience, the researcher shares these sentiments and believes that resources serve a critical role and a lack of adequate resources makes the lives of social workers terrible.

2.9.3 Improve salaries

A study conducted on paediatric oncology social workers' experiences of compassion fatigue by Yi et al., (2018:676) found that social workers recommended increasing salaries as one of the prevention strategies to deal with compassion fatigue. Based on the professional experience and observation of the researcher among hospital social workers, lower salaries is one of the fundamental issues that demotivates them.

2.9.4 Education on compassion fatigue

Social work education in general teaches more theory than practice. The theory part of social work does not put much effort into addressing the challenges of being a social worker, such as experiencing compassion fatigue. As stated in the research findings by Yi et al., (2018:676) it has been admitted by social workers that social work curriculum taught in higher institutions does not place much attention on the psychological suffering that social workers may encounter when practicing social work, therefore they maintained that it is necessary for them to further their knowledge about compassion fatigue

2.9.5 Create supportive environment

The findings of the study conducted by Yi et al., (2018:676) showed that even though there are lots of different types of approaches that social workers can apply to deal with compassion

fatigue, a well-structured form of support from their workplace environment plays a key role. This shows the importance of support in social work practice.

In conclusion, this chapter discussed in detailed previous literature on compassion fatigue in hospital social work.

2.10 SUMMARY OF THE CHAPTER

This chapter carefully scrutinised previous literature on the history of hospital social work and compassion fatigue. This was done to provide a comprehensive background about hospital social work in relation to compassion fatigue. In this chapter, the history of hospital social work was discussed followed by a thorough explanation of different types and functions of South African hospitals. The different roles of social workers working in government hospitals and challenges they come across was discussed in-depth. Discussion on compassion fatigue was done covering the following, overall description of compassion fatigue as compared to other similar terms, signs of compassion fatigue, compassion satisfaction, causes of compassion fatigue, effects of compassion fatigue on a personal level ,effects of compassion fatigue on a professional level, how it affects service delivery, ways in which hospital social workers deal with compassion fatigue, and things that managers can do to assist hospital social workers who are experiencing compassion fatigue. The next chapter will discuss the application of the research methodology and research methods.

CHAPTER 3 APPLICATION OF THE RESEARCH METHODOLOGY AND RESEARCH METHODS

3.1 INTRODUCTION

Chapters one and two laid the foundation for this research study. They enabled the researcher to decide on the most suitable research methodology and methods for researching the experiences and responses to compassion fatigue amongst social workers employed in government hospitals. Chapter three will present and discuss the research approach, research design, and the methods followed, ensuring that the researcher executes the planned research scientifically.

3.2 THE RESEARCH METHODOLOGY

The research methodology includes the research approach, and the design and methods that are used to conduct a research study. Kothari and Garg (2019:7) outline the following regarding research methodology:

- A well-structured method of solving a research problem.
- Can be referred to as a scientific way to study how research is done and the way of doing research.
- Some of the things that are included steps which researchers normally adopt to study a research problem and the rationale.

Authors like Thomas (2017:320) and Walter (2019:2) share the same sentiments by stating that a research methodology entails the methods to be used to collect data, how the research is planned and conducted, and the strategies and techniques that will be applied to conduct the research.

This study used a qualitative research approach and an explanation of this approach will be presented next.

3.2.1 The qualitative research approach

Research approaches determine the research methods that will be applied in a research study so that the research question can be answered by means of following the research goal and objectives. The most well-known research approaches are qualitative, quantitative and mixed methods (Creswell, 2014:3). Because the researcher opted for a qualitative research approach for this study, it is deemed important to elaborate on the characteristics of qualitative research and how it is applied to this research study.

The characteristics of a qualitative research approach are depicted in the table below (Klenke, 2016:6-10; Merriam & Tisdell, 2016:15-18).

Table 3.1: Characteristics of qualitative research

- **Focus on meaning and understanding**: Drawing from the philosophies of constructionism, phenomenology and symbolic interactionism, qualitative researchers are interested in how people interpret their experiences, how they construct their worlds, and what meaning they attribute to their experiences. The overall purpose of qualitative research is to achieve an understanding of how people make sense out of their lives, delineate the process (rather than outcome or product) of meaning-making and describe how people interpret what they experience. The key concern is understanding the phenomenon of interest from the participants' perspectives, not the researchers', hence hospital social workers were allowed to share their experiences of, and responses to, compassion fatigue whilst working at a government hospital.
- Fundamentally, qualitative research is a process of naturalistic inquiry that seeks in-depth understanding of social phenomena within their natural setting or context. For this research study the participants were the narrators of their experiences of, and responses to, compassion fatigue as they experienced them on a daily basis - from their point of view, not from the point of view of an outsider. This approach also helped the researcher to understand that in qualitative research it is very important to study participants in their natural environment such as in this case the participants' workplace.
- The researcher becomes **a key tool** in collecting data and analysing it. Even in this research study, the researcher was the main person to collect data as he interviewed the participants.
- **An inductive process:** Often qualitative researchers undertake a qualitative study because there is a lack of theory or an existing theory fails to adequately explain a phenomenon. Therefore, another important characteristic of qualitative research is that the process is inductive, that is, researchers gather data to build concepts, hypotheses, or theories rather than deductively testing hypotheses as in positivist research. For the purpose of this study, based on available data, there is a lack of theory or information regarding the experiences of, and responses to, compassion fatigue amongst social workers employed in government hospitals.

- **Rich description**: Finally, the product of qualitative inquiry is richly descriptive. Words and pictures, rather than numbers, are used to convey what the researcher has learned about a phenomenon. There are likely to be descriptions of the context, the participants involved, and the activities of interest. In addition, data in the form of quotes from documents, field notes, and participant's interviews, excerpts from videotapes, electronic communication, or a combination of these are always included in support of the findings of the study. For the purpose of this research study the researcher used the words of the participants to share what was learned from the participants to understand the topic. This information was a result of what the researcher obtained from interviewing the participants. For the researcher to be able to remember everything shared by participants, an audio recorder was used.

In summary, a qualitative research approach focuses on people and their real-life/lived experiences to create an understanding of a particular phenomenon that is relatively unexplored so that it can be best understood (Campbell, Taylor & McGlade, 2017:50). According to Lune and Berg (2017:15), in qualitative research researchers are concerned with how people understand the environment they live in together with their customs, and the aim is to pursue solutions by exploring people together with their environment. There are various reasons for when it is better to use a qualitative research approach as depicted by Merriam and Grenier (2019:4-6); Creswell and Creswell (2018:45); Urban and Eeden-Moorefield (2017:26); McMillan and Weyers (2014:127); Plooy-Cilliers et al., (2014:172):

- When researchers want to investigate meaning and lived experiences related to phenomena.
- When the focus is not on reporting numbers, but researchers want to report rich and in-depth meaning and experiences.
- When researchers want to explore real stories lived by people and want the people to describe their stories by themselves.
- When researchers want to understand the actual world of people in relation to the context in which they live.
- When the researcher is the key tool for gathering evidence.

Even in this research study where the topic is new, the researcher wanted to hospital social workers understand perspectives of the participants about their experiences of, and responses to, compassion fatigue, thus giving them a voice to talk about their experiences.

In addition, Leedy and Ormrod (2019:230) outline the advantages of qualitative approach as follows:

- Qualitative research provides great insight into a topic that has not been well explored previously by other researchers.
- A qualitative approach allows researchers the opportunity to scrutinise a research problem from different angles and to describe it from a holistic approach.
- A qualitative approach provides researchers with the opportunity to verify and confirm theories and beliefs.
- They promote the development of fresh theories.
- Assist researchers to identify a root problem and its underlying factors.
- Qualitative research bolsters an opportunity to evaluate a particular approach or system.

3.2.2 Research design

Kothari and Garg (2019:29) describe a research design as follows:

- A research design paves the way for how the data will be gathered and analysed in such a way that is relevant to the reason why the research is being done.
- A research design contains a planned vision of the research and contains a plan of the process for data collection, data analysis, measurement of data, and the overall process of research until the last phase.
- More importantly the design of the research must be able to provide clarity on the following: the general essence of the study, the reasons for conducting a study, the environment in which the study will be carried out, the kind of information that is needed, the place where the information will be gathered, the study's timelines, the manner in which the sampling will be designed, which methods will be used to gather information, the manner in which the information collected will be analysed, and the manner in which the final report will be done.

Various authors like Walter (2019:29), Thomas (2017:104) and De Vaus (2013:9) concur with the above description of a research design and state that, a research design is a fundamental plan that outlines the research question in hand, ensure that all the tasks to be completed for the research study will answer the research question at hand, outline the goals and objectives of the research, as well as how the data will be analysed and how the results will be communicated.

For this research study, the researcher followed an exploratory, descriptive, contextual and phenomenological research design.

3.2.2.1 Phenomenological research design

Leedy and Ormrod (2019:233) posit that a phenomenological study is an inquiry that is undertaken to determine the viewpoints of human beings and their insights linked to a specific situation, as well as an attempt to respond to a question of how people feel when undergoing a specific circumstance. Creswell and Poth (2018:75) concur by asserting that a phenomenological inquiry outlines the commonalities and actual encounters that human beings come across.

The researcher used phenomenology as a qualitative strategy of inquiry. The principle of phenomenology was crucial in this research, since it helped the researcher to identify the real issues as felt by hospital social workers, the daily lived experiences of hospital social workers, and their perceptions and detailed views since employed by government hospitals.

Another important feature of phenomenology is bracketing (Sorsa,Kikkala, Astedt-Kurki, 2015:9). When a researcher follows the principle of bracketing, he put aside his knowledge, beliefs and assumptions because it can influence the research and he focus on the information that is shared by participants (Cresswell, 2013:78). Various authors, Sorsa et al., (2015:10) and Chan, Fung and Chien (2013:1,2,6) concur and state that by following the principle of bracketing, the researcher put aside his own beliefs, knowledge, assumptions and by doing that it ensures that he doesn't influence information provided by participants and their understanding of what the researcher is researching about. Even on this study, the researcher put aside his own understanding of the topic and focused on the understanding of participants.

3.2.2.2 Descriptive research design

Spickard (2017:376) asserts that descriptive research mostly delineates an experience and addresses in detail what ways human beings experience a particular circumstance. In addition, Walter (2019:10) posits that a descriptive research design establishes and brings forth elucidation of a societal circumstance

The researcher used a descriptive research design and saw this as relevant to this study since the researcher wanted to describe the phenomenon of compassion fatigue as responded to and experienced by hospital social workers.

3.2.2.3 Exploratory research design

Walter (2019:10) defines exploratory research as an inquiry that is taken to further investigate a field of research and probe new topics. Flick (2018:600) concurs and asserts that an exploratory research design can be utilised when researchers are investigating a new topic and want to scrutinise it in detail.

The researcher used an exploratory research design and saw its relevance to this study since little is known and the topic regarding government hospital social workers' experiences of, and responses to, compassion fatigue seemed to be new.

3.2.2.4 Contextual research design

Gray (2018:163) postulates that qualitative research is contextual, meaning that data is gathered within the daily environment of the participants. Various authors (Creswell & Poth, 2018:44; Patten & Newhart, 2018:114; Terre Blanche, Durrheim & Painter, 2014:287) concur by stating that a contextual research design entails studying people within the physical environment in which they are based which encompasses the working environment, political environment, social environment and how this environment affects their experiences.

In qualitative research, it is very important to study participants in their everyday context. In terms of contextual design, the context of this research was Gauteng government hospitals. In reference to Chapter one, the researcher approached the setting, mindful that government hospitals consist of a political environment, organisational culture, relationships between social workers and their managers, and relationships between social workers and patients. This was applied by the researcher to further understand how all the abovementioned factors affect social workers' experiences of, and responses to, compassion fatigue. Although, the researcher himself is a social worker who approached the research with his own understanding of compassion fatigue, this time he allowed Gauteng government hospital social workers to share their own personal experiences of compassion fatigue in relation to their environment.

3.3 RESEARCH METHOD

Barbour (2014:335) asserts that using particular instruments to bring about and obtain evidence in a diverse way is called a method. Various authors like Walter (2019:12), Gray (2018:769), Williamson and Johanson (2018:584) and Thomas (2017:320) concur by stating that a method refers to the approach or strategies used to collect data, whether data will be collected through interviews, questionnaires and how the data will be analysed. For this research study, the researcher interviewed participants individually to collect data.

3.3.1 Population of the study

Frankfort-Nachmias, Nachmias and DeWaard (2015:145) define a population as a group of people living together with whom the researcher aims to conduct an investigation. Walter (2019:121) and Thomas (2017:322) and concur and assert that a population is a whole number of specific group of people or objects the researcher wants to study.

The population for this research study included ten hospital social workers and two social work supervisors working in government hospitals in Gauteng, South Africa. They represented different categories of hospitals namely one regional hospital, three district hospitals and one central hospital in Gauteng, South Africa.

The rationale for including them is because they meet the criteria of inclusion since they have a Degree of Social Work, have been employed for more than two years and have interacted with patients in their employment setting. Therefore, the researcher only interviewed hospital social workers and social work supervisors who were employed in government hospitals in Gauteng.

Inclusion criteria – Participants for this research study met the following criteria:

- Had been employed for at least two years in their current position as a hospital social worker.
- Work in a Gauteng government hospital.
- Both sexes.
- Registered social workers (this then included supervisors, as they met all the criteria).

Exclusion criteria - Participants were excluded if they:

- Had been employed for less than two years
- If they were not employed in Gauteng government hospitals.

3.3.2 Sampling

Flick (2018:605) postulates that a sample is when cases and data are chosen from a larger group of people. Frankfort-Nachmias et al., (2015:144) and Walter (2019:11) concur by stating that a sample is a number of cases that are chosen from the study population and results are interpreted in the form of overgeneralisation.

There are two types of sampling techniques namely, probability sampling and non-probability sampling (Giri & Biswas, 2019:27). The researcher followed non-probability sampling technique. Non-probability sampling consists of four classifications which are convenience

sampling, judgement or purposive sampling, quota sampling and snowball sampling (Giri & Biswas, 2019:31-34). Various authors concur that non-probability sampling requires the researcher to make his judgement on who will be selected to participate on the research (Giri & Biswas, 2019:31; Gray, 2014:686; Bryman, 2012:713;). For this study, the researcher used convenience sampling and purposive sampling.

Convenience sampling

In convenience sampling the researcher select participants who are easily available to be reached (Jensen & Laurie, 2016:97). Various authors agree and state that in convenience sampling, the researcher select participants who are reachable and convenient (Giri & Biswas, 2019:32; Gray, 2014:681). The researcher selected hospital social workers who were made available by the gatekeepers to participate in the research.

Purposive sampling

For this research study, the researcher used purposive sampling to select participants from the research population, namely all social workers working in Gauteng's government hospitals. According to Babbie (2021:193) purposive sampling is done on the basis that an investigator uses his own sense regarding what will be helpful in his research and is another category of non-probability sampling. Gray (2018:770); Thomas (2017:322) and Frankfort-Nachmias et al., (2015:149) concur and state that in purposive sampling researchers use their own judgement when selecting participants who the researcher believes will represent the whole study population.

To select the sample, the researcher followed the following procedures:

- The researcher submitted an online application to the NHRD (National Health Research Database) to request permission to gain entry into Gauteng government hospitals.
- The NHRD provisionally approved the request and selected hospitals who the researcher could approach to ask permission to conduct the research.
- After the selected hospitals provisionally approved the request, the researcher went back to the NHRD, which gave final approval.
- Only one hospital followed a different approach for approval since they requested the researcher make a presentation to the research committee, which the researcher did. Due to COVID-19 regulations, the presentation was done online via Microsoft Teams.

- After the NHRD gave a final approval, the researcher approached the hospital CEOs and, in some instances, clinical managers to request permission to gain access to interview the social workers.
- The hospital management (COEs & clinical management) briefed the social work supervisors regarding the research.
- The social work supervisors briefed the social workers about the research and they shared a list of social workers who were interested in participating in the study with the researcher.
- The researcher contacted the social workers to request permission to interview them for a research study.

Based on the abovementioned, the NHRD, the hospital CEOs and the clinical mangers served as gatekeeper for the Gauteng government hospitals. Yin (2016:116,120&123) delineates the following regarding gatekeepers:

- Before researchers start with the proceedings of any research, it is important to request permission from the leaders of a specific community to grant authorisation and approval to conduct research.
- Gatekeepers can be an official in the workplace or someone representing a well-structured organisation.
- Gatekeepers are people responsible for granting access to researchers to enable authorised entry to research participants.

Gray (2018:767); Spickard (2017:377); and Ruanne (2016:212) concur and postulate that gatekeepers are people who have say and power, either to give or deny access into a field of research.

The researcher did not determine how many participants would be interviewed, prior the interviews. Instead, the researcher interviewed participants until no new information was obtained and only repetition was evident in participants' responses. This principle is referred to as data saturation and the researcher adhered to it. Gray (2018:765) asserts that data saturation is when information comes to a point where it is repeated by participants, and no new information surfaces and then the researcher stops collecting information. Various authors (Thomas 2017:324 & Barbour 2014:337) concur that data saturation is the point at which data collection is full of repetitive responses from participants and serves as a sign that the researcher has explored all possibilities to obtain data.

3.4 DATA COLLECTION

3.4.1 Preparation for data collection

Thomas (2017:316) defines data collection as the process of documenting, assessing and examining data collected in a study. The researcher observed the following when preparing for data collection:

The researcher provided participants with enough, relevant information regarding the research so they were able to make a well-informed choice. Information was shared and sent via email for all participants to read through. The researcher also explained to the participants that they should feel free to ask clarity-seeking questions regarding the study before they made a decision whether to participate or not. The researcher indicated that the interview would take approximately 45 minutes to an hour. The information which was shared with participants before they agreed or disagreed to participate included an invitation letter to participate in the study which covered the purpose of the study, the nature of the study, the benefits of the study, the issue of confidentiality, and how collected data would be protected; a consent form and research questions. The participants were given a consent form to sign if they agreed to participate on the study. As stated by Ruanne (2016:225) informed consent involves ensuring that research participants are provided with sufficient facts regarding possible research in order to capacitate them to make a choice whether to participate or not in a study. The participants sent the signed consent forms via email to the researcher before the interview dates. Some participants struggled to return the signed consent forms to the researcher electronically and informed the researcher that they would sign the form and give the researcher hardcopies on the day of the interview. For those who did not manage to sign and email the consent forms, the researcher went with copies during the interview dates for participants to sign. Gournelos, Hammonds and Wilson (2019:13) posit the following, as a researcher it is important to have candidates who are intending to be part of the study, and once there are candidates who are willing to partake in the study it is important that they provide their agreement in writing immediately.

The researcher did not impose a date and time for interviews, instead times and dates for interviews were determined by participants. The researcher sent participants emails and, in some instances, called participants five days' prior to the interviews to remind and confirm the interview dates with them`. This practice is supported by Gray (2018:386) who states that days prior to the actual interview a researcher must communicate with the candidates to ensure if they are continuing with the research and obtain final consent regarding logistical arrangements for the interview and check if they have any questions.

The researcher advised the participants to go through the questions a few days before the interview so that they could familiarise themselves with the questions. This made the participants well-prepared in return, which resulted in the participants sharing valuable information.

Two days before interviews the researcher ensured that he checked that the voice recorders were working. The researcher also made sure that he printed enough copies of the research questions. Gray (2018:386) supports this practise by indicating that it is important that prior to the interview the researcher must confirm if they have all the relevant things they require and ensure that the interview questions are ready. Yin (2016:180) concurs by stating the following regarding using a voice recorder and preparation:

- It is important for a researcher to ensure before each interview that the voice recorder is fully functional.
- Because if the recorder is not functioning properly it can cause disruption, even to the point of affecting the relationship between the researcher and the research participants since the participants may question if the researcher is well prepared.

The researcher ensured that he prepared two voice recorders for each interview. The second recorder was for backup in case the first recorder was faulty or not functional. This practice is supported by Yin (2016:180) who postulates that

- It is important to get to know the voice recorder in and out so that the researcher can trust that the recorder will bring about the desired outcomes.
- Having two recorders assists in that the spare recorder becomes a backup if the first one is not functioning properly, or certain voices are not clear.

The researcher rehearsed the interview questions and read them to a colleague before he conducted the actual interviews. This practice is supported by Gournelos et al., (2019:112) who state that:

- It is important for a researcher to be familiar with the questions that will be asked to participants.
- To familiarise himself, the researcher must practice the questions by role playing either alone or with a friend or a colleague.
- Rehearsing the all the questions with a neutral person is important to be able to amend or improve the questions.

- Rehearsing the questions serves the purpose of ensuring that the questions are clear, easily understandable and will not confuse participants.

The researcher did not impose interview venues but allowed participants to choose their preferred venues for their interviews. Some participants chose their offices while others chose Microsoft Teams.

For those interviews which were done via Microsoft Teams, the researcher ensured that he had enough data a day before the interviews to be able to connect to the internet. Only two participants opted for Microsoft Teams interviews. The researcher offered to provide data to the two participants who opted to use Microsoft Teams. Moreover, both indicated that they had enough available data to connect for the interviews.

The final preparation step for data collection was that the researcher ensured that there are clean formal clothes that he will be wearing to ensure that he is professionally presentable. As stated by Yin (2016:127) it is important to dress appropriately but avoid looking fancy as this can draw unnecessary attention, because even though the research participants are the subjects to be studied they will indeed observe the researcher's behaviour and how they present themselves.

3.4.2 Application of the method of data collection

Spickard (2017:375) asserts that the data collection method is an approach used for collecting a particular kind of information. Rose, Mckinley and Baffoe-Djan (2020:2) concur and assert that, "Data collection refers to the actual methods used to gather data for analysis".

There are various methods which can be used to collect data such as questionnaires, observation, face-to-face interviews, focus groups and tests (Yin, 2016:137; Rose et al., 2020:2). For this research study, the researcher interviewed participants individually to collect data. For qualitative research, interviews are broadly the most utilised method of gathering information (Pattern & Newhart, 2018:161).

According to Corbin and Strauss (2015:37,38,39) there are basically three types of interviews, namely, unstructured interviews, semi-structured interviews, and structured interviews. Thomas (2017:202) shares the same sentiment and asserts that when conducting interviews, three types of interviews that can be utilised are structured, unstructured, and semi-structured.

Below is a table comparing the types of interviews depicted by Corbin and Straus (2015:38-39).

Table 3.2: Types of interviews

UNSTRUCTURED INTERVIEWS	STRUCTURED INTERVIEWS	SEMI-STRUCTURED INTERVIEWS
• This type of interview provides those participating in research with too much authority throughout the whole process of the interview. • Since they decide what they feel comfortable talking about and they also decide to what extent they will share.	• When doing these types of interviews, researchers design a list of questions to ask participants. • All participants are provided with similar questions. • Even though the structured questions bring consistency, they are seen to be lacking effectiveness. • Since researchers do not have the opportunity to make adjustments to the questions to rectify mistakes or challenges from previous interviews. • Too much authority is with the researcher.	• The most preferred mode of interviews by researchers because it provides consistency. • Participants are asked similar questions. • It provides researchers with an opportunity to ask additional questions so that participants can provide further clarity and give comprehensive answers.

The researcher used semi-structured interviews to collect data. Patten and Newhart (2018:161) delineate the following with regard to semi-structured interviews:

- Since the questions are prepared in advance by the researcher, this allows the researcher the opportunity to refine the questions so that they do not lead the participants.
- Even though the questions are prepared prior to the interviews, they still give the researcher room to play around with them during the interviews in order to collect valuable data.

In addition, Gray (2018:378) posits that the advantage of semi-structured interviews is that researchers are able to ask further questions so that participants can simplify what a researcher does not understand, and it permits the researcher to acquire comprehensive information.

Steps followed by the researcher during the interviews were as follows:

Before each interview, the researcher made sure that participants signed the consent forms. Due to the fact that interviews were done during the high rise of Covid-19 ,some participants requested that they must be interviewed via Microsoft teams online while other participants preferred to be interviewed face to face inside their office spaces. Moreover, only two participants preferred online interviews while the rest preferred face to face . Punch (2014:286) states that one of the other methods that could be utilised to gather information in qualitative research is by using the internet. Warren and Karner (2015:132) resonate with Punch and state the importance of internet-based research as it is now becoming a regular tool that is used by researchers to collect data.

During the interviews which were done face-to-face, the researcher followed all protocols to curb the spread of Covid-19. In terms of the Department of Labour Government Gazzette (South Africa 2020:No 479) all South Africans had to adhere to the following regulations :

- Minimum contact of between one and half metres between individuals when in public spaces or at work.
- Every employee to avail himself to be screened at the time that they report for work, to ascertain whether they have any of the observable symptoms associated with Covid-19, namely fever, cough, sore throat, redness of eyes or shortness of breath.
- All workplaces must have hand sanitisers at their entrance for everyone to sanitise when entering the premises.
- Everyone must wear a face mask when outside their home. The main benefit of everyone wearing a cloth mask is to reduce the amount of virus droplets being coughed up by those with the infection and transmitted to others and to surfaces that others may touch.

The researcher ensured that a minimum distance was maintained as required by the Department of Health. The researcher wore a mask throughout all the interviews that were done face-to-face and he ensured that he carried hand sanitiser to regularly clean his hands.

During the interviews which were done face-to-face, the researcher advised participants to close the doors to ensure privacy but kept the windows open for proper ventilation. The researcher arrived 30 minutes or more early for all the interviews.

An audio recorder was used to record all the interviews. Thomas (2017:2014) supports this by stating that various methods which researchers can use to record data include taking notes

during or after the interview and a recording device can be utilised. Gray (2018:392) concurs with the notion and asserts that when recording an interview with an audio recorder it is also important to take notes at the same time. He further states that a voice recorder ensures that the researcher is not distracted and has full concentration because he will be making fewer notes while the recorder captures the whole interview.

Before any recording could happen, the researcher clearly explained to each participant why recording was necessary and the method of recording that would be used. For each interview, the researcher asked permission from participants to record. In addition, the researcher explained to participants that recordings would be kept safe in a locked cabinet and would thereafter be destroyed. Thomas (2017:204) states that participants must be informed about a method that will be used to collect information, how the information will be used and the way the information will be kept safe.

The researcher asked all participants' permission to switch on the digital recorder. Gournelos et al., (2019:113&114) postulate the following regarding recording research interviews:

- It is against the law to record someone without his or her permission.
- Just because participants agreed to participate in a study does not mean they have automatically agreed to be recorded, so the researcher must ask for permission to record.
- Permission to record must be done in writing and participants must sign.
- Participants must also be informed about how the data being recorded is going to be used.
- Cell phones can also be used for recording.
- It is important to use two recording devices simultaneously for backup purposes.
- Before starting to record the interview, a participant must be made aware that the recording is now starting.
- Then place the recorder not far away from both the researcher and participant.

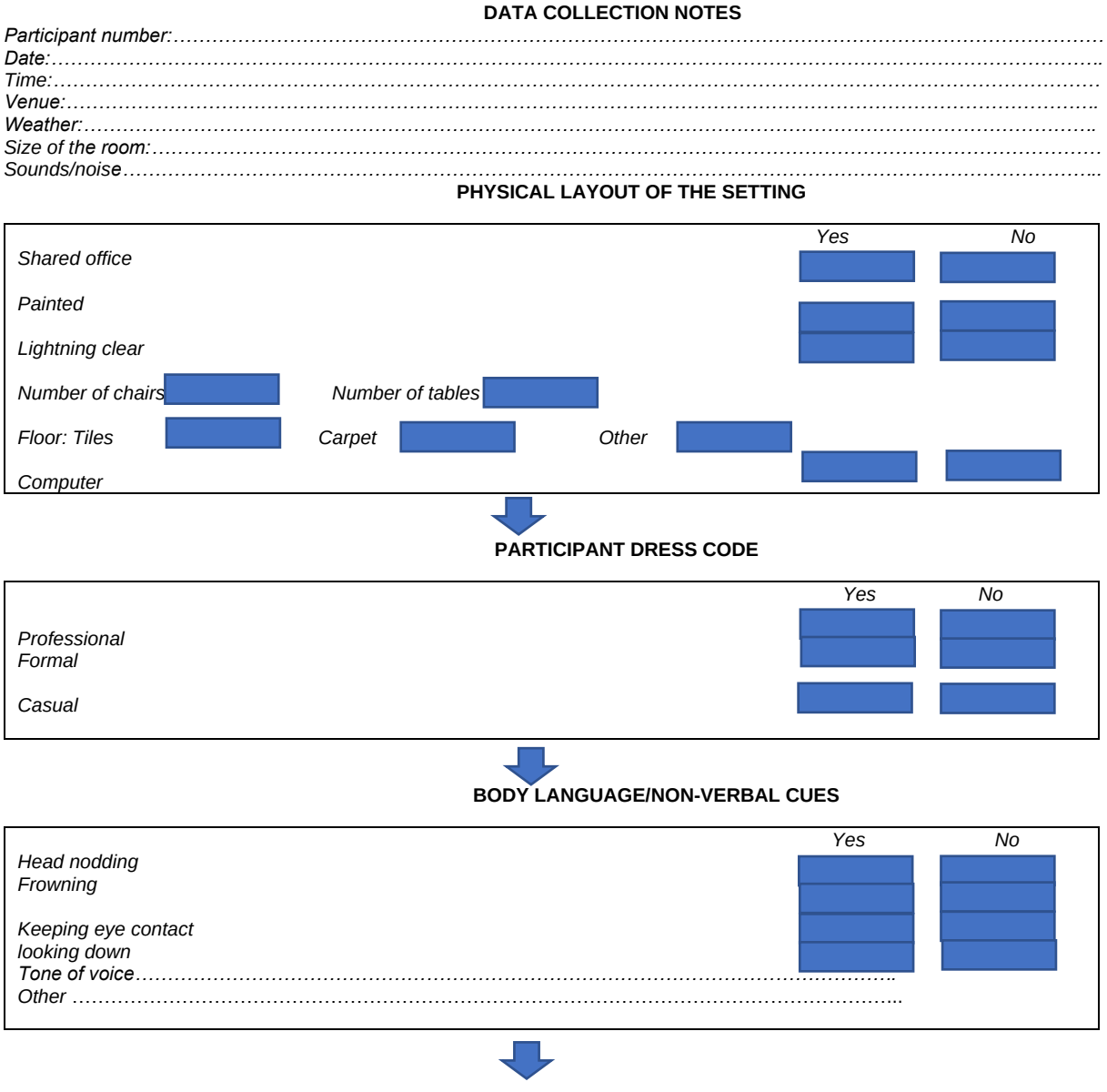
Before the researcher started recording, he checked with the participants if they were ready and again rechecked if they permitted the researcher to record the interviews and take notes.

The researcher also had a clipboard to take field notes in writing during and after the interviews. According to Barbour (2014:334) the minutes that are written down when executing interviews are called field notes. Flick (2018:600) concurs and asserts that researchers take field notes to jot down their ideas and what they observe during interviews

with regards to the participants and the research setting. Gournelos et al., (2019:114) postulate what can be written as part of field notes as follows:

- Any note the researcher may think there is a necessity to do so.
- Make notes about the research environment.
- The time in which the research is conducted.
- The duration of the interview.
- Any, body kinesics participants display.
- Observing the body kinesics will also alert the researcher if there is a particular question which triggers the emotions of participants.
- Make as many notes as you can.

Below is a sketch of the type of information the researcher was collecting as field notes.



NOTICEABLE EMOTIONAL RESPOND TO A QUESTION

Question number:……...
Comments
……
……
……

ANY OTHER ISSUES/COMMENTS

……
……
……

Sketch 0.1: Data collection field notes

Yin (2016:172) posits that the use of field notes is important to ensure that during the data collection process, a researcher should maintain a good relationship with participants and be able to remember important information shared by participants, and researchers can use variety of methods to document field notes, such as using drawings or sketches. The sketch helped the researcher to summarise the notes and ensure that the process of taking notes is quiet and does not interrupt the interviews. Ruane (2016:219) asserts that field notes should consist of small symbols that the researcher jots down, that will be transferred onto a larger scale after the interviews and since the researcher only jots down few items, it does not affect the attention of the researcher. Yin (2016:164) concurs with the above, by stating that the task of taking notes must be peaceful, not causing noise, not disrupting the flow of the interview and not making the researcher less attentive.

To encapsulate the steps followed by the researcher during the interviews, the researcher adhered to the following tips for interviewing as cited by Faulkner and Faulkner (2019:38):

- The researcher became closely acquainted with the research topic.
- Selected a research environment which would not have many disturbances.
- Described the reasons for conducting the interviews
- Ensured that all participants understood in detail what confidentiality is.
- Ensured that a full description was made to participants on how the interviews were going to be conducted.
- Explained the duration of the interviews.
- Gave participants his contact details.
- Gave participants an opportunity to ask any clarifying questions or questions about anything they were not sure about with regard to the research interviews.
- Prepared the voice recorder, a pen and notebook to make notes.
- Used clear questions and avoided long questions.

- Ensured that he refrained from speaking fast and ensured that participants understood him.
- Did not take any concerns and viewpoints of participants personally.
- Ensured that he stuck to the topic and refrained from any deviations.
- If he did not clearly understand what the participants were saying, he asked for clarity.

The researcher used the same set of questions for all participants. The first questions consisted of biographical details and were followed by research topic questions. The questions were asked as follows:

Biographical questions

- Kindly confirm that you are appointed as a hospital social worker in a Gauteng government hospital.
- How long have you been employed as a hospital social worker?
- Please share your reasons for choosing to work as a hospital social worker.

Research interview questions

- What are the challenges you face daily as a hospital social worker?
- What is your understanding of compassion fatigue?
- What causes compassion fatigue in relation to the job you are doing?
- How does compassion fatigue affect you as a person?
- How does compassion fatigue affect you as a professional?
- How does compassion fatigue affect your standard of service delivery?
- Tell me about your experiences in relation to compassion fatigue?
- Share with me what strategies you apply to cope with compassion fatigue?
- What can the manager/ supervisor do about hospital social workers experiencing compassion fatigue?

The researcher used the following research interview skills when it was suitable to use them:

3.4.2.1 Rapport

The first interview skill that the researcher used was to build trust and make the participants feel relaxed. This skill is called rapport.

Gray (2018:388) outlines rapport as follows:

- Rapport occurs when there is a trusting relationship built between the researcher and the participant, and that relationship consists of mutual respect and understanding.

- Building rapport paves the way for kickstarting a good relationship between a researcher and participant, to make participants feel safe and comfortable.
- To build rapport, a researcher should explain in detail the way in which the research interview will take place, the duration and all aspects that will be included in the interview.
- Requesting permission from a participant for the researcher to record the interview also forms part of rapport.
- The researcher must also get permission from participants to make notes during the interview.
- Building rapport also encompasses the researcher explaining to the participants what confidentiality is and how is it going to be adhered to.
- It also involves allowing participants to ask questions.

Various authors, like Durand and Chantler (2014:51&52) and Thomas (2017:202), concur with the above sentiment and add that rapport entails building trust by starting a conversation with ice breakers, making the participant comfortable and creating a non-judgemental conducive environment for participants to be able to share their experiences freely. To build rapport with participants before starting the interviews, the researcher broke the ice by talking either about the weather, his journey to the interview venue or the physical appearances of the hospital at which the participant worked. The researcher also explained the purpose of the interview, explained how the interview would be conducted, and estimated the duration of the interview. The researcher explained the importance of confidentiality, the importance of recording, how the recording would be done, and for asked permission to record. Finally, the researcher asked each participant whether they had questions before the interviews started.

3.4.2.2 Open-ended questions

Babbie (2021:252) defines open-ended questions as questions for which the participant is asked to provide his or her own answers. Various authors (Walter, 2019:169; Thomas, 2017:204) concur by stating that open-ended questions allow participants the full freedom to respond as they wish and do not channel participants to give certain answers. The researcher did not ask participants leading questions but asked questions which allowed participants to provide a full description of their experiences. The manner in which the questions were asked, allowed participants to feel free when answering questions.

3.4.2.3 Probing and minimal encouragers

The researcher used probes when interviewing participants. In addition, the researcher used words like “eeh, mmm, uumm, I see, go on” and non-verbal responses such as nodding his head, to ensure that the participants kept talking without being interrupted. Thomas (2017:207) asserts that the use of probing motivates participants to continue providing information without being interrupted and can be used either using words or body language. Babbie (2021:271) concurs and adds that probing is a form of questioning that is accompanied by encouraging participants to say more or elaborate without being interrupted by the researcher. The researcher also used silent probes to encourage the flow of communication without interruptions. Bernard (2013:187-188) asserts that when using the silent probe, the researcher uses his body language, such as nodding his head, and asks the participants to elaborate.

The use of minimal encouragers ensured that the interviews flowed without disturbances or interrupting participants.

3.4.2.4 Follow up questions

The researcher used follow up questions when he did not clearly understand what the participants had said. Walter (2019:276) defines a follow up question as a type of question that motivates participants to broaden and simplify their responses. Also, the researcher asked follow-up questions to encourage participants to provide more detailed answers. Patten and Newhart (2018:161) postulate that asking follow up questions helps the researcher to gain more clarity, a better understanding and more comprehensive answers from participants. The researcher used phrases like, “Can you please tell me more about that,” and, “Is there anything you would like to add?” (Gray, 2018:381). As postulated by Gray (2018:381), semi-structured interviews permit probing to occur in a manner that allows researchers to ask participants to elaborate on the information that they have provided. Follow up questions also came in handy if the researcher did not hear what the participants had said or if there was an interruption of outside noise because hospitals are busy environments. More especially during online interviews where the network sometimes created problems.

3.4.2.5 Paraphrasing

Mantell (2013:109) posits that paraphrasing entails verifying and rephrasing what participants have shared to ensure researchers clearly understand what participants have said through the eyes of the participants. The researcher used this skill to confirm if he understood what the participants were sharing about their experiences.

3.4.2.6 Observation of non-verbal behaviour

Frankfort-Nachmias et al., (2015:173) state the following regarding non-verbal behaviour:

- It does not involve using words but the way in which the body moves and the message expressed by how the body moves.
- The participant's facial expressions are very important during data collection and the researcher may be able to identify a lot of emotions by being attentive to facial expressions.
- Non-verbal behaviour can also be used to corroborate what is said verbally.

Gray (2018:391) postulates that if the researcher carefully observes non-verbal cues, he or she should be able to identify whether the participant is comfortable or not, how the interview is going and be able to pick up valuable information that the participant is not able to share by using words but is expressed with behaviour.

The researcher observed the non-verbal behaviour of participants such as facial expressions and tone of the voice.

3.4.2.7 Multi-tasking skill

For a researcher to be able to collect more valuable information during a research interview, without interrupting the interview process, multi-tasking is required.

Yin (2016:170) delineates the following regarding multi-tasking:

- The researcher must be able to create his own simple method to collect notes and be able to observe and listen at the same time.
- During the research interview a researcher must be able to document the words, unspoken words, and body movements of the participant and this requires a researcher to be multi-skilled.
- Since it will be difficult to remember everything that happened during an interview, it is important for a researcher to take enough notes during the research interview.

Ruanne (2016:218) concurs by stating that taking valuable field notes, is a multi-skill strength that requires a researcher to listen attentively, to observe and have an overall sense of what is happening during an interview.

3.4.2.8 Listening

Mantell (2013:109) asserts that active listening is a form of active awareness of things that the participants share with the researcher.

The success of the abovementioned skills was a result of the meticulous utilisation of the active listening skill. Active listening enabled the researcher to be able to ask follow up questions, ask clarity-seeking questions and also to respond to the participants' questions and concerns. In addition, listening attentively allowed the researcher to be there for the participants, not only to just collect the data and leave the participant drained with emotions. To manage to be there for the participants as more than just an information collector but to respond to what was bothering participants and their emotions.

Before the end of every interview, the researcher gave each participant an opportunity to ask any questions that they would like to ask the researcher. The researcher believes that by doing this, he was showing the participants that he was not only there to collect data but that he cared for the participants. In addition, this was a continuation of building rapport, since the researcher believes that building rapport does not only occur in the beginning of a relationship but also at the end.

Yin (2016:127) delineates the following regarding allowing participants to ask questions:

- Asking questions must be a two-way approach, meaning that participants must also be allowed to ask a researcher questions because participants may also have questions they want to ask the researcher.
- The questions of interest might not be limited to the research study, but may even be personal questions or the researcher's views
- Therefore, the researcher must always be prepared to be asked questions and needs to encourage participants to ask questions.

Gray (2018:392) concurs with Yin (2016:127) and asserts that at the end of a research interview, a researcher should check with participants if they have any closing remarks so that both participants and the researcher leave the interview without any unresolved issues. The researcher must analyse if he has asked every question he wanted to ask and finally, participants are also asked whether they want to ask any questions. When the interview is over the researcher thanked each participant for their time, effort and the valuable information they shared. As stated by Gournelos et al., (2019:115), at the end of an interview a researcher must show appreciation towards research participants, acknowledge that any information shared is worthy and will make a great difference in terms of providing answers towards the research question. Gray (2018:392) concurs by stating that it is important to appreciate the information collected from the participant even if the information shared does not delight the researcher.

3.4.3 Pilot testing

Gray (2018:771) asserts that a pilot study is a mini study that is done prior to the full research to check if the instruments, like questionnaires and other research related activities to be used to conduct the research are ready to be used for the larger research study. Kumar (2014:13) and Thomas (2017:322) resonate with the above statement by stating that a pilot study is a small project that is conducted before the final large study to identify gaps, challenges and problems the final study may pose, and serves to assure the researcher that the final large study is achievable with the chosen data collection methods.

For this research study, the researcher conducted a pilot study for the following purpose:

- To test the questionnaire that was used as a guideline during the interviews.
- To test if the questions were clear for participants to understand.
- To test the recording device/s.
- To identify any other problems that the researcher might have been unaware of that could have affected the data collection process.

3.4.3.1 The pilot testing process

Two social workers who were employed in Gauteng government hospitals were recruited through their hospital managers as part of the pilot study. However, the two social workers were not included among the population that the researcher interviewed when collecting data after the pilot study. After recruiting the two social workers, the researcher sent them all the necessary information outlining the research study together with the consent forms and research questions. The researcher reminded and confirmed the interview dates with the two participants telephonically two days before the actual interview and also checked if they had received the questions and consent forms and if they might have any questions.

The researcher read the interview questions to a colleague two days before the pilot study to ensure that he understood all the questions. The researcher also tested the two recording devices, the actual recorder and one for back up. In addition, the researcher prepared formal clothing to wear two days before the pilot interviews to ensure that he was presentable. The researcher also prepared a clipboard for taking field notes.

The researcher arrived thirty minutes before each interview. The first step during the pilot interview was to confirm with the participant if they had signed the consent form. Then the researcher began by explaining confidentiality and that the information was going to be kept in a locked cabinet. The researcher then checked with each participant if they had any questions before the interview started. The researcher explained the aim of the pilot study

which was to test the questions and to identify any other areas that needed to be modified or amended. The researcher also explained the importance of recording the interview, which was just a reminder because it was included in the consent form. Still the researcher asked for permission to record the interview and explained the method of recording, namely, audio recording. When the participant agreed for recording to proceed, the researcher checked if the participant was ready to start with the interview. Then the researcher alerted the participant that the interview was starting and when the recording was starting.

Despite attempts for the researcher to conduct the interviews virtually through Microsoft Teams because of the Covid-19 pandemic, both the interviews were conducted face-to-face inside the offices of the social workers as per the preference of the participants. Because of the Covid-19 pandemic, both the researcher and the participants were wearing face masks and two-metre social distancing was observed. The researcher also carried a hand sanitiser for disinfection.

To analyse the data of the pilot test, the researcher followed steps of Tesch (as discussed on the process of data analysis below) and critically verified if all questions were understood and whether it provided sufficient and in-depth information.

3.4.3.2 Outcomes of pilot test

Since data collection was done during the Covid-19 pandemic, the researcher's initial plan was to request that the two participant interviews be conducted via Microsoft Teams as part of social distancing to curb the spread of Covid-19. Instead, the participants indicated that they could not do interviews via Microsoft Teams, citing IT challenges. This drastically changed the researcher's plan to only focus on collecting data via Microsoft Teams. Going forward, when the researcher recruited participants to be interviewed, he gave them the option to choose whether they preferred the interview to be done face-to-face or via Microsoft Teams. However, for those interviews that were done face-to-face, the researcher adhered to strict Covid-19 regulations.

The pilot study assured the researcher that the audio recorder was functioning optimally. In addition, the pilot study gave the researcher the assurance that all the questions were clear and that they did not need to be changed. The questions which were asked during the pilot study remained the same and were used as they were with the overall population. The questions asked to the overall population were similar to those listed in 3.4.2

The pilot study served as an eye opener for the researcher to sharpen his listening and attentive skills. After the first pilot interview the researcher realised that he was rushing the

process and this caused him to not hear some few words the participant said properly and because of a lack of attentive listening the researcher did not paraphrase or ask clarity-seeking questions. The researcher reflected and improved on his skills with the later interviews.

3.5 DATA ANALYSIS

Flick (2018:420) describes qualitative data analysis as follows;

- Qualitative data analysis is the interpretation and classification of linguistic (or visual) material with the following aims, to make statements about implicit and explicit dimensions and structures of meaning-making in the material and what is represented in it. Meaning-making can refer to subjective or social meanings.
- Often qualitative data analysis combines rough analysis of the material (overviews, condensation, summaries) with detailed analysis (development of categories or hermeneutic interpretations).
- Often the final aim is to arrive at statements that can be generalised in one way or the other by comparing various materials or various texts or several cases.

Various authors (Babbie 2021:385; Gray 2018:684) concur that data analysis is a process in which data is interpreted and given meaning.

The researcher followed Tesch's eight steps in the coding process (cited by Creswell, 2014:198) as follows:

1. After each and every interview, the researcher typed each interview verbatim (word-for-word). After typing each interview word-for-word, the researcher carefully went through each typed interview to understand in detail the meaning found in the interview. In addition, the researcher made notes of ideas when reading the transcriptions.

2. The researcher picked one interview which was the most interesting one or the shortest one, and went through it, asking himself, "What is this about?". In addition, the researcher was thinking about its underlying meaning.

3. After completing this task for several participants, the researcher made a list of all the topics and clustered together similar topics. These similar topics were clustered into columns. The columns were clustered as major, unique, and leftover topics.

4. The researcher took this list and went back to the data to abbreviate the topics as codes and wrote the codes next to the appropriate segments of the text. The researcher tried this preliminary organising scheme to see if new categories and codes emerged

5. The researcher found the most descriptive wording for the topics and turned them into categories. The researcher furthermore looked for ways to reduce his total list of categories by grouping topics together that related to each other. For those which were relevant, the researcher drew lines between his categories to show interrelationships.

6. The researcher made a final decision on the abbreviation for each category and alphabetised these codes.

7. The researcher assembled the data belonging to each category in one place and performed a preliminary analysis.

8. The researcher recoded his existing data and reported the findings of the research study.

3.6 DATA VERIFICATION

As stated by Maree (2016:39), it is crucial for a researcher to validate the research results, as it is important that results remain similar (results must be consistent), even when they are obtained on different occasions or by different forms of the same assessment or measuring mechanism (results must be reliable). To sum up, you need to facilitate quality assurance, namely, data verification.

The researcher utilised Guba's model to ensure the validity and trustworthiness of the results. Guba's model, as summarised by Krefting (1990:217), places the focus on four strategies to establish trustworthiness, namely credibility, transferability, dependability, and confirmability. Flynn and McDermott (2016:111) also agree by indicating the importance of ensuring that research findings are credible and can be confirmed. Saldana and Omasta (2018:420) assert that, ''trustworthiness is the perceived rigor and truth value of a qualitative study''. Hammond and Wellington (2013:146) concur by stating that, "trustworthiness has become a term used within 'qualitative' and mainstream interpretive research in order to describe the strength of the claims to knowledge the researcher is".

The researcher appointed an independent coder who checked, amongst other things, the accuracy of the transcripts and the connection between the research interview questions, the data, and the themes. This kind of measure contributed to the level of reliability of the data, themes, and findings.

3.6.1 Credibility

Saldana and Omasta (2018:272) postulate that credibility ensures that the way in which research proceedings are analysed, together with the research results, convince whoever who will scrutinise the research, that the research was conducted in a trustworthy manner.

Credibility assists in ensuring that research findings are a true reflection of the real circumstances of participants (Williamson & Johansson, 2018:15). Credibility was employed in order to ensure that a trustworthy job was done by the researcher and that the findings of the research are a true reflection of the daily circumstances of the research participants.

To ensure credibility of the findings, the researcher followed the aspect of triangulation, observations, and member checking.

Triangulation

Triangulation ensures that information is not only collected from one source but from various sources (Bryman, 2012:717). Various authors concur and state that the element of triangulation entails the process of collecting data from different sources of information to have a comprehensive rich data (Creswell, 2013:302; Gray, 2014:692, Jensen & Laurie, 2016:219 & Thomas, 2009:111). Even on this study, information was collected not only from one participant but from various participants to understand the phenomenon which has been studied from different perspective.

Observations

Observations are very important in the process of collecting data and it is very important for the researcher to carefully watch anything during the process of data collection that can bring added information (Thomas, 2009:183). The researcher observed even the non-verbal cues to ensure that they corroborate what participants were saying.

Member checking

This involve taking back information that was analysed to participants so that they can confirm the findings (Birt, Scott, Cavers, Campbell & Walter, 2016:3,6&7). Curtin & Fossey (2007:9) concur by stating that by doing members checking it means participants are involved in the process of data analysing and finalising the research findings. The researcher involved participants by sending back the findings to the participants so that they can indicate if the findings is a true reflection of what they shared during data collection process. Findings were sent individually to participants.

3.6.2 Transferability

Hammond and Wellington (2013:175) describe transferability as the extent to which the results of the research study could be used apart from the research study. Transferability applies where there are some similarities between contexts, meaning that some findings may be transferable, and are comparable to external validity as stated by Williamson and

Johansson (2018:15). By employing transferability, the findings of the research could also be utilised beyond the research study itself.

In addition, the researcher used thick descriptions. Thick description is a ‘’A quality assurance technique where you provide the reader with extended verbatim extracts from your data, this way the reader can have a broader perspective on the context of the quotations and so can decide to what extent you have made an accurate interpretation of the participant’s account’’ (Jensen & Laurie, 2016:288) .The researcher adhered to the principle of thick description by ensuring that the study contain a well comprehensive rich data in a way that anyone who is reading the research can be able to have in-depth information regarding the research (Gray, 2014:691; Bryman, 2012:717; Thomas, 2009:76; Curtin & Fossey, 2007:4).

3.6.3 Dependability

According to Trochim and Donnelly (cited in Kumar 2014:219) dependability is concerned with whether we would obtain the same results if we conducted the same study twice. This is also supported by Williamson and Johansson (2018:15) who the emphasised consistency and obtaining stable results. This entails that if the research is repeated, the same results can be obtained.

3.6.4 Confirmability

Hammond and Wellington (2013:163) assert that “confirmability is the degree to which the findings are supported by the data. This may be demonstrated, for example, by the use of member checking and participant validation, i.e. participant feedback on the descriptive and interpretive reporting”. According to Kumar (2014:219) confirmability ensures that the research findings are reliable and comparable.

The researcher adhered to the aspect of bracketing and reflexibility by jotting down his views, feelings, knowledge and emotions regarding the topic. available data from previous research done by different authors to support the findings of the research study. Reflexivity ensures that the researcher understand his role in the research and will avoid all circumstance or possibilities that can bring bias to the research (Jensen & Laurie, 2016:288). Various authors agree and state that reflexivity means that the researcher must be aware of any previous assumption, values, views, knowledge regarding the studied phenomenon in order to refrain from bias (Gray, 2014:690; Chan et al., 2013:6; Bryman, 2012:393; Curtin & Fossey, 2007:11). To achieve this, the researcher ensured that before interviews he wrote down his feelings and knowledge about the topic as a form of reflection to ensure that when he started the interviews, he doesn’t bring his own views or knowledge regarding the topic at hand.

3.7 APPLICATION OF ETHICAL CONSIDERATIONS

Ethics are defined by Anderson and Corneli (2018:2) as what researchers are allowed and not allowed to do during research proceedings. Walter (2019:84), Flick (2018:136) and Thomas (2017:317) concur by stating that ethics regulate the behaviours of researchers towards participants, what is allowed and not allowed, what is right and wrong, and serves as guidelines for best practices.

3.7.1 Informed consent

Lune and Berg (2017:46) assert that informed consent ensures that participants take part in a study without being forced or lured by researchers using false incentives or negative influence. Various authors resonate with the above statement, (Babbie, 2021:65; Walter, 2019:91; Flick, 2018:140; Gray, 2018:768) that informed consent means that participants are provided with full information about all aspect of their research, such as risks of research, benefits of research, their rights to withdraw at any time and how privacy will be maintained.

The researcher provided participants with enough information regarding the research for them to decide whether to participate or not. The researcher also made it clear in writing that participation was voluntary and there would not be any financial benefits. As stated by Anderson and Corneli (2018:68) informed consent ensures that the decision lies with the participants whether to partake or not in the study, that they know their rights before making a decision to participate to know what the research is all about and reason why the research is being done.

By ensuring that participants have enough information before they make a decision to either participate, the researcher shared in writing the following:

- The research question/title
- Purpose of the study
- Benefits of the study
- Information on negative consequences of the study
- Confidentiality
- Debriefing
- Data protection
- Withdrawal to participate in the study at any time the participant wishes to (see addendum D)
- How interviews will be conducted
- Venue and date to conduct the interviews were determined by the participants

- Recording of interviews
- Consent form
- Research questions

All participants were asked to give written permission to participate in the research study without being forced before each and every interview.

3.7.2 Confidentiality

Saldana and Omasta (2018:412) posit that confidentiality refers to ensuring that any identifying data received from the participants which may cause them to be recognised, is protected. Walter (2019:97), Anderson and Corneli (2018:34); and Lune and Berg (2017:48) concur that confidentiality is about protecting the information of the participants by removing any information that might reveal the identities of the participants so that information shared by participants is protected and cannot be linked back to them.

The researcher assured participants that no information would be shared with other participants, colleagues of participants or anyone else. However, the researcher explained to participants that since the results would be published, it would be done with integrity and there would not be any information that would infringe on confidentiality. As cited by Babbie (2021:67), to ensure confidentiality, a researcher must provide assurance that even if the data shared by participants is revealed, it will be done in an ethical manner, respecting the rights of the participants and not divulged in an open manner.

To ensure that the information of the participants is protected and could not be traced back to the participants, the researcher used pseudonyms instead of real names to report the research findings. Lahman (2018:83) asserts that the use of pseudonyms in research is considered as a needed key technique to increase the confidentiality of participants.

3.7.3 Beneficence

Lahman (2018:58) postulates that to ensure the principle of beneficence, the researcher needs to clarify the reasons for conducting the research in relation to a shortage of knowledge regarding the subject matter, how the research will be useful to participants or overall population, what difference the outcome of the research will make, and any danger that participants could find themselves in for participating in the research study. Babbie (2021:64), Walter (2019:90) and Spickard (2017:90) resonate with the above sentiment by stating that the research must not cause risk or harm to the participants and the research must benefit the participants.

The researcher ensured that participants did not experience any harm, be it sexual, verbal emotional or financial. The research benefited participants in that it served as a form of debriefing towards the fatigue they were experiencing from the nature of their work. Some participants were even thankful to the researcher for choosing such a topic and taking the time to listen to them. The research report will also have an academic and practical benefit, since it will assist in theoretical and practical knowledge application.

3.7.4 Privacy

Leedy and Ormrod (2019:114) assert that research proceedings done with people must adhere to the principle of keeping information secret since people are morally entitled to privacy and researchers must take into consideration their privacy right. Anderson and Corneli (2018:34) and Frankfort-Nachmias et al., (2015:463) concur and state that when participants are ensured privacy they are free to share only the information they are comfortable sharing, choose who they are comfortable sharing it with, and they also have a say in the conditions in which information is shared.

To respect the privacy of participants, interviews were done in a way that no one could intrude. All face-to-face interviews were done inside offices of social workers with the door closed. As Anderson and Corneli (2018:34) assert, that to lower the risk of infringement of participants' right to privacy, researchers must conduct interviews in a place which other people will not be able to overhear participants. Even during the interviews that were done via Microsoft Teams, each participant was interviewed while inside their office space, alone with the door closed. The researcher was also alone inside his office space. However, closing the door was not imposed by the researcher, its importance was discussed with the participants who then made a final decision.

3.7.5 Anonymity

Anonymity entails guarding the real identity of the participants and ensuring that information that can reveal the personal information of participants remains a secret (Saldana & Omasta, 2018:411). Different authors (Babbie 2021:67; Walter 2019:96) concur with the above sentiments by mentioning that anonymity refers to the protection of participants and ensures that people who read the research findings cannot link the information to any single participant.

Lune and Berg (2017:48) and Franfort-Nachmias et al., (2015:71) assert that anonymity entails that the real names of participants are not used so that no one can link the information shared to any one participant.

For this research study, real names were not used to report the findings. Instead, fictitious names or pseudonyms were created to report the findings of the research. As postulated by Thomas (2017:46), to guarantee anonymity, the identities of participants and the organisations they belong to can be substituted with something fictional.

3.7.6 Debriefing

During the research proceedings, it might happen that certain questions evoke emotional reactions or consequences from the participants. Therefore, debriefing might be necessary. According to Babbie (2021:70), a researcher must be able to identify any issues that might make participants uncomfortable or provoke the emotions of participants to the extent that those emotions should be attended to by the researcher.

During the process of recruiting participants, the researcher in writing explained that should the interview evoke the emotions of the participant, the researcher had counsellor on standby to debrief the participants. But for the purpose of this study, since the researcher is also a counsellor, the interviews also served as debriefing. There were a few participants whose emotions seemed evoked, but after the researcher suggested referring them to a counsellor, they indicated that they were fine from the interview conversation. However, the researcher indicated that if after the interview they needed to see a counsellor they should inform him so he could arrange the counsellor. When doing debriefing, a researcher must be able to establish which participants had experienced unforeseen distress and be able to establish which participants required further assistance (Patten & Newhart, 2018:36).

3.7.7 Management of information

Walter (2019:109) asserts that the process of managing information requires that all data collected from participants must be handled with high ethics to ensure that it is properly safeguarded by researchers and to promote participants' rights to confidentiality and anonymity. Thomas (2017:46) resonates with the above sentiment by stating that researchers bear an ethical duty to ensure that information gathered from participants is safeguarded.

In addition, the researcher followed the steps elucidated by Anderson and Corneli (2018:42-43) to protect data as follows:

- Used participant's identification numbers instead of participant names on all hard copy and electronic study documents, including surveys, field notes, photographs, and audio and video recordings. The researcher used participant's pseudonyms instead of their real names.

- The researcher collected only those personal identifiers that were absolutely necessary. If risk of a breach of data would pose significant harm to participants, the researcher considered collecting no personal identifiers.
- Breaches of confidentiality may happen during transport. After collecting data in the field, the researcher returned to the study office immediately with any completed questionnaires, field notes, and recording devices to appropriately log and store them. The researcher uploaded the audio recordings to a secure location in the cloud prior to leaving the data collection site. The researcher erased interviews from recording devices as soon as audio files were stored on a secure server.
- The researcher used passwords to protect all electronic document files and stored them on secure servers or password-protected computers.
- The researcher stored all hard copy research records, such as handwritten interview notes and printed transcripts, in locked cabinets.
- The researcher avoided storing any research records on portable USB flash drives. In situations where such storage was temporarily necessary, the records were copied to a secure server as soon as possible and deleted from the less secure temporary storage devices.
- The researcher limited access to study files to essential study staff.
- The researcher kept signed consent forms and other documents that included participant's names, such as master participants list and contact information sheets, separate from documents containing participant data. Hard copies of these files were stored in separate, locked cabinets. Electronic files were kept in separate electronic folders with different passwords; for example, the same password should not be used for interview transcripts and the master participant list.
- Because re-identification would not be necessary, the researcher destroyed all documents that would allow for the re-identification of participants, such as the master list of participants' identifiers, as soon as possible after completion of the research.

3.8 SUMMARY OF THE CHAPTER

This chapter explicated and elucidated the research methodology that was used to explore the research topic. In addition, this chapter outlined how the research was conducted. The research question, research goal, research objectives, application of research methodology, data collection, data analysis, data verification and ethical considerations were presented in detail. The next chapter will focus on the narrative and comprehensive report of the findings of the research study.

4 RESEARCH FINDINGS

4.1 INTRODUCTION

The layout of this chapter includes the findings of this research study, “The experiences of, and responses to, compassion fatigue among social workers employed in government hospitals”. The findings will first be presented with the biographical details of the participants which will be done in a table format. Followed by a discussion of the themes, sub-themes and categories. The theory which underpins this study will also be used to support the findings. Finally, the findings will be presented as extracts of the participants in the form of a narrative. A literature control will be used each time to either support or oppose the findings.

Twelve participants were selected by applying the purposive sampling methods and subsequently interviewed using semi-structured interviews as a data collection method. All the participants were social workers working in various government hospitals in Gauteng, South African (see inclusion and exclusion criteria mentioned in Chapter 3). An independent coder was outsourced to code the data. Therefore, the final conclusion of the data analysis was built with the agreement of the independent coder, researcher and the researcher’s supervisor. The process of data verification and the application thereof are mentioned and presented in Chapter three.

4.2 PARTICIPANTS’ BIOGRAPHICAL PROFILES

The biographical profiles of the participants are first presented in Table 4.1 below, followed up by a discussion.

Table 4.1: Biographical details of the participants (not real names but pseudonyms)

NAME (NOT REAL NAME BUT PSEUDONYM)	GENDER	YEARS OF SERVICE IN A GOVERNMENT HOSPITAL
Amahle	Female	2
Boitumelo	Female	2
Cindi	Female	16
Dudu	Female	24
Eshe	Female	2
Femada	Female	2
Galeboe	Female	4
Helen	Female	33
Indira	Female	19

Jendayi	Female	2
Kgomotso	Female	2
Lerato	Female	2

The study consists of twelve social workers who represent and are employed by different categories of hospitals, namely; one regional hospital, three district hospitals and one central hospital in Gauteng, South African. The participants worked in different wards of the hospitals, including oncology wards, paediatric wards, medical wards, surgical wards, gynaecological wards, outpatients wards, orthopaedic wards, labour wards, psychiatric wards, and HIV/aids section.

4.2.1 Gender of participants

During sampling, the researcher did not discriminate in terms of the gender of the participants, but it happened that all participants interviewed were female. One of the inclusion criteria was to include all genders but during the recruitment and data collection phase the researcher came across only females. Although the dominance of female social workers interviewed was not prognosticated, it was inevitable since the scarcity of males is evident and seems to be endemic in social work practice. As stated by Crabtree and Parker (2014:07), there is scarcity of male social workers across the globe, not only in practice but also in the teaching of social work. Baum (2016:1463) concurs and posits that the focal point and issue of women dominating social work has been deep-rooted and is not a new phenomenon.

Galley (2020:24), Segev and Lander (2019:529, 535,536), Abukar and Wedin (2016:16); Baum (2016:1466) and Schaub (2015:321) resonate with the above statements and provide a variety of reasons that cause the scarcity of male social workers as follows:

- Social work has been a caring profession and caring is perceived as a traditional role of women.
- Social work is seen as a home for the emotional life and emotions play central role. Emotions are not associated with masculinity by society.
- Social work is not seen as a first career choice for men. Men who study social work are labelled, receive negative reactions and are resisted by family and society.
- Gender bias from clients. The majority of perpetrators are men, so even most female clients prefer female social workers.
- Few men enrol for social work.
- The commitment of the social work profession is to help the weak, powerless, oppressed and discriminated.

4.2.2 Participants' names

The researcher created pseudonyms to protect the identity of the participants and to adhere to the ethical principle of anonymity as stipulated in Chapters 1 and 3. Since the use of real names can make it easier for the participants to be linked to information shared, the researcher committed to adhere to ethical commitments such as confidentiality, informed consent, beneficence, anonymity, privacy, debriefing and management of information as mentioned in chapter three. As stated by Saldana and Omasta (2018:418), in order to ensure that participants are protected and cannot be identified, false names were utilised instead of real names. Anderson and Corneli (2018:41) share the same sentiments and postulate that the moment the discoveries of the research, the information gathered is shared with the outside world, a reader must not be able to recognise or link participants with the information but instead the identity of the participants must be safeguarded at all times. Gaudet and Robert (2018:132) and Lahman (2018:83) also concur with the usage of pseudonyms to ensure confidentiality, anonymity and prevent participants being identifiable.

4.2.3 Duration of being a hospital social worker

All the participants had been working in a government hospital for more than two years of service which was one of the aspects outlined in the inclusion criteria. Seven participants had been employed for only two years, one participant for four years and four participants had been employed for more than 16 years in a government hospital setting.

4.3 PRESENTATION OF THEMES AND A LITERATURE CONTROL

The research goal that was put together at the beginning of this research study is: "To develop an in-depth understanding of hospital social workers' experiences of, and responses to, compassion fatigue whilst working in Gauteng government".

With this goal in mind, the research objectives for this study is:

- To explore social workers' experiences of, and responses to, compassion fatigue whilst working in government hospitals in Gauteng.
- To describe, as findings, government social workers' experiences of, and responses to, compassion fatigue whilst working in government hospitals in Gauteng.
- To report the findings, draw conclusions, and make recommendations in relation to hospital social workers' experiences of, and responses to, compassion fatigue whilst working in government hospitals in Gauteng.

Semi-structured interviews were done with the twelve participants who were employed as social workers from different state hospitals in Gauteng (demography of the 12 participants

was depicted in Table 4.1). The following table depicts the findings of the research summarised into themes, sub-themes, and categories.

Below is a summary of themes, sub-themes that came out of the interviews with the participants.

Table 4.2: Overview: Themes, sub-themes and categories

THEMES	SUB-THEMES	CATEGORIES
4.3.1 Social workers' reasons for choosing to work as a hospital social worker	4.3.1.1 Wanted to work in the medical field 4.3.1.2 For financial reasons 4.3.1.3 Enjoyed the work	
4.3.2 Social workers' descriptions of their work as a hospital social worker and to whom they report	4.3.2.1 Descriptions of their work as a hospital social worker	4.3.2.1 .1 Works at a district hospital 4.3.2.1. 2 Works in various wards 4.3.2.1.3 Works in a specific unit/ ward
	4.3.2.3 Descriptions of to whom they report	4.3.2.3.1 Reports to a social worker 4.3.2.3.2 Reports to a non-social worker
4.3.3 Social workers' accounts of the daily challenges they face as a hospital social worker	4.3.3.1 High workload 4.3.3.2 Lack of resources 4.3.3.3 Lack of support 4.3.3.4 Other professions do not understand social worker's role 4.3.3.5 Being pressurised to place patients elsewhere 4.3.3.6 The death of patients	
4.3.4 Hospital social workers' explanations of	4.3.4.1 Feeling overwhelmed by the work	

what they understand to be compassion fatigue	4.3.4.2 Being stressed/ traumatised from the work 4.3.4.3 Being tired 4.3.4.4 Feeling of not doing enough for patients	
4.3.5 Hospital social workers' accounts of what causes compassion fatigue	4.3.5.1 Experience many ugly situations and deaths 4.3.5.2 High caseloads and the focus is on quantity 4.3.5.3 Lack of support, recognition and understanding 4.3.5.4 Lack of resources 4.3.5.5 Working with clients with same problem as own	
4.3.6. Hospital social workers' descriptions of how compassion fatigue affects them personally and professionally	4.3.6.1 Personal effects	4.3.6.1.1 Becomes irritable, angry or moody 4.3.6.1.2 Feels fearful or alert 4.3.6.1.3 Feels hopeless, tired, pessimistic or numb 4.3.6.1.4 Has physical symptoms 4.3.6.1 5 Family is affected or takes work home
	4.3.6.2 Professional effects	4.3.6.2.1 Empathy, energy or motivation is reduced and feels worthless 4.3.6.2.2 Becomes irritable, angry or rude 4.3.6.2.3 Cannot or does not want to work 4.3.6.2.4 Questions self and/or profession
	4.3.6.3 Service delivery effects	

4.3.7 Hospital social workers' explanations of what they do to deal with compassion fatigue	4.3.7.1 Takes time off 4.3.7.2 Talks to or debriefs with colleagues 4.3.7.3 Participates in activities, hobbies or takes trips 4.3.7.4 Self-care 4.3.7.5 Does not take work home 4.3.7.6 Does not take on others' problems 4.3.7.7 Just does what can or is expected to do 4.3.7.8 Relies on faith or social work training	
4.3.8 Hospital social workers' suggestions on what supervisors/managers can do to assist social workers experiencing compassion fatigue	4.3.8.1 Schedule supervision/ debriefing sessions 4.3.8.2 Undertake team building 4.3.8.3 Provide support 4.3.8.4 Provide more resources	

The following segment of this report narrates each theme in detail, together with the sub-themes and categories. Where necessary, quotes and storyline are utilised to authenticate and endorse the findings. In addition, a body of knowledge will be used to highlight similarities and differences in the research findings, and quotations will be used to argue the disparities. This means that a literature control will be done per theme.

4.3.1 Theme 1: Social workers' reasons for choosing to work as a hospital social worker

When the participants were asked to provide their motives for choosing to work as hospital social workers, the participants' described three (3) sub-themes that include wanting to work in the medical field; financial reasons; and enjoying the work.

4.3.1.1 Sub-theme 1.1: Wanted to work in the medical field

A number of the participants articulated that they had wanted to work in the medical field and had consequently chosen to work as a hospital social worker.

Amahle said: "*My first reason was that at least I can be in a medical field. I wanted to be a doctor but I knew mathematics was not my good sign. So social work was where I could go and…I love the fact of being in a medical field helping people who are sick…It became my first choice when I realised that I am not good in maths*" [Amahle 29-35].

The above finding shows that a decision to become social worker was not a choice but certain circumstances dictate that people choose a certain career. To confirm this, as stated in the findings of research done by Bukuliki, Hojer and Jansson (2019:718), some students mentioned that it was not their choice to study social work but the decision was dictated by circumstances beyond their control.

Cindi gave her reasons in these words: *"… when I started working, I started working in Limpopo in rural area. I was placed in a hospital setting, and it's where my passion started there…and in a hospital setting you will learn lots of things personally and professionally and that is why I am interested in working there*" [Cindi 32-39].

Dudu's reasons were the range of challenges people faced when in hospital: "*As a student social worker I realised that people, most people are admitted in hospitals, and they've got challenges that need social work intervention. Challenges like, gender-based violence, rape, hijacking, adoption and teenage pregnancy. So, I realised that there is a need for one to work in a hospital setting so as to attend or assist these patients who come to hospital with these challenges*" [Dudu 20-25].

Kgomotso's reason was that it was a calling for her: "*I will say it's a calling. Helping people is my passion, so I applied as everybody else and I got chosen to be part of the staff of an interesting hospital and ja, as I have said that helping people is my passion. I am enjoying helping the people who are really, really in need. So, I feel good when I manage to help one person a day, so that gives me pleasure…though it's not easy sometimes*" [Kgomotso 24-29].

Consistent with research done by Bukuliki et al., (2019:717) on the reasons for students to study social work in Uganda, it was discovered that two factors were the main reasons, namely, working with people and helping them. This is also confirmed by the excerpts of a study by Stoltzfus (2017:854) where the reasons for wanting to become a social worker were motivated by wanting to help people who require help from experts and to better their standard of life.

4.3.1.2 Sub-theme 1.2: Financial reasons

Some participants stated that their reason for choosing to work as a hospital social worker was due to financial reasons.

Femada explained as follows: "*I think my love for helping people has always been one of the reasons but of course the benefits that came with working in government…the salary. I come from a background of working in an NGO (non-governmental organisation), so the salary, the benefits, the medical aid, the housing was a good thing for me to move over and also just the different setup in the hospital compared to my NPO (Non-profit organisation) experience…that is what attracted me this side*" [Femada 21-28].

Galeboe echoed what Femada said: "*…not necessarily that I wanted to work in a hospital to be honest. I just wanted to work for a government institution, it could have been Department of Social Development or anything but fortunately for me there was an advertisement for a social work supervisor, Department of Health and then I took my chances and I have applied and I got the position…the reason being I worked for NGOs for quite some time and I felt I needed to move from NGOs to government…that was the main driving force actually…NGOs were starting to have financial issues mainly. So I mainly focus on my, my personal life in terms of not being, not finding myself unemployed because of retrenchment brought by the NGOs not having enough money. So, it was shaky for me and I realised with government at least it's stable. You still get your salaries irrespective of financial challenges and all of that. So that was the main*" [Galeboe 27-44].

Based on the above findings, the issue of better pay, motivated participants to seek finding employment in government hospitals. The above findings resonate with previous findings of a study done by Skhosana (2020:114) on the dilemma faced by NPO's in retaining social workers where it emerged that due to the disparities in salaries between NPO's and government social workers, it becomes difficult for social workers to stay in NPO's, hence there is high influx of social workers from NPO's to government entities. In addition, Price and Kelly (2021:73) also confirm that based on the fact that government social workers receive better pay than social workers employed in NGO's, social workers working in NGO's leave to look for better salaries from government institutions.

Conversely, even though most social workers leave NGO's for government institutions for better salaries, some stay at underpaying organisations because of their passion for social work. This is confirmed by one of the excerpts from Price and Kelly (2021:72) that although

money is important, some social workers stay even in environments where the salary is low because of their love for their profession and assisting people.

4.3.1.3 Sub-theme 1.3: Enjoyed the work

In addition, some of the other participants said they chose to work as hospital social workers because they enjoyed the work.

Helen said: "*First of all, I landed in a hospital because at the time I had a Health services bursary for 3 years so as a result of that I had to start working in a hospital. And in general, I have always been interested in the health field and related services. And then once when I started working in a hospital to work off my bursary requirement I decided to stay because I enjoyed the patients' work*" [Helen 23-28].

Indira said: "*I will take you back. In the olden days when I was still a student, remember we were doing practical work, so I was placed in the hospital setting so that is where my interest came in, you know that time when we were at the hospital. I did my practical work for six months so meaning I was in the hospital day in day out for six months and then that is where I learned much of what is happening in the hospital setting and then when the post came and I applied for the job in the hospital and then I got it*" [Indira 23-29].

The findings seem to be a true reflection of reasons why people decide to study social work. This is confirmed by the findings of research done by Bukuliki et al., (2019:719 & 720) that being exposed to an internship in a hospital setting resulted in having a passion for working in a hospital setting. This confirms that exposure to a particular social work setting can increase a passion for working in that environment. In addition, since some social workers are given internships to study social work and in return have to pay back the internship by working in the particular environment, it means that this also has a huge influence in social workers choosing the environment in which they want to spend the majority of their life working.

4.3.2 Theme 2: Social workers' descriptions of their work as a hospital social worker and to whom they report

The participating social workers where requested to outline their work as hospital social workers and to whom they reported. Their responses are divided into two (2) sub-themes, namely: Descriptions of their work as a hospital social worker and descriptions of to whom they report.

4.3.2.1 Sub-theme 2.1: Descriptions of their work as a hospital social worker

In response to the request to describe their work as a hospital social worker, the participants responded by describing where they work within the hospital setting. Their responses in the form of storylines are given under three (3) categories, namely: Works in a district hospital; works in various wards; and works in a specific unit/ward.

4.3.2.1.1 Works in a district hospital

Some of the participants work at a district hospital and Galeboe described her work as a social worker at a district hospital as follows:

"…hospital social work it's, it's different from any other social work. It's difficult to have programmes, to implement programmes in the hospitals. Hospital settings, you do one-on-one mainly. Individual casework and then it's not long-term…it's like short-term…The hospital that I am working at is a district hospital… a district hospital is just a step away from the clinic. What happens they are called the step-down hospital. We have big hospitals like Bara, like Steve Biko and all that. Those big hospitals they have got a complex of patients and whatever…for an example a patient that has done an operation, a major operation, is being treated in a big hospital and then after that once that person is recovering but not ready to go home. They bring that person step down to a lower hospital…the bigger hospitals when they do operations they do major treatment but as the person is recovering, they bring them to step down hospitals which is our hospital, Pretoria West, and then in this hospital then we take them to the level of recovery before they can go home" [Galeboe 49-69].

The excerpt suggests that working in a district hospital, one of the core tasks is to prepare patients for discharge. Heenan and Birell (2019:1748) concur with the notion that hospital discharge planning and ensuring safe discharge that ensures the wellbeing of patients is a core role of hospital social workers. There is a consensus regarding discharge planning as a core function of hospital social work according to Parveen (2017:27); and Heenan and Birrell (2019:1744).

4.3.2.1.2 Works in various wards

Some of the participants described how they work in various wards within the hospital.

Dudu described the wards where she works as follows: "*We are allocated wards here in hospital but we sometimes after three years we rotate…for us to all have exposure to different wards. There are medical wards, surgical wards, gyne wards and there's also out-patients. There are also orthopaedic wards, there is crisis centre with rape victims. So, most of the patients that I see currently are the teenage pregnancy cases in the labour ward…there are*

a lot of teenage pregnancy cases that we have to see…for now I am placed in the teenage pregnancy wards. But other medical wards where we experience a lot of para-suicide wards, para-suicidal patients. So those cases get referred to us social workers and there are again in medical wards those cases of stroke, which is called CVA and cases of other medical conditions that are very much severe, chronic illness in medical wards, patients that are in need of placements. Those cases you get referred to us. I am doing gyne ward currently, surgical ward and medical ward" [Dudu 178-193].

This finding is confirmed by Heenan and Birrell (2019:1748) who mention that hospital social workers are not only concerned about the sickness of their patients, but with the wider issues that affect patients, such as patient's households, the place where the patients stay and ensuring that they mobilise any resource that can be used to ensure that patients receive comprehensive holistic care.

Femada explained the various units where she works within the hospital: *"…we see the different cases, the emergencies. I deal with rape victims…my primary care is rape victims; children that have been abused, the assaulted. I deal with renal patients because the kidney unit for people that has issues with their kidneys. I do medical patients and I do the psychiatric ward…*" [Femada 38–43]. The extract is consistent with Cuatero and Campos-Vidal (2019:274) that, in a daily basis, social workers come across different cases such as abuse of children, emotional pains and emotional crisis.

4.3.2.2 Sub-theme 2.2: Works in a specific unit/ward

There were some of the participants who described that they were allocated to work in a specific unit or ward.

Amahle gave this description of her work in a specific unit: "*I am currently a social worker in Tshwane district hospital…In the wing of CCMT ARV clinic (which is) Comprehensive care and management treatment for HIV*" [Amahle 19-23].

Jeyandi's description was related to her work in the oncology ward : *"…I am based in oncology. I work with children who are diagnosed with cancer*" [Jeyandi 34-35]. She explained further: "*Cancer treatment normally takes six to eight months or beyond that. Even up to two years depending on the type of cancer and how it is responding to the chemotherapy. So the patients don't stay in hospital for a period of a month but they come and go. You find that they come in intervals every two weeks for three days or every month for three weeks, it depends. So, you bond with them because you go to the ward, you see them every day. You provide counselling*" [Jeyandi, 110-116].

Yi et al., (2018:668) share similar sentiments by outlining that there are social workers who work with children within children's wards and their role includes ensuring that children who are living with cancer, together with their families, receive proper care and support in order to cope with the consequences of cancer in their lives. Ostadhashemi et al*.,* (2019:01) concur and assert that social workers who work within children's wards have a major part to play to ensure that they provide children who are diagnosed with cancer, together with their families, with support from the moment they recognise they have cancer until their last day of living with cancer.

4.3.2.3 Sub-theme 2.3: Descriptions of to whom they report

The participants were asked to whom they report within the hospital setting. Their responses are given in two (2) categories, namely: Reporting to a social worker; and reporting to someone who is not social worker.

4.3.2.1.1 Reports to a social worker

Some of the participants mentioned that they report to a social worker. As Indira said: *"My supervisor is a social worker, is a social work supervisor at supervision level"* [Indira 299-300].

Femada said she also reports to a social worker but added that this is not always the case in a hospital setting: *"…we're fortunate that in our hospital we actually report to social work management or supervisor. I know in the clinics they can report to anything from a physiotherapist to a dietician so no we report to a social worker. And our head of department reports to a Doctor and I think that is where the issues can be…reporting to a Doctor challenges things…they don't understand what we do. We need to get grant, we need to get clothes…without money…that is their understanding of social workers. Tracing of relatives, finding placement for patients but they don't realise we sit with open sores here, people bleeding their hearts out and with so much complications so much trauma that we sit with every day when we deal with our patients…for my real patients, for the medical patients where there is no hope what can I do? How can I make a difference? You are not gonna get the kidney you are gonna die…and you need to sit, you need to open the road and do bereavement while the patient is still alive*" [Femada 496-511].

As a social worker, reporting to a social worker is the norm and is consistent with the supervision framework for the social work profession of South Africa (2012:18) that social workers must be supervised by another social worker who has been exposed to the field of social work for a longer period

4.3.2.1.2 Reports to a non-social worker

The majority of the participants responded that they report to another professional who is not a social worker.

Cindi was one such hospital social worker: "*I report to a clinical manager, a Doctor…It poses a challenge. You are reporting to somebody who doesn't understand, they can just understand some basics, little bit, but they are not from within. Some of the resources when you ask it's like I mean you are asking too much, if the car is not there it's not there…When you're talking about your challenges they don't understand. When you are talking about having relationships with other stakeholders…the SARS, the Home Affairs; when you want to go to their meetings they don't understand why are you going to Home Affairs why are you supposed to go to their meeting? You have to explain yourself*" [Cindi 264-280].

Boitumelo was another hospital social worker who does not report to a social worker and she had this to say about the situation: *"…in the first place as a social worker in South Africa, Act 110 of 1998, the Social Services Profession Act…it states that a social worker has to be managed or supervised by a social worker. That is not the case in the Health Department…Here a social worker is supposed to be managed by a clinical manager who is clueless about social work…That is why we experience so much lack of support we are not attended, no one is attending to us. We do things on our own but we have to report. How we should report to them is not exactly what is, what should happen because they, they are just managers for pen, just for signing…they are not interested in finding out what is the real problem here, they just sign…that is how a manager is in the Health Department*" [Boitumelo 49-66].

On the other hand, Galeboe who also reports to a non-social worker was more positive which was contrary to what Boitumelo asserted: *"…it's a Doctor, a clinical manager"* [Galeboe 347]. When asked by the researcher whether she experienced any challenges with this, Galeboe said: *"No, not all…the clinical manager that I report to is a professional doctor…We got a clinical manager who is a female but she has been off sick so the acting is a he. And then what happens is that they oversee a lot of professions, it's not only social workers. They're overseeing doctors, they oversee physios, dieticians, radiographers, so we are allied. These other professions that are in the hospital and then our clinical manager will be overseeing us…It works well. We have got an open door policy we have got to see them and we have regular routines but then sometimes we have to stop them because of the infections and all the stuff but then you use the Teams…it's going okay, there is that communication flowing in*

all of this. And you know technology also helped. You can always have your Whatsapp groups…at least we should keep up and update each other" [Galeboe 351-364].

The excerpts are consistent with what Engelbrecht (2015:323) posits, that for any field of practice, in order for prosperous overseeing of that organisation, people who manage or supervise staff must have intense background of the ins and outs of that particular organisation in terms of the skills, knowledge, and principles, and social work is no exception.

The notion that a social worker must be only supervised by another social worker is supported by the discussions and resolutions of social work indaba held in Durban, South Africa (2015:25,50) as follows:

- Candidates who attended that indaba based their discussions and arguments on what is stipulated in Social Services Professions Act 110 of 1978 and the Code of Ethics Chapter 2, Section 15 (1) (a), (b) and Rule 7 (3).
- The task of supervising social workers is a role of managers. Although it is important that social work supervisors must have management skills, it is more important that they have practical knowledge about social work practice.
- Therefore, social work supervisors or managers must have a social work qualification, be registered as social workers and must have experience of having practiced as social workers.
- Social work supervisors who are not qualified as social workers must be transferred to where they belong.

The researcher concurs with the resolutions because one of the main function of supervision is that it must be educational, and if a social work supervisor does not have a qualification as a social worker it would be impractical to be able to fulfil the function of education in supervision.

4.3.3 Theme 3: Social workers' accounts of the daily challenges they face as a hospital social worker

After describing their work, the participants were requested to describe the challenges they were confronted with on a daily basis. Six (6) sub-themes emerged, namely: High workload; lack of resources; lack of support; co-workers do not understand a social worker's role; people with no documents, address or family contacts; and patients dying.

4.3.3.1 Sub-theme 3.1: High workload

Many participants described the main challenge they faced every day in their work as a high workload.

Amahle described the high workload as being a daily challenge in this way: *"…the load of patients are patients coming in, can be too much because maybe you will be seeing ten patients per day…And each with their own baggage of emotions…So you have to treat each and every one differently and sometimes your patience runs very thin, it wears down and my fear is when my patience wears down I get to miss the, the main thing that the, the person is about…And it does happen that I do miss those issues that the person is going through*" [Amahle 51-61].

Cindi also cited the high workload as a challenge: *"…you must have human resources…where I am working we are only three, then with a lot of patients…For the whole hospital but the other is working in the ARV side…then with me I only have two social workers and as a supervisor I am working there. I have to do everything. I have to do admission; I have to do lots of things; and I have to see the patients… You end up not doing things that you're supposed to do. Proper supervision, because you are also working with patients…you have to refer, conduct home visits and you are a supervisor…Even in a hospital setting it's generic because you will be …doing family therapy…you will be doing referral for abandonment, like kids, like the whole cases of kids like adoption but we refer. Even with abandonment we write reports to Social Development. We do placement of psychiatric patients, substance abuse cases, then we do work with chronic illnesses…we do placement of HIV patients…palliative care patients*" [Cindi 128-146].

Dudu echoed the above storylines in terms of daily challenges: "*It is high caseload. We are not many at this hospital and at times the cases overwhelm us. We don't sometimes know which ward is allocated to who because there are a lot of patients that need social work intervention So this makes us very, very, very weary in terms of conducting our services*" [Dudu 56-60].

Helen added that the pandemic and lockdown had added to the workload: "*I think in the past two years, the pandemic and the lockdown have been the biggest challenge. The Department of Health, you work, you are available twenty-four seven so as a result during the lockdown we came to work every day. There were not such as limited work hours or work from home. So as a result for the past two years if I can focus on that what really was a challenge because many of the other social work services, they either worked from home, they worked limited hours. There was quite an influx of people from the community to the hospital looking for social services. We could not meet all of the demands, all of the services they ask (for) because we are social work health care that limits us*" [Helen 31-40].

Lerato added: "*The workload is too much and then you have to go and attend. The doctors want to see you, you know the meetings, endless meetings so that is the biggest challenge*" [Lerato 32-34].

The participants' descriptions of too much workload is consistent with the findings of a research study by Parveen (2017:37) that hospital social workers are faced with hurtful, undesirable consequences resulting from having to render services to a large number of patients daily, which puts them under strenuous pressure to meet daily targets. The excerpts can also be confirmed by the findings of Limon (2018:23) on challenges which medical social workers face, where they indicated that having to offer services to too many patients cause challenges.

In contrast to the storylines, a different study confirms that workload is something that can be contained. Figley and Ludick (2017:175) posit that having workloads and working under strenuous conditions is inevitable but social workers have the capability to respond positively to strenuous conditions.

While it is conspicuous that high workload is a challenge to hospital social workers, the COVID-19 pandemic exacerbated it, as one of the excerpts indicate COVID-19 as a challenge. This assertion is supported by the results of a study done on compassion fatigue, burnout, compassion satisfaction and perceived stress in health care professionals during the COVID-19 health crisis in Spain (Ruiz-Fernandez, Ramos-Pichardo, Ibanez-Masero,Cabrera-Troya, Carmona-Rega & Ortega-Galan, 2020:4324) that although health care workers have been working under strenuous conditions and experiencing compassion fatigue, COVID-19 has made matters worse.

4.3.3.2 Sub-theme 3.2: Lack of resources

All participants mentioned absence of resources as a daily challenge that they face in carrying out their work. This is clarified in the storylines below.

Cindi explained: "*And again the resources. Transport is a challenge where I am conducting home visits you need a transport. Even finance is a challenge because a person will be discharged; there is no money for the patient to go home*" [Cindi 58-60]. Later, Cindi expanded further on the lack of resources: *"…now we have got a lot of unemployment; we have got lots of foreign nationals and they don't qualify for anything. They don't qualify for food parcels (it's) a hopeless case. It makes you feel guilty, because if someone doesn't have an ID they don't qualify for a grant, they don't qualify for food parcels and we don't have a lot of charities around; maybe we can get food…they don't have accommodation, they live on the street and*

when they get sick they come to the hospital. And when the person is discharged it's a challenge because you cannot discharge somebody back to the street, and then everyone will be looking at the social worker for the social worker to assist…and it is also a challenge for us because we're supposed to. If it's a foreign national we are supposed to refer to immigration officer in Home Affairs. But now they are telling us they cannot assist us because financially they are constrained because the moment they, they take this person to Beit Bridge after five days the person is back and now they are constrained financially…and it makes someone feel tired. It's like you are not doing anything, you are not offering anything" [Cindi 208-223].

Dudu spoke of similar challenges: *"…the first challenge that we are facing is that we are receiving mostly patients who are, who have no place to stay and even those who are in need of hospice. So, the challenges that we have is the place that we can place them in. We have a scarcity of resources in terms of beds, and most of them are foreign national, nationals who are undocumented. So it's even harder for them to get those places because most of those places they need someone with an ID ,someone who earns a disability grant or any form of income so these foreign nationals they don't even have any of this and we get stuck with those patients in our wards*" [Dudu 29-36]. She continued further: "*The issue of placement. We used to have some places a long time ago like here next to Roodepoort that used to assist us…it used to take patients that have nowhere to go and shelter. There is a shelter in Roodepoort that used to assist us…and the one in Krugersdorp but now these shelters are always full so our patients get stuck here in hospital. We can't move and the doctors are always on top of us that we want the bed and we understand…it's not a placement area, it's a hospital. The doctors have to admit more patients so we end fighting with the doctors and the staff in the wards because we can't move with regards to placing the patients that are referred to us*" [Dudu 78-86].

Indira said: *"…and then one other thing that is a challenge is the resources that are…dwindling, resources that are diminishing. We don't have many NGOs as we used to have before*" [Indira 64-66].

Kgomotso expanded: "*The resources are limited, especially working in the big hospital like Steve Biko. It's not easy; like the patients come with the problems and then we need to refer them somewhere after they are discharged. And then we find that where we refer them, there is a huge challenge. There is no service delivery most of the time and due to a lack of resources especially now we have a pandemic it's even worse now…most of the time I am working with the patients who have renal failure…so you find them they come with challenges*

like they lost their jobs, the divorce is very high because there is no finance, and then they have lost the income, they have lost everything. I am dealing with the loss. So, then you're trying to rebuild this person who is in need…they have to come for dialysis three times a week and there are no resources. You find out that he is unemployed, there is no support at home. We have got a 70-year-old mother or a father who is also unable to support himself so we refer them to SASSA (South African Social Security Agency) and at SASSA there is a lot of challenges there. I don't know what is happening. Because when you refer the patient there, they will tell you stories that they give them the attitudes. That they say 'No they're not qualifying; they are well' by looking at the person; say 'no you need to go back and work, you are still well'. But the person has got a medical report on them" [Kgomotso 34-55].

The excerpts are consistent with previous findings that a lack of resources is a challenge for hospital social workers. This can be confirmed by the results of a study done by Fronek et al., (2017:677) which found that social workers were working under stress and struggled to provide fundamental services to patients due to a shortage of resources.

In support of this, a study done by Limon (2018:28) on the challenges of medical social workers, reported that the majority of social workers in the study mentioned that a shortage of resources caused them greater distress since they could not provide better services. Limon (2018:28) further states that it is very difficult seeing the will to assist patients as a social workers disappear because of a shortage of resources, such as financial support or external support.

4.3.3.3 Sub-theme 3.3: Lack of support

Another challenge cited by many of the participants was the lack of support they receive in carrying out their role.

Cindi explained this challenge as follows: "*When you don't have support from other members, especially allied doctors, because we are working as a team isn't it? And then come to find out that you are stuck with a patient and you don't have support of your manager, you don't have support from other colleagues, you are on your own…and you end up feeling…hopeless because when you are assisting your patients, you must have finance you must have human resources*" [Cindi 122-126].

Boitumelo also spoke of the lack of support in terms of funding: "*…the other thing which, which adds to the lack of support is Gauteng Health denies us the funds. Social work programmes are not funded, even if you know as, as I mentioned that I am a HAST (HIV and AIDS, social, sexual diseases and TB) social worker, we have HAST services there are funds*

available but the Health Department doesn't want to give that out to us. We are struggling even if we have funds…so we cannot even do exactly what we have to do for our patients and the community" [Boitumelo 91-98].

Dudu spoke of the lack of support from other agencies that should assist, being a challenge: "*And then there is also an issue of the South African Police who take their time in terms of responding to our rape victims. And then also we have to refer our adoption cases, our teenage pregnancies to Department of Social Development. There are social workers there who have to see to it that they place or remove those children from the hospital. But they also take time in terms of attending to our cases so this is a challenge that we are experiencing, we're facing as hospital social workers"* [Dudu 36-42]. She added that embassies are also not supportive: *"Sometimes we interact with the embassies to help and assist us in terms of getting them (foreign nationals) documented but they also take time. Their phones are forever out of order. They also take time in terms of coming to assist us. We're still having a challenge even now to get them to get documents*" [Dudu 45-48].

These findings are in line with the findings of Yi et al., (2018:674) that due to a lack of support and misunderstanding of the role of hospital social workers by other colleagues from different fraternities, hospital social workers ended up feeling undervalued and unsupported, which stressed them out

4.3.3.4 Sub-theme 3.4: Other professions do not understand social worker's role

Another challenge mentioned by the participants was that they work in a health setting which is not primarily a social work setting, and the other professions do not understand the role of social workers in a hospital environment.

Eshe was one of the hospital social workers who highlighted this lack of understanding of a social worker's role as a challenge: *"…working in a multidisciplinary team again is a challenge because most, many doctors, some of them they don't understand our role as social workers. So, they just think everything oh just give to a social worker will do it…like when someone wants to apply for a social grant they can just say go and see a social worker. So, I think they refer all the cases to us because they feel like social workers can do them…a social worker can provide transport, they can give you food, they can provide shelter for you. So, I think that is a challenge for a hospital social worker because I have to explain to them that 'No is not my role, how about you contact this person or how about you refer this case to this team?' So, it's a challenge sometimes…I think it is a learning journey for us as we work together to explain roles and understand our roles as well"* [Eshe 35-46].

Jeyandi emphasised the lack of understanding of a social worker's role as being a challenge: "*…another challenge is, in the hospital setting, it's not our primary setting as social workers. It's a primary environment for health care workers, nurses and doctors. For us it's a secondary environment. You find that your role is misunderstood a lot. That is why sometimes they even refer things that are not related to our work…you constantly have to teach them about your role as a social worker…I can say it's my role as a social worker because…I am based in (the) oncology unit. I work with the multidisciplinary team as a whole. So sometimes I find myself explaining to them that as a social worker this is the service that I provide and…the others are beyond me. I will take it upon myself to teach them*" [Jeyandi -54].

Indira expressed the same challenge: "*…people claim to be counsellors…Our co-workers, like the nurses…this makes our work difficult because they tend to listen to patients' problems and they try handling those problems so…when they see that they cannot help, it's then when they refer the patient to you and it becomes a problem where the patient found it difficult to, to go about explaining themselves to each and every person because remember when you meet the first person you develop trust and then you tell that person everything thinking that person will assist you. Along the way they refer you to the social worker and when you come to the social worker obviously you will feel bored because you were expecting the person that you were telling him or her your problem is supposed to be the one who is handling your problem…they don't know what we are doing when we are counselling the patients, those principles and those skills that we're taught, they don't have and they end up making the patient angry. When they come to you they don't want to open up…we're always at loggerheads wherein some people they undermine other people's profession. Even if you have training…We used to have training wherein we go and explain our roles what it's that we are doing. So some people they still think that we are there for material things. They only refer when there is a need for SASSA, the need for a food parcel of which we time and again, we explain to them that it's SASSA department it's not social work department. So that is the serious challenge we are facing where we end up feeling like you are not doing your work to the fullest*" [Indira 33-56]

Later, Indira came back to the issue of counselling by other professions: "*It's a way of undermining us to say we all have counselling…there are lay counsellors they think they can counsel and for as much as they can counsel and remember before the lay counsellors came, we were the ones who were doing the HIV counselling. So that is why I am thinking that maybe because of that people think that everybody can be a social worker. There is no need for people to be trained as social workers because anybody can claim to know how to counsel.*

Even the pastors at church can counsel even though they don't have counselling courses. They just think counselling is something that anybody can do" [Indira 87-95].

Helen also emphasised that the hospital is a secondary setting for social work: *"Hospital social work is quite unique in a way; you are not a primary service, you are a secondary service at the hospital. The primary service at the hospital is health and everything focuses on the health. Social work is secondary, and you have to fit in to the multidisciplinary team to, to give your contribution. In general, in this hospital work is fast paced. It is crisis intervention most of the time it's short-term work. For example, if you get referrals today, you start attending today. You cannot make an appointment for next week*" [Helen 43-50]. Heenan and Birrell (2019:1745) avers that confusion on the roles of social workers when they are working with different fraternities is inevitable and can cause trouble in social work practice. The researcher is in agreement with the notion and since in a hospital there are a variety of professionals, confusion regarding roles seems to be unavoidable.

This can be confirmed by a study done by Limon (2018:25) which revealed that when social workers are working together with other different professionals in a hospital setting, their role becomes misunderstood. Furthermore, the findings of Limon (2018:25) reported that because other professionals misunderstand the roles of hospital social workers, cases which are not social work related, end up referred to social workers

4.3.3.5 Sub-theme 3.5: Being pressurised to place patients elsewhere

Most of the participants highlighted the challenge of being pressurised to place patients elsewhere because beds are needed. However, some patients do not have documents, an address or family contacts.

Indira explained this in these words: "*…some of the people who have COVID…my colleague…he has got a person from Eastern Cape and then we don't have funds to transport the patient back home. We need to communicate with other agencies like the police that other side to come, go and search for the family so those…things they make our work difficult because we don't communicate as colleagues like social worker to social worker, we are using other agencies like the police station to help us in the other provinces…I am also looking at the issue of the homeless. We have so many homeless that we end up not knowing where to place them because when you phone they will tell you that they need contact details for their family members and this person is from the street and when you ask them about their family members' details they don't have and you end up being with that patient in the hospital for long. The doctor will be coming to you to say this patient has been referred to you we need*

the bed and what can we do with this patient. So, it's a challenge but we end up making, even though it's hard. And then another thing like I said that the, our co-workers who claim to be social workers, they are also making our work difficult" [Indira 67-83].

Cindi said in this regard: "*…most of the time I do advise the out-patient department to say when the patient is being admitted, make sure you get the proper address. Make sure if the patients came as an unknown because we get patients that are brought by the…police…make sure as soon as the patient is admitted. Inform the social worker because when the patient is alive it's better than when the patient is no longer there. Because is easy for the social worker to get the information when the patient is alive and when the patient came as unknown what I do is I will call the Home Affairs to do fingerprints you know. It makes it easier because when you do fingerprints when the results come back they will tell you if the patient is a foreign national or the patient doesn't have an ID at all. But if the person has been admitted and died in the ward without being referred, the patient being referred to me is a challenge. We end up doing radio announcements but when we do radio announcements we don't announce that the patient is deceased, we just say we need the family of this patient who is admitted in this particular hospital. Then after maybe three months if we don't locate any family member then we refer to the mortuary to do pauper (burial)*" [Cindi 94-111].

Cindi also mentioned a similar situation when families neglected patients in hospital: "*…the other problem is neglected patients in the hospital. Our people will abandon their patients in the ward, especially the elderly. They don't visit, they don't come when you call them, they are not there when you do home visit, they are not there and I find this a challenge especially in elderly and chronic in-patients and in kids. Kids can be admitted, their parents don't come or care givers don't come. It's a very serious challenge because there in the ward, doctor will say: 'Social worker, can you, I need a bed, can you make sure there is a discharge? Can you make sure this elderly is discharged?' That is a challenge that I am having*" [Cindi 80-88].

In addition, Cindi mentioned the challenges linked to the foreign nationals: "*The hospital is near informal settlements and we have got a lot of foreign nationals. The challenges are that we are having there are we have got a lot of unclaimed bodies…they don't have documents, they don't have relatives around. Then when they are dead, if they pass away, there is no-one to claim them, it's a challenge*" [Cindi 51-57].

The pressure of having to place patients somewhere is confirmed by study results of research done by Fronek et al., (2017:680) who report that hospital social workers are often faced with a dilemma to discharge patients because of pressure and attitudes from doctors who are

unapologetic when needing beds, to place patients somewhere even though the environments in which patients are discharged are not conducive. Davis and Connolly (Cited in Albrithen and Yalli 2016:132) state that social workers in England experienced negative attitudes from doctors whom they work with in hospitals.

4.3.3.6 Sub-theme 3.6: The death of patients

The participants also expressed that the death of patients is a challenge for them.

Jeyandi said patients' dying is a daily challenge for her: "*For me personally, daily challenges (are) losing patients as I am based in oncology. I work with children who are diagnosed with cancer. They die a lot, so that is a daily challenge for me because I wake up knowing that today I might find somebody gone…*" [Jeyandi 34-37].

Lerato said: "*Basically the first biggest challenge I face very day is the death of patients because their medical condition is so critical. The death of a patient it is the biggest challenge*" [Lerato 28-30].

Kgomotso explained how the deaths sometimes become too much: "*The thing is that we are seeing here, the death that we are experiencing here. Sometimes it's people that we know…We've lost so much people that we know, people that we loved, people that we work with. So sometimes it's too much we can't take it…The death and the, I can say the death and chronic diagnosis, the life-threatening illnesses like cancer…diabetes…Some are manageable but some are not*" [Kgomotso 214-225].

The storylines articulated above can be confirmed by the results of a study done by Daphna-Tekoah (2021:247) which indicates that the daily practice of hospital social work results in face-to-face incidences that are disturbing, such as patients dying. The results of another study by Limon (2018:27) confirm that one of the major challenges that demoralised the hospital social workers was experiencing their patients dying, which made difficult for them to cope.

4.3.4 Theme 4: Hospital social workers' explanations of what they understand to be compassion fatigue

After explaining the daily challenges they face, the participants were asked to explain what they understood compassion fatigue to be. The four (4) sub-themes which emerged are: Being overwhelmed by the work; being stressed or traumatised from the work; being tired; and the feeling of not doing enough.

4.3.4.1 Sub-theme 4.1: Feeling overwhelmed by the work

Some of the hospital social workers explained how they understood compassion fatigue as being the feeling of being overwhelmed by the work.

Amahle said: "*…compassion fatigue is when I deal with people who have traumatic stresses, sexual assault, and children, because I deal mostly with HIV, so children who are HIV…And their mothers don't know how to deal with that and teenagers who find themselves being HIV. So it's, it's, it's quite a heavy load because you have to think about the teenager who is in his teenage years to start with. And if you go through their Erikson stages. They go through the adulthood and intimacy and they're trying to figure themselves out…And then they have the rebellious stages and then on top of that they have to perform at school…Some of them they don't talk, they cry, so you find that I have three of these cases. And it strains me to talk about all these separate issues…And each and every one is different in their own home settings. So trying to be, be with them in their level, that is what crosses me most of the time, just to sink in and drown into this system, not the system but the fatigueness of my body, my capability of helping them…Children, it's normally birth until the age of ten…When they, their mothers have problems in administering their treatment…normally the parent is in denial then the child suffers and then you have to be in the mother's shoes and the child's shoes at the same time and say this is for the child it's not for you even though you are the one who is in the situation*" [Amahle 124-152].

Helen explained it in this way: "*Compassion fatigue for me in the hospital I can see with all the other disciplines I work, with all, with the allied staff which is social workers, the physios (physiotherapists) the OTs (occupational therapists)…the health professions, like the nursing staff and the doctors. I think from time to time you get overwhelmed. You usually sit on an emotional, physical, spiritual level because we deal with the person at his most vulnerable sometimes every day… And then you can see symptoms like you're getting tired, you're getting emotional. Your motivation goes down. And you feel like how am I going to help this person, how am I going to assist the person? I think everybody experiences it, especially those in the helping professions sometime or another. And I think we must be aware of that*" [Helen 56-65].

Cummings, Singer, Hisaka and Benuto (2021:304) assert that compassion fatigue may overwhelm professionals who assist patients to become emotional stressed eventually themselves. In contrast, according to Xu, Harmon-Darrow and Frey (2019:11) social workers not only encounter negative reactions when dealing with patients who experience trauma but can also encounter positive reactions when helping and dealing with traumatised patients.

4.3.4.2 Sub-theme 4.2: Being stressed or traumatised from the work

Many of the participants responded and explained that they understood compassion fatigue as being fatigued or stressed from the work.

Boitumelo explained this in these words: "*…compassion fatigue. To be compassionate is like that as a social worker I am expected to be sensitive, to have sensitivity towards others, to help, to motivate, you know to be kind, to manage other people's problems. And when you say compassionate, compassion fatigue is like maybe you are being stressed from what you are supposed to do*" [Boitumelo 72-76].

Cindi said: "*My understanding is when you become emotionally and psychologically drained from what is happening. You are drained because of what you are doing*" [Cindi 113-116].

Eshe echoed the previous explanations: *"…compassion fatigue I will explain it in simpler like in simple terms…I think it's a stress that we experience as professionals who are working with individuals with problems. So that is my understanding because sometimes we work with different people from different backgrounds with different stories. So, in our social work it says that understand the story of a patient from their frame of reference. So, when putting yourself in their shoes I think it creates a stress, because then you try to think like okay these people are experiencing this, and it's very hard. It is a personal thing, so I will say it's a stress*" [Eshe 48-57].

Eshe went further to explain about empathy and mixing personal and client issues: "*…I think it is very important for us as social workers to differentiate between personal things and work-related matters. So I think what creates compassion fatigue is when we take our personal things and patients' things and then we combine them together. I think that clashes and creates compassion fatigue because then you're putting yourself in their shoes and then now you're trying to live your life through their lives because then you cannot differentiate a lot of times between okay this person is a client so I need to put everything aside and focus on this person and immediately when they leave you can collect your personal whatever and can be okay. But then I think it's a struggle because then we sit down and with our client stories even when you are at home then you think about the stories and that creates a stress*" [Eshe 60-72].

Kgomotso: "*Compassion fatigue is when a dramatic event happens to someone and then you have to be there for that person. Remember whatever that has transpired I am also a human I won't just say agh, when that person is gone you start to rethink…you become scared and*

sometimes you even feel like you're also having the condition. You become traumatised I can say that" [Kgomotse 122-127].

Jeyandi also spoke of compassionate fatigue as being from working with the traumatised: "*My understanding of compassion fatigue, from the little research that I have done myself, as I told you that here in the hospital we conduct personnel development whereby every official has to come up with a topic and conduct a workshop for obtaining points…so this year my topic was based on compassion fatigue fortunately. So, what I understand about compassion fatigue is that it is secondary trauma. It's a trauma that you get yourself from working with traumatised patients, it's that what I understand by compassion fatigue*" [Jeyandi 60-67].

Against the background of the current COVID-19 pandemic, Galeboe explained how she foresees compassion fatigue lasting for a long time amongst the hospital social workers: *"…it's gonna stay with us for a very long time this fatigue. Because now you are also expected to do that we were not normally doing. Right now when you came through screening in the tents, because they had to write your name, everybody has that shift. My shift will start at twelve to go and work at the tent and then until two and then over the weekends we also rotate to go at that tent… We do other things we didn't know about"* [Galeboe 394-406].

These findings and the understanding that compassion fatigue is a result of working with traumatised people is consistent with Parker (2020:177) who asserts that compassion fatigue happens over time, it happens as a reaction to directly assisting patients who have experienced emotional suffering and hurt. Portogese et al., (2020:2) concur and posit that compassion fatigue occurs because of social workers being exposed to emotionally wounded patients and they end up being emotionally wounded themselves.

4.3.4.3 Sub-theme 4.3: Being tired

A number of the participating participants explained compassion fatigue as being tired.

Dudu explained this tiredness: "*Compassion fatigue: I think it's a lack of interest in terms of doing whatever that you are supposed to do. That tiredness; not feeling to carry on any more*" [Dudu 51-53].

Femada said: "*I think compassion fatigue is just an accumulation like secondary trauma. It's just because of seeing every day, day in, day out, day in, day out. You become tired emotionally, physically, psychologically and you've just heard enough…and you start losing your empathy for the job and for the patients*" [Femada 50-54].

Indira spoke in a similar vein: "*…compassion fatigue I will say it goes with the emotional and the physical tiredness, wherein you get tired of all what is happening in your environment of work…be it the doctor, be it the nurses and the counsellors because we undermine each other and we step on each other's toes wherein some people they just make funny referrals just to get back at you, knowing that if you don't understand yourself, you don't respect other people, you're not a responsible person you will end up fighting with them .They just doing that to cause friction because as I am saying to you that we do call meetings to explain our roles and then even the cases that we are expecting them to refer to us but you find somebody referring something that you see that this is not a social work thing but because it is a referral you need to attend to it. You will just go there and then correct it in a professional manner but if you are not that person who is professional then you will end up losing yourself and…end up exchanging words with that person which is not something that is acceptable. So, I think such kinds of attitude or behaviour are the ones that makes us to end up compassionate (fatigued) because you always say these people they don't respect us why should I respect them?*" [Indira 99-117].

Yi et al., (2018:668) confirm that the ability to be able to feel the pain of the patients who are emotionally wounded, deteriorates the level of care provided by hospital social worker who is experienceing compassion fatigue. Cavanagh et al., (2020:640) are in support of this view by mentioning that when there is a recurrence of professionals facing traumatised patients on a regular basis, professionals end up showing signs of apathy and their ability to be kind-hearted collapses.

4.3.4.4 Sub-theme 4.4: Not doing enough for patients

Some of the participants said compassion fatigue is about the feeling of not doing enough for the patients.

Femada explained: "*…like I said the workload, the work demands, the administrative part of our work, having to account for a minute worked like the stats part of it, you know. The feeling of not doing enough for patients. Also the feeling of not getting the recognition, lack of support generally*" [Femada 56-61].

Indira put this feeling into these words: "*It's like you adopt an 'I don't care' policy. As long as I did my job it's fine. You don't go extra miles*" [Indira, 201-202].

Lerato said: "*It makes me to feel helpless; it's like I didn't do much. I didn't do what I was supposed to do, though I did everything*" [Lerato 66-67].

These findings are in line with the risk factors associated with compassion fatigue by Brown et al., (2017:120) who posit that social workers that experience compassion fatigue end up with a feeling of sadness because they are not able to do enough to help patients or be concerned about their patient's needs. Engler-Gross, Goldzweig, Hasson-Ohayon, Laor-Maayany and Braun (2019:494) concur and postulate that compassion fatigue results in the psychological and bodily tiredness of professionals, which has an impact on provision of better services to patients and results in professionals not doing enough for patients since their abilities to care and to be there for patients diminishes.

4.3.5 Theme 5: Hospital social workers' accounts of what causes compassion fatigue

After giving explanations of what they understand by the term compassion fatigue, the participants were asked to give an account of what causes compassion fatigue. Five sub-themes appeared which are: Experience many disturbing situations and deaths; high caseloads and the focus is on quantity; lack of resources; lack of support, recognition and understanding; and working with clients with same problems as own.

4.3.5.1 Sub-theme 5.1: Experience many disturbing situations and deaths

Several participants said specifically that one of the many causes of compassion fatigue was that in their work they experience many disturbing situations and deaths.

Femada referred to the disturbing situations in her work: "*Like I said to you I deal with rape, it's one of my primary departments and ja it gets very brutal. The cases that we see can be very ugly and very traumatic. And when we deal with it and you have children to go home to, you take it home to them*" [Femada 264-267].

Helen said: "*For me as well especially the more serious illnesses where patients are confronted with life-death situation, again the patient and the family, you do the counselling. You go through emotions, you go through the psychological effects…because it's a continuous process*" [Helen 84-87].

Jeyandi spoke of how patients' dying causes her compassion fatigue: "*For me is the passing away of the patients. That is causing compassion fatigue. I find myself traumatised a lot by that because sometimes people die in front of me. So that causes compassion fatigue for me, it does*" [Jeyandi 70-72].

Galeboe echoed what Jeyandi said: "*For me it's the passing away of the patients. That is causing compassion fatigue. I find myself traumatised a lot by that because sometimes people die in front of me. So that causes compassion fatigue for me, it does*" [Galeboe 70-72].

Lerato: "*It's the death of patients, the severity of the conditions. Sometimes, the patient might not die now while in the hospital but because of the poor prognosis… the patient is informed that there is nothing to be done. It's very stressful to the patient as well as to me because it's like the patient becomes hopeless; so, it is the death of patients. The severity of the conditions it causes trauma*" [Lerato 56-61].

Consistent with other research, Ostadhashemi et al., (2019:01) assert that hospital social workers; due to their excessive daily encounters with patients who are going through pain and to some extent are dying, makes them susceptible to compassion fatigue. A range of theorists have explored this phenomenon. Yi et al., (2018:671) and Portoghese et al., (2020:02) posit that it is not easy for social workers to not form attachment to the patients they care for, this also involved seeing patients dying and feeling the pain when their patients die. Consistent with previous research, findings of a study by Daphna-Tekoah (2021:248) assert that it is so traumatic and overwhelming having to mostly deal with patients who are gravely ill, who can pass on anytime and having to deal with patients who have passed on. According to findings of a study by Moon, Fraser and McDermont (2019:448) it is crystal clear that irrespective of having personal experience of having lost close relatives or family members through death, no one can ever be prepared to the face deaths of their patients. This shows that irrespective of social workers being exposed to many cases of patients dying or family members dying, they can never get used to or normalise the dying of patients in front of them. Moreover, unlike when family members or relatives of hospital social worker die, they are given an opportunity to grieve while when their patients die, they are not given an opportunity to mourn and grieve. This can lead to disenfranchised grief. A classical work on disenfranchised grief by Doka (1989:3-5) delineates disenfranchised grief as follows:

- Sometimes social workers are faced with a dilemma that when their patients pass away, they do not have the privilege of going through the normal process of mourning for loss due to their expected professional behaviour towards their patients.
- Disenfranchised grief refers to a pain which social workers undergo after their patients die in the way that they are not afforded an opportunity to cry for their patients. Socially and professionally, social workers are not afforded an opportunity to undergo the process of grief when their patients pass on.
- Every community has its own regulations when comes to mourning. The regulations determine the following; how mourning should be done, the minimum time frame for mourning, who should mourn for who (mostly social worker's relationship with patients is seen as strictly professional). Therefore it is not socially or culturally acceptable that

they should mourn when their patients die. Organisations that employ social workers have guidelines in place on who should mourn for who and the mourning period.

- The closeness of social workers to their patients and how they feel when their patients die is not taken into consideration.
- Under normal circumstances, a type of grief that seems to be acknowledged is that of family and friends. The moment the relationship is between a professional and a patient then professionals are not recognised as needing to grieve publicly despite their closeness to the patient who died.

In addition, Engler-Gross et al., (2019:494-498) concur and postulate the following:

- It is inevitable for health care professionals to develop close relationships with their patients since they must provide support throughout the lifespan of sick patients and when their patients die it is normal that they will experience pain of loss. In addition, health care professionals are exposed to a huge number of patients dying, since the majority of their patients are living with chronic illnesses.
- Since a relationship between hospital social workers and their patients is perceived as being professional, it is difficult for social workers to go through the normal process of mourning when their patients die. This in return results in having dire consequences for the wellbeing of hospital social workers.
- It is evident that when someone close dies, there are certain procedures that people who are in mourning must undergo to obtain closure and move forward with life. However, hospital social workers, despite their close relationships with patients and the fact that their patients die daily, are not afforded an opportunity to mourn when their patients die.
- Since disenfranchised grief deprives hospital social workers from undergoing the normal grieving process, they end up experiencing lots of negative emotions as a consequence of grieving for the loss of their patients.
- Depriving hospital social workers of an opportunity to mourn the death of their patients can lead to compassion fatigue. Thus, the service that hospital social workers provide to patients will deteriorate because of compassion fatigue. Conversely, the occurrence of companion fatigue can be prevented if hospital social works are afforded an opportunity to undergo a normal grief for the death of their patients.
- When someone close dies, it is normal to feel pain and undergo grief. Failure to do so might result in atrocious consequences.

4.3.5.2 Sub-theme 5.2: High caseloads and the focus is on quantity

Numerous participants stated that a cause of compassion fatigue is the high caseloads and the focus being on quantity rather than quality of work.

Kgomotso said: "*…because we are working with the high caseload and you find out that some cases differ, some are resolvable, some they take long. They take long and the more they take long, the more it also drains you as a person*" [Kgomotso 185-188].

Femada said: "*…like I said the workload, the work demands, the administrative part of our work, having to account for a minute worked, like the stats part of it…*" [Femada 57-59].

Helen referred to the fact that despite her high caseload, other staff will also ask for assistance: *"…another thing in general I thought about is inevitably although all the social workers in health care we are not appointed to assist staff. Sometimes a staff member will ask you 'Can I talk to you for a few minutes?' You have to tread very carefully because it's a colleague but now they are going to talk to you of more personal things…so sometimes you have to draw the line very carefully…Participant: I keep secret record…but in general I do not give feedback to the supervisor…for example things like a disciplinary hearing or something I don't want to be drawn into that. It's just a general enquiry of: 'I am having trouble with my kid, where can I take him?...but if it is more work related I will step away. I cannot be drawn into disciplinary hearings and warnings and stuff like that*" [Helen 88-102].

The participant's excerpts confirm the assertion that a high workload among social workers may cause compassion fatigue (Masson 2019:62). Kheswa (2019:7) and Yi et al., (2018:674) and also confirm that workload can cause stress among social workers and even cause the health of social workers to deteriorate.

4.3.5.3 Sub-theme 5.3: Lack of support, recognition and understanding

Another cause of compassion fatigue was mentioned as being a shortage of support, absence of recognition and understanding the social worker's experience.

Femada: "*Also the feeling of not getting the recognition, lack of support generally*" [Femada 60-61]. She continued: "*So it just adds up, just adds up…Lack of support from colleagues, from management, in the hospital. The difficulty in the hospital is we're not, we are not doctors, so social work is like the back seat. Our needs are not a priority to the management. If we need a desk or whatever…they will rather get medical equipment first. It's not like DSD (Department of Social Development) where the primary services is social work. So we always have to really beg and fight them for what we need. The unfairness...it's like a double-sided sword because at the one side they can say to us we are not doctors, we are not the primary*

*cause of it. But yet with Covid times we were expected to be here every da*y" [Femada 68-77].

Indira said: "*In social work I would say…the people, co-workers who are referring silly things…not previously what usually comes to us social workers. When we are in a meeting we discuss the kind of referrals that we get from our colleagues. Somebody will refer this person; there are no contact details in the patient's file. How is that a social worker's problem? 'Please assist the patient.' We all have access to phone the family members we all have files, we all work with files, we can peruse a file and see if there is no contact details. There are clerks, clerks are the ones who're supposed to do that. But they will refer that to you as a social worker and… for myself that is what I am thinking each and every issue if a person wants to turn it into a social problem it might be*" [Indira 120-131].

Galeboe spoke of the lack of understanding, particularly regarding the social worker's role: "*When it comes to the doctors you will forever fight with them to understand social workers' role. I don't think they understand it…We have got permanent residential doctors that are here that have been here for a long time. But then every year we get intern doctors, service doctors like everything. You have to teach them the role of a social worker, otherwise they G167 send everything, everything to social worker, everything, that like they will see a patient and they've been thinking there must be something wrong with this patient they send to social worker without assessing, without doing anything or let's say they see a patient is dirty, coming to the hospital they will just assume this patient is homeless. They don't interact that much with the patient and then they just call a social worker. This guy looks like, like whatever, and then social worker please intervene…So that one of not understanding the role it is there. They really don't understand until you teach them, you explain to G176 them… which we do it every time when new doctors come*" [Galeboe 161-176].

These storylines are in line with the findings of the study on paediatric oncology social workers experiences of compassion fatigue, which asserts that factors such as; shortage of support, lack of acknowledgement of what hospital social workers do and not being valued enough may cause compassion fatigue (Yi et al., 2018:671). The findings can be further confirmed by Kheswa (2019:5) who states that a lack of support from social work managers may cause trouble that is associated with one's job and can discourage social workers to perform well in their duties, especially if other professionals they work with receive support. Parveen (2017:21) further confirms that one of the challenges of hospital social workers is that their needs are not being prioritised since they are working as a secondary service in hospitals.

4.3.5.4 Sub-theme 5.4: Lack of resources

Lack of resources was mentioned by the participants as a challenge they face daily and it was also cited as a cause for the compassion fatigue they experience.

Indira said: "*In the hospital you can see I don't have technological things. I don't have computer, I must use my own computer and you know this time I base everything digital so the emails, you use a personal email and then again government used to fund, we used to have many NGOs that are assisting but this nowadays things are getting lesser and lesser…so that is why I am saying we don't have resources like we used to have - shelters for homeless; there were many old age. They also have so many policies that make it difficult for the social workers without the family to get them into the old age homes. And the family they dump their family members in the hospital and then those available resources they will leave the family to be part of the process and you will find the families they don't want to be involved. So, you end up being frustrated not knowing what to do…I do I have a case of a patient who is from Zimbabwe, from Mozambique, he is being in this hospital now it's two years. He has been transferred from Jubilee, Jubilee to Olive, Olive to George Mukhari, George Mukhari to us because he doesn't have, he is illegal and then he has TB of the spine, he is paralysed. I did call, he didn't have an ID. I called the victim verification and they came and verified and found out he doesn't have any criminal record, yes he is not a South African. Repatriation centre they couldn't repatriate him because of the condition that he is in, so we are stuck with him*" [Indira 151-174].

Galeboe: "*…lack of resources in terms of us wanting to help the patient. We can only go as far as I mean if they say shelters are full there is no shelter stays, and you've got patients here that need to be taken to shelters…it makes it difficult for our job. Another thing is the issue of, even though we want to put people into shelters, the shelter wants money. They are NGOs, they get subsidy from government but it's not enough…a person must be either getting either SASSA before they can take or the family must be able to top up. So in that case it's a lot of foreigners. They don't qualify for SASSA; they don't have any families that can pay on their behalf. So those are the things that really cause our work not to be smooth*" [Galeboe 107-130].

These findings may be explained by Kinnman and Grant (2020:93) who posit that not having enough resources to perform one's duties may cause compassion fatigue. Kreitzer et al., (2020:1947) further confirm that social workers who are experiencing a lack of resources end up not providing services to cater for the needs of their patients and it causes them great

anguish. Furthermore, the findings of a research study by Kheswa (2019:2,5) confirm the following:

- Lack of the necessary tools of the trade such as phones, computers and unavailability of internet may make it difficult for social workers to perform their duties and in return may result in experiencing hardships.
- Sharing of cars may create difficulties for social workers to render services and may make them look disorganised.
- Having equipment's which is broken and not functional may pose challenges fpr social workers.

4.3.5.5 Sub-theme 5.5: Working with clients with same problems as own

The participants also stated how working with clients/patients experiencing the same problems as the hospital social workers are experiencing personally is a cause of compassion fatigue.

Helen explained her personal situation and how her experiences in the hospital had resonated with her and she had had to remove herself from dealing with the same situation in the hospital: *"I have two daughters, the youngest one is in heaven, she was born with severe disabilities and then she passed away at the age of six and a half. And I felt just for a certain period for me to go through my own healing process and not to project my personal loss onto patients, I said I will prefer not to work with paediatric patients for a few months, you understand…it was many years ago, twelve years ago so with time to be realistic and save yourself. That is why I always maintain don't lie to yourself, don't be superwoman or superman and acknowledge this is going to be difficult, you cannot deflect this onto patient's services"* [Helen 247-256].

Femada supported Helen in this respect: *"…and it is also a matter of coming to work with your own home stress and having to be in the space where you deal with people with similar problems or the same problems*" [Femada 63-66].

The findings are consistent with the findings of Armes, Lee, Bride and Seponski (2020:7) who that personal trauma history in social workers leads to stress. According to the forefather of compassion fatigue, Figley (1995:09,10,11) further concurs and states the following:

- That professionals who have experienced personal trauma which they have not dealt with, may experience countertransference.

- Countertransference may happen when the patient's trauma is similar to what a professional went through or reminds the professional of what they went through.
- Countertransference has detrimental effects on the relationship between a patient and a professional. Therefore, professionals who experience it must seek professional help.

4.3.6 Theme 6: Hospital social workers' descriptions of how compassion fatigue affects them personally, professionally and in their service delivery

The participating participants were asked to describe how compassion fatigue affects them personally, professionally and in their service delivery after they had explained what causes compassion fatigue. Three key themes appeared, namely; Personal effects; professional effects; and service delivery effects.

4.3.6.1 Sub-theme 6.1: Personal effects

Under the personal effects resulting from compassion fatigue, the participants identified the following five (5) categories: Becomes irritable, angry or moody; feels fearful or alert; feels hopeless, tired, pessimistic or numb; has physical symptoms; and family is affected or takes work home.

Before expanding on these categories, it is relevant to note that one social worker said she does not allow compassion fatigue to affect her personally: *"As a person, I don't allow that, I am, I choose to be assertive…And I block a lot of things that coming my way or…disturb me. I don't allow that…I choose to be myself whatever way"* [Boitumelo 101-107].

This finding may be explained by Shepherd and Newell (2020:47) who state that some professionals who experience compassion fatigue might not be emotionally scarred. Masson (2019:61) share the same sentiments and posit that some social workers may flourish and respond positively to situations which have the potential to hurt them emotionally.

4.3.6.1.1 Becomes irritable, angry or moody

Many of the participants' first responses was to say that when they experienced compassion fatigue they became irritable, angry or moody.

Amahle said: "*And when I, when people start coming in and I get irritated…And my patience runs very thin and because they don't get to the point of whatever that is disturbing them or they're having difficulties, whatever their experiences…I get too irritable…*" [Amahle 73-79]. Later, she added: "*and at home, my social life at home I get irritated at my son*" [Amahle 165-166].

Jeyandi explained how compassion fatigue affects her in this way: "*It affects me as a person, sometimes you find yourself being irritable in your personal life. You get home and your daughter…you are tired you have lost two patients in a day. There is your child seeking for attention…and you find yourself snapping at your child. You are fatigued; you just lost two patients and your child doesn't understand I lost two patients. She just thinks this person is just snapping for no reason so that is how it affects me personally*" [Jeyandi 83-89].

Cindi said: "*It's like you no longer enjoy what you are doing. You get short-tempered sometimes. And you, you are exhausted. And you get angered by little things and sometimes they will affect you at home. You get angry at home*" [Cindi 150-153].

"*I become moody at times, where at home they know when to back off. I am not in the good space type of a thing. I become very irritable*" [Femada 115-117].

These findings are in line with Stoewen (2020:1207) who states that a range of unfavourable emotions such as being angry, irritated, bitter and uncertain might result from compassion fatigue. The findings of research by Kheswa (2019:6) also concur by reporting that social workers who are overburdened by the cases they come across might end up having anger which is accumulated over time and ends up showing their frustrations to innocent patients.

4.3.6.1.2 Feels fearful or alert

Another personal effect resulting from compassion fatigue was identified by the participants as feeling fearful or alert. The following storylines explain this:

"*I am referring to becoming a mother…you meet parents that are having problems with their children, so you become fearful of becoming a mother. And you say what if I become a mother to a child like this? How will I deal with a child like this? So you ask yourself many questions and that becomes fearful you and then you're trying to be protective and say maybe not now. Maybe when I am ready…because what if then I have a child right now and then I experience a child who's struggling or using substances?*" [Eshe 131-138].

"*…as a person it has made me quite vigilant and distant. I don't allow people too close to me. Vigilant in terms of wherever I am whatever I do I am always on the lookout for possible abuse…all those community evils…I am always alert to that*" [Femada 111-115].

Jeyandi explained the situation with her daughter as a result of being fearful from compassion fatigue: "*The stomach is big I don't know what is going on. I even called my supervisor that time and say my child is having cancer. Only to find out that my child was just only bloated. So when I came to work I spoke to my supervisor. She made me realise that I was compassion*

fatigued. I was traumatised by what I was seeing in the wards so immediately when I saw my child with that stomach I just felt that yoh, my child is having cancer…that is when I started realising the impact it does…I started not knowing and then I realised oh this was a symptom of compassion fatigue. I was traumatised and that trauma I took it home" [Jeyandi 153].

Lerato: "*Sometimes when someone is sick I feel like she is going to die because I am surrounded by the death. It is overwhelming. It creates fear when even my close person when she is sick of anything I just become fearful that maybe she might die because of the death that is in my mind and I am always thinking about death because I am only with people that usually die*" [Lerato 68-72].

The findings are consistent with Dubois and Mistretta (2020:67) who reported that one of the many negative consequence of compassion fatigue is a condition whereby professionals are fearful and experience anxiety. In support of this view Brill and Nahmani (2017:19) posit that professionals who are experiencing extraordinary ongoing cases of trauma are vulnerable to stress which can result in negative emotions such as being fearful, it can affect sleep patterns, cause challenges for professionals in their relationships and can even cause a lack of self-confidence.

4.3.6.1.3 Feels hopeless, tired, numb or worthless

The participants added that compassion fatigue has the effect of making them feel hopeless, tired, numb or worthless.

"*Kids need to be helped with their homework but you can't because when you come back from work you just go straight to your bed because you are tired*" [Cindi 153-155].

"*I almost feel numb at times. I can't care, I feel despondent. I feel like 'You know what? This is enough'…*" [Femada 117-118]

"*…you feel hopeless and…when you are not happy with what you are doing, you can't go to work…difficulty in concentrating…you get angered and it's also difficult to work with other team members*" [Cindi 157-161].

"*I think you get tired, there is a physical tiredness. Sometimes there is emotional tiredness.*" [Helen 228-229].

"*I sometimes I feel like I become such a pessimist. I don't see the beauty anymore. It's just ugly, it's just ugly. With COVID we're locked in and all those things just affect me…we really feel it's not worth it anymore. I look at my patients: his father passed, uncle, grandfather…we had a little kid that was so badly raped, a toddler she was torn all around and she had to go*

to theatre. So those things stay with me…I can't continue as if you have never seen it, never heard it, never dealt with (it). I think of the families sitting in my office crying out of frustration. Frustration at the system, the legal system…all those things it does sit with you" [Femada 275-285].

"…(you) feel like you are not doing your work, you feel like I am not worth it. Especially with the issue of the doctors who think they know better. They know everything. You start now measuring yourself…they are much better than me and whatever" [Galeboe 135-139].

The findings of the study by Kreitzer et al., (2020:1945) are supportive of this view by asserting that challenges in the working environment can cause compassion fatigue which may result in social workers experiencing tiredness to a point that they may even resign. In addition, Parker (2020:175) concurs by stating that being tired from traumatised cases might even affect sleep patterns of professionals which in turn will make professionals always feeling tired. Kheswa (2019:7) shares the same sentiments by stipulating that social workers who are stressed out, end up feeling tired psychologically and end up hating their job because they are psychologically discouraged. The issue of feeling discouraged and losing hope is further articulated by Yi et al., (2018:671) who agree that compassion fatigue can result from engaging with deep emotional cases.

4.3.6.1.4 Has physical symptoms

Some of the participants attested to experiencing physical symptoms because of compassion fatigue.

"*And ja, I start to have these kind of symptoms, I get headaches… And then I have an upset stomach, I get bloated*" [Amahle 110-113].

"*…it really affects you as in I don't sleep at night…it's probably one of the side effects…come eleven o clock at night I am awake. I will probably doze off again at five in the morning. I lay around…thinking of my cases; how this one affected me. What is the plan of this one if she comes back? I need to one two three, I really overthink a lot and a lot of that overthinking…cases where you know this was so bad*" [Femada 269-274].

"*You become a different person because I remember…for the first three months I lost weight… when I was employed here I used to wear size 44 but I dropped to 38, because I was always traumatised, always traumatised until I get used to it*" [Kgomotso 263-267].

The findings are consistent with the findings of Yi et al., (2018:675) whose study reported that most of the social workers experienced physical tiredness, psychological tiredness and even

their wellbeing was at risk because of compassion fatigue. Another different study by Stoewen (2020:1207) reported signs and consequences of compassion fatigue as it affects the totality of a human being, psychologically and physically.

4.3.6.1.5 Family is affected or takes work home

The consequences of compassion fatigue are that the participants' families were affected or they take their work home with them.

"*…as a human being…it affects me in terms of your relationships with your family…it affects you because then you become more afraid of the whole and you become more protective of yourself and your family…you meet with people from different backgrounds, then you hear their stories…you become afraid so…and then you want to protect your family, like the people that are close to you*" [Eshe 113-123].

"*…I know that, I have to go on leave because this thing is starting to get to you, then you know that you have to, even at home it starts to show…*" [Amahle 96-98].

"*I deal with rape, it's one of my primary departments and ja, it gets very brutal. The cases that we see can be very ugly and very traumatic. And when we deal with it and you have children to go home to, you take it home to them*" [Femada 264-267].

In support of this view, in the classical work by Figley (1995:1) it is stated that professionals who deal with traumatic patients, end up showing the same attributes and behaviour of their patients to an extent that it even affects their relationships with their families at home. The findings of research by Yi et al., (2018:675) concur and report that the social workers studied, acknowledged that one of the impacts of compassion fatigue was a lack of attentiveness towards their family's needs.

4.3.6.2 Sub-theme 6.2: Professional effects

The participants' responses to the question on how compassion fatigue affects them professionally are given in five (5) categories, namely: Empathy, energy or motivation is reduced and feels worthless; becomes irritable, angry or rude; cannot or does not want to work; questions self and profession; and only does casework.

4.3.6.2.1 Empathy, energy or motivation is reduced and feels worthless

Many of the social workers said that the way in which compassion fatigue affected them professionally was by reducing their empathy, energy and motivation and also making them feel worthless. The storylines below confirm these effects on their work.

"*I think it affects your ability to have the energy and to have empathy. I think your production at work as well like it affects that"* [Eshe 92-93]. Eshe expanded further*: "It reduces your motivation as well. Your energy and your level of empathy as well, I think everything gets reduced because then you are that person who always trusts and I think it also creates a burnout because when you're having burnout then you don't know how, you just want to be alone. You are demotivated, you don't want to see people. So as a professional I think it reduces your skills…*" [Eshe 144-149].

"*As a professional…it gets to the point where you treat your patients as just another number. Now you're pushing numbers. No real connection, no real empathy, very rushed with the process at times*" [Femada 131-134]. Femada added: *"…so you become distant from your patients, not really connecting emotionally with them. Not really helping them as they need to be helped because in your head most of the time…it's just (an) inconvenience for you…so we get to that point*" [Femada 142-145].

In agreement with the findings is Cuartero and Campos-Vidal (2019:275) who state that when social workers experience compassion fatigue the magnitude in which they used to provide caring services to patients declines and they start detaching from their patients. There is a consensus in the fraternity on the fact that when social workers are affected by compassion fatigue; empathy will diminish, they do not connect with their patients, work performance is affected, they just perform their job for the sake of doing it, this will affect the quality of the relationships they have with their patients (Dubois & Mistretta 2020:60; Kinman & Grant 2020:90; Stoewen 2020:1207; Yi et al., 2018:668) .

4.3.6.2.2 Becomes irritable, angry or rude

Other participants explained how they become irritable, angry or rude as a result of compassion fatigue.

Amahle said: "*…when people start coming in and I get irritated. And my patience runs very thin and because they don't get to the point of whatever that is disturbing them or they're having difficulties whatever their experiences…I get too irritable*" [Amahle 74-77].

"*It's like you no longer enjoy what you are doing. You get short-tempered sometimes…And you get angered by little things*" [Cindi 150-152].

"*…compassion fatigue can also be created by someone like a patient who is rude towards you and then you don't know how to deal with that and hence we get people that are saying oh someone treated me this way because then you cannot, like you are not able to differentiate between people. You're taking all the experiences in yourself and then you treat*

people the same way because of what happened to you the previous day so then you become rude towards people because of that certain patient who was rude to you but it's you. So I think it reduces the ability… of yourself being energised and motivated and having like empathy towards people" [Eshe 97-106].

Kheswa (2019:7) also arrived at a similar assertion that "Owing to overwhelming workload experienced by social workers, it emerged that some participants have harboured anger and they would vent it out to innocent individuals. Such behaviour is called displacement".

4.3.6.2.3 Cannot or does not want to work

Numerous participants said that compassion fatigue leads them being unable to work or not wanting to work.

Dudu said in this regard: "*…when looking at other professions, you see the dietician, you see the physiotherapist they only attend to that part of the body that is broken and they get done with it. But ours is like a dumping profession because everyone from the ward if they don't have the means of attending to that patient they will just say refer social work. Anyone who is stuck in the wards the doctors they don't know what to do with the patient they refer to a social worker. So I feel like they use social work as a dumping profession so it makes me feel like quitting at times or not being called a social worker because there is a lot that is expected…that makes me very tired and not feel like being called a social worker at times*" [Dudu 121-129].

"*…I will avoid some of the wards; I will avoid some of the calls; I will avoid some of the doctors because it's too much. Sometimes you will find that I can't take it anymore it's, like you see here (pointing to papers on a table) those are new referrals, only yesterday. The work is so, the volume here it's too much for one person*" [Kgomotso 178-182].

"*…like you feel hopeless and helpless and again absenteeism. When you are not happy with what you are doing, you can't go to work…*" [Cindi 158-159].

"*…professionally it also causes me to take Fringe leave like, like our department's sick leave profile has gone up and I think that is because people are honestly fatigued*" [Femada 147-149].

"…sometimes I feel like not coming to work. Feel like not continuing anymore because I am very tired" [Dudu 89-90].

Consistent with Kinman and Grant (2020:90) compassion fatigue can even cause social workers to avoid going to work or cause them to resign. The findings of the study by Wirth,

Mette, Prill, Harth and Nienhaus (2019:266) shares the same sentiments by asserting that one of the strategies used by social workers to cope with stress was distancing themselves from work. Various authors concur and state that social workers who are experiencing compassion fatigue can disengage from their patients or even leave the social work profession (Stoewen 2020:1208; Cherny et al., 2018:253).

4.3.6.2.4 Questions self and/or profession

The participants recounted how compassion fatigue affected them in that they questioned themselves and their profession.

"*Professionally it also makes me question: Is this where I want to be, is this time for me to change professions?*" [Femada 146-147].

Galeboe echoed what Femada said: "*And you even question your profession…social work is it really all about this? Because sometimes you will find something that makes you also have compassion fatigue. It's that thing that they will make you do things that are not social work related and you sit down and ask yourself but this, like they will be insisting that you arrange transport for a patient… such things and is this social work really? Why should a social worker be doing…this or admin work like that? I mean everybody can just complete a form and ask for a transport for a patient why should it be a social worker?*" [Galeboe 150-158]

Galeboe also questions herself: *"…you're short-tempered, feel like you are not doing your work…you feel like I am not worth it. Especially with the issue of the doctors who think they know better, they know everything. You start now measuring yourself…they are much better than me and whatever*" [Galeboe 134-139].

Consistent with the findings of a research study by Fox (2019:1), it is reported that because of compassion fatigue, hospital social workers end up resigning from their work because they are doubt themselves and ask themselves questions, such as if social work is the right profession for them. Kheswa (2019:8) concur and assert that because of compassion fatigue, social workers end up quitting their jobs because they no longer have aspirations regarding their jobs, and they become worried about what will happen tomorrow.

4.3.6.3 Sub-theme 6.3: Service delivery effects

All of the hospital social workers asserted that compassion fatigue affects their service delivery negatively. They give less service, the quality is poorer, they are not so focused and they do not go the extra mile, to cite a few examples. Their responses are encapsulated in the following storylines.

"*Poor service delivery, because you are supposed to write reports. You are supposed to communicate with other departments that refer to you. But when you are tired you won't report in time which means everything will be delayed. Sometimes you will need a patient's report and it's not there in patient's files because you are tired. And even poor decision making because when you are tired sometimes you take decisions…but now because you are tired or you are hopeless…you want to make sure they are getting what they want but it's not possible because you are tired and which is poor service delivery…Some other team members will need their things in time…when you don't offer things in time which means it affects service delivery because when you are working as a social worker…to empty the ward it means you must be fully at work, you must be committed to what you are doing*" [Cindi 164-177].

"*…my intervention in terms of service delivery gets affected because now I no longer have that interest, that drive that says to me let me help this person fully…(but) you are thinking of the backlog of your reports that you still need to complete or submit to your supervisor. So that makes one do things quickly…let me just see this one for ten minutes for twenty minutes and then get done with that and not going deep into whatever that is supposed to be done…maybe perhaps you have to make a follow up to assist her again so at times you end up making follow ups but sometimes those follow ups, you find out that you have got other new cases on that day and then there is a limited time to see a follow up case*" [Dudu 94-107].

"*…if you are fatigued…you won't give your all, you will just do what is required and all that. And another thing is, it becomes monotonous when you get these cases that are the same. So you don't put as much effort you just look at the referral and you say homeless, let me just go there…and hear what he says you know and then you will just write this patient needs shelter but cannot afford shelter. Just like that"* [Galeboe 179-185].

"*As a professional you end up not providing services the way you are supposed to…for example: I lost two patients today. I go home, the following morning when I come there is a patient that has died, I have to provide grief counselling, I am not yet over what has happened yesterday…now I have to bury what has happened yesterday and go provide debriefing to this mother of the child and…we just do touch ups, you are mourning…The patients at oncology we bond with…the child has been my patient since 2019 until the day they die…so they become your family, they become your daily life. So when you lose them, you mourn their loss…you won't provide services to your clients fully. You just do touch ups*" [Jeyandi 92-104].

"*…I'm sometimes not psychologically there for patients…so that makes me not to provide the quality service…it makes me to burn out…this is uncontrollable. It makes me to feel overwhelmed as a social worker. I am still looking forward to help but you know it creates burnout…At the end of the day there is a referral…a patient that needs to be attended yet I am not psychologically fit to attend to the next one while I am still adjusting…*" [Lerato 79-89].

In support of this view Miller, Lianekhammy, Pope, Lee and Grise-Owens (2017:868) assert that when hospital social workers encounter difficulties at work, it lowers the standard of service they offer their patients. A range of theorists has explored this phenomenon and assert that stressful situations and compassion fatigue can cause poor service delivery and the services that are offered to patients (Dziegielewski & Holliman 2020:322; Masson 2019:58; Ostadhashemi et al., 2019:2).

4.3.7 Theme 7: Social workers' explanations of what they do to deal with compassion fatigue

After having explained how compassion fatigue affects them in the hospital context, the participants were asked to describe what they do to deal with compassion fatigue. Their responses are given under the eight (8) sub-themes that emerged, namely: Takes time off; talks or debriefs with colleagues; participates in activities, hobbies or takes trips; self-care; does not take work home; does not take on others' problems; just does what they can; and relies on faith or social work training.

4.3.7.1 Sub-theme 7.1: Takes time off

Many of the hospital social workers said that they deal with the compassion fatigue they experience by taking time off work.

"*Strategies that I normally use is day off or…to take leave…I make sure that each and every month I take at least two days or one day leave*" [Kgomotso 200-206].

"*…I think…you must have time like taking leave, so that you can rest*" [Cindi 227-228].

"*…most of the time I look on the calendar to see when is the next holiday. When is the next long weekend so I can extend that weekend and stay at home for some time, for a longer period. I take leave. I become sick even when I am not sick seriously. Just to stay at home and have a rest*" [Dudu 139-143].

The above findings can be confirmed by Smith, Vasileiou and Kagee (2020:9) who state that professionals who experience work-related stress, prefer to go on leave in order to recuperate. Various authors share the same sentiments and postulate that when hospital

social workers experience compassion fatigue, one of the strategies they apply to deal with it is to take normal leave or sick leave to recuperate (Ehfad 2020:70; Yi et al., 2018:675).

4.3.7.2 Sub-theme 7.2: Talks to or debriefs with colleagues

Talking to or debriefing with their colleagues or fellow social workers is one of the strategies that the participants employed to deal with compassion fatigue.

"*…have support group, especially we are working in psychology department team, most of the time we'll do debriefing about the challenges that we are having. And sometimes we'll discuss some issues with our other mother hospitals. At least it makes you feel at peace"* [Clement 229-231].

"*Most of the time if I feel overwhelmed, we have meetings we have supervisors, we use them to debrief whatever we are going through. We talk to them, sometimes it helps, sometimes it does not help…*" [Kgomotso 201-204].

"*…every Friday we meet to discuss about cases that we are dealing with…the ones that we're having problems with and the ones that we seem not to be coping or they're draining me or this one seem to be getting me down. We sit down and talk about that so, that helps a lot*" [Amahle 243-247].

"*…for me to cope is to understand more about the medical condition and the severity…okay this person it was at the end stage of life, it was classified as palliative…to get more knowledge, I come here and probe more; that is how I cope…I do read and Google and find out what is actually, maybe for example a patient maybe is diagnosed with cancer I keep looking and then it's stage four…there is no more curative treatment to be given…it gives me peace to say okay everything was done…*" [Lerato 114-122].

"…my colleagues are very supportive…sometimes I just call them and tell them 'Guys I am not coping'…there is an organisation that offers counselling over the phone. I just call them and say 'Guys I am tired, I am so heartbroken I feel hopeless'…Sometimes supervision it does help if I'm consulting with my supervisor. Sometimes I tell him how I am feeling and I am…I am breaking down and I am not coping. So for me to be honest with them, let me just share…" [Lerato 122-134].

These findings are in line with classical work by Figley (1995:168,194) on the importance of peer support and supervision as follows:

- Talking with colleagues helps to create reconnections and to intensify professionalism.

- Talking with colleagues assists in sharing ideas on how to cope with compassion fatigue. Peers will share the best strategies on how they deal with traumatic patients.
- Support by colleagues is reciprocal, meaning colleagues must be able to give and receive it.
- Peer support helps in terms of creating a space to vent out negative feelings of dealing with traumatic patients when professionals feel like they aren't coping anymore.

Dziegilewski and Holliman (2020:322), Cherny et al., (2018:255), Figley and Ludick (2017:583) concur and state that social workers must have a support system in the form of a colleague, close friend, or family member which they will lean on when experiencing challenges and will help them to bounce back from emotionally challenging cases. Having support during difficult times, can be linked to resilience theoretical framework which underpins this study, which state that resilience involves having support factors in the environment which someone find himself/herself in (Van Breda & Dickens, 2017:4).

4.3.7.3 Sub-theme 7.3: Participates in activities, hobbies or takes trips

A number of the participants explained how they participate in activities or hobbies and take trips to deal with compassion fatigue.

Although, Amahle does not participate she wished she could: "*I wish I could do, I need to do it…but with COVID, I can't take time off and go zip lining…I want that one…I would love to do bungee jumping. That will be my way of releasing it once in a while. Throwing everything down there*" [Amahle 251-264].

Dudu said: "*…I am a person who also loves to go to the gym. So I get revived by going to the gym and I get strength from going to the gym and I also go on holidays a lot…I love going out to Bela Bela this is the nearest. Taking my family to Bela Bela and just swimming for it gives me that relief…and then when I come back to work I come revived, revived and energised. Places like Durban especially because here in Gauteng we don't have the opportunity of having too much swimming pools and a sea. So going to Durban and just sitting…watching the waves it revives me…and I start doing my work again with energy*" [Dudu 162-171].

"*For me personally I have lots of hobbies at home…which are not really work related…The simple thing like a vegetable garden is something different to take care of that. My daughter is now second year at university, to help with her studies… family we love music…we like going for hikes…to get away from the things H272 at work*" [Helen 264-272].

These findings may be explained by the classical work of Figley (1995:141,166,186) as follows:

- Working with traumatised patients can be challenging, therefore for professionals to be able to provide good quality service to their patients, they need to be in a good psychological and physical state.
- Professionals must have activities in place that they use in order to recuperate.
- Having a balanced lifestyle is necessary to be able to be in a good state to do justice to patients.
- Living a healthy lifestyle includes eating healthy, exercising, having a good laugh, going to a spa for a body massage, dance, road trips, visiting nature reserves and having enough relaxation schedule.

Dziegielewski and Holliman (2020:322) resonate with the above views and assert that social workers can participate in sports activities such as exercising as one of the strategies to deal with compassion fatigue.

4.3.7.4 Sub-theme 7.4: Self-care

Self-care was also indicated as a means of dealing with compassion fatigue by the participants.

"*I read a lot about stress, burnout, compassion fatigue and how to deal with it so I think It's very important to read and to learn about compassion fatigue and to have hobbies or self-care as well…That was a learning experience for me to say okay that happened a long time ago and then is this how you want to deal with your client moving forward? So self-care is very important*" [Eshe 218-225].

"…I read a lot. I do self-care, I like the bubble bath, the reading of the book in the bath. I do the pampering sessions" [Femada 342-343]. Femada continued: "*I do things that make (me) happy. I incorporate things in my workplace that make a little bit…my office looks colourful, happy place. It's where I spend most of my days. Let's bring happiness or nice things and that will also cheer you up and not let me sit in that feeling of this place, this place…*" [Femada 364-369].

The participants' description of the importance of self-care is consistent with the description by Lewis and King (2019:97) who postulate that self-care is a fundamental aspect of social work practice and if social workers do not engage in self-care, it may lower the standards in which services are given to patients. In addition, the importance of self-care can be confirmed

by findings of a study done by Cuartero and Campos-Vidal (2019:276,284) that social workers who regularly implemented self-care activities, were not badly affected by compassion fatigue.

A plethora of authors such as Mcmahon (2021:2), Kohli and Padmakumari (2020:169), Ostadhashemi et al., (2019:3), Xu et al., (2019:21), Figley and Ludick (2017:585) delineated that in order to overcome compassion fatigue it is important to practice self-care activities such as living healthily because the welfare of social workers who do not practice self-care ended up negatively affected which resulted in giving patients poor service. In addition, self-care is one of the protective components that promote resilience (Bolton et al., 2016:171). Conversely, Miller et al., (2017:876,877,878) have a different view on self-care and assert that most self-care activities require money and only social workers who are financially stable will be able to afford.

4.3.7.5 Sub-theme 7.5: Does not take work home

The participating participants cautioned that work should not be taken home and this is a way to deal with compassion fatigue.

"*…sometimes I do take my work home but I don't do it anymore because I have seen I am hurting myself even more…I stopped because I have seen that it doesn't do good for myself and for my health*" [Kgomotso 206-209].

"…the other thing is to not take (work) home, because if you don't finish your report you are going to finish at home and it's also exhausting, and what I do I don't take work home" [Cindi 231-234].

"…when I leave here at four o'clock, okay certain things stay with you. You might mention to your husband at home 'I saw this today' but leave your stuff at work" [Helen 265-267].

These findings are consistent with the findings of a research study by Ostadhashemi et al., (2019:4) which reported that it is important to draw boundaries between one's personal and professional lives by way of not taking work home. The concept of separating work and home can be seen as keeping professional boundaries. As postulated by Masson (2019:68) the ability to draw a line between personal and work issues does not only help social workers to avoid stress but it also helps to keep their professionalism intact. Another different finding in research study done by Yi et al., (2018:675) discovered that one of the fundamental strategies which social workers used to deal with compassion fatigue was to strengthen boundaries.

4.3.7.6 Sub-theme 7.6: Does not take on others' problems

The participants also reflected that not taking on other people's problems was also a way of dealing with compassion fatigue.

"…in terms of my patients, I avoid taking others' problems. I always remind myself that this person came to me with the aim of trying to seek help from what he is experiencing so I don't have to put myself in his or her position. I should be the manager and listen to this person, work together with him or her to resolve the issue" [Boitumelo 202-206].

"*…sometimes you are grateful that you're sitting on this side of the table not that side. The types of things that I have seen have made me realise that…your life can change so quickly. I have seen psychiatric patients that are an accountant, a chief accountant…a lawyer that is now a psyche patient in a government hospital. So it also has taught you to be grateful for the life…you have, no matter how bad, it's still here…no matter how bad you feel your life is or your world is your work is*" [Femada 511-518].

These excerpts are consistent with the findings of Yi et al., (2018:676) that a social worker's strategy of not trying to take on patients problems as their own was effective in helping to deal with compassion fatigue. Figley and Ludick (2017:575) share the same sentiments and state that social workers must understand that they need professional boundaries when assisting patients and they must not carry patient's pain as if it were their own pain. However, according to the researcher, the strategy used by social workers to not take on a patient's problems as their own might affect the quality of service delivered because it might mean that the social worker does not take the challenges of patients seriously and does not even try to understand the challenges of the patients as they see them themselves.

4.3.7.7 Sub-theme 7.7: Just does what can or is expected to do

Some participants recounted that a way to deal with compassion fatigue was to do what one can or at least what one is supposed to do.

After the death of her young child, Helen experienced trauma and her advice was that social workers should just do what they can: *"…save yourself, that is why I always maintain don't lie to yourself, don't be superwoman or superman and acknowledge this is going to be difficult, you cannot deflect this onto patient's services"* [Helen 254-256].

"*I came here with energy and interest to do, to help these patients but looking at how things are in the health department, it can somehow destroy myself or my profession as a social*

worker…but I try to block that by just doing…what I am expected to do and I can only manage where I can" [Boitumelo 79-83].

Although some of the social workers said they just do what they can or are expected to do, Boitumelo again said this when she explained how she does extra things: *"… also what I enjoy is these little projects…today, let the department let's plan for awareness campaign. And we all focus on that today…and then we feel like yes, we have achieved something, just building up our spirit. Reminding myself every day that…this is paying your bills but also yes, this is your passion…this is what you went to school for…even if you reach one person, then you are blessed; you have done something…"* [Femada 344-350].

The findings resonate with Figley (1995:36) who asserts that it is important for professionals to understand that there are things they are able to do and there are things they cannot do. The findings in the narratives of social workers at hospitals conducted by Daphna-Tekoah (2021:248) share the same sentiment that sometimes social workers only perform certain duties and understand that they are not miracle workers. Being able to set limits can be associated with one of the characteristics of resilient theory, that people who are resilient are the ones who are able to set own limits (Grant & Kinman, 2014:18).

4.3.7.8 Sub-theme 7.8: Relies on faith or social work training

Participants also said how they rely on their faith or social work training to deal with compassion fatigue.

"*…to cope with this compassion fatigue, I am a child of God. I love God with whole of my heart. What I normally do is prayer every day. I start my day with prayer. I read the Bible before I start my work. And then I ask God for the strength and the ability to manage my job and that is what keeps me going*" [Dudu 158-162].

"*Social workers you make ourselves happy where there is no happiness. Because there is no happiness. Working with other people, we don't understand each other and some people they don't give themselves to understand other people, they don't have time for them. But…our profession somewhere, somehow it moulds, it's the one that grooms you to be the person. I will say the person I am today, it really helps. That is why some…staff members when they are overwhelmed they will come to my office and say, we know you are going to listen to us, we just want to talk. And then they will tell you whatever they are going through in the hospital and you end up saying that you know what, we are here to work. Don't harbour personal issues, because the moment you start bringing personal issues in the hospital or in a work setting, you are going to experience serious problems*" [Indira 308-320].

"*…you look at your theory and you take your counselling from there. You are still a professional assisting a patient and the family. And then what is very important, even after how many years of being in the profession, is supervision. No social worker should think after I've worked for five or ten years…I don't need supervision…even if it's on a consultation basis…And this is what makes our profession so very unique. Sometimes we can think it's too structured, but supervision with a supervisor, with a colleague that is also very, very important to have that door available*" [Helen 125-134].

Dziegielewski and Holliman (2020:308) posit that during difficult times, social workers lean on their religion for support and to bounce back. Masson (2019:60) shares the same sentiments and asserts that religion plays a major role in increasing the resilience of social workers. Results of research by Kheswa (2019:07) further confirm that spirituality helps social workers to cope with the challenges they come across. This can be linked to element of resilience theory based on the fact that according to resilient theory, people have external factors such as leaning to spirituality during difficult which create meaningfulness and purpose in life (Bolton et al., 2016:176-177).

4.3.8 Theme 8: Social workers' suggestions on what managers or supervisors can do to assist hospital social workers experiencing compassion fatigue

The final question the participants were asked by the researcher, was for their suggestions regarding what managers or supervisors can do to assist hospital social workers who are experiencing compassion fatigue.

Before giving their responses, it is relevant to note that one social worker, Femada, stated the following about compassion fatigue:

"*I think it's important for it to be accepted as a reality that these things are happening and not that social workers are untouched by compassion fatigue…it is very easy to minimise it or ignore it or to avoid it*" [Femada 390-393]. She continued: *"… (there) is a real need for it to be recognised because I think it's a broad thing where it's overlooked or underplayed even…yesterday you had a bad day, tomorrow you must be better…it's like that the understanding is if it's recognised it's like okay you had your day yesterday, today you should be better…not realising hello sometimes it's not as easy as like that*" [Femada 468-473].

The finding resonates with Stoewen (2020:1208) who posits that it is important to know the signs of compassion fatigue because being able to pick out the signs at an early stage prevents severe consequences. Figley and Ludick, (2017:588) concur with the latter and

assert that compassion fatigue is inevitable in the caring profession and those who are in the caring profession must know the signs of compassion fatigue in order to deal with it.

Four (4) sub–themes emerged from the participants' responses, namely: Schedule supervision/debriefing sessions; undertake team building; provide support; and provide more resources.

4.3.8.1 Sub-theme 8.1: Schedule supervision/debriefing sessions

Many of the participants responded by suggesting that supervisors/managers should make sure that supervision/debriefing sessions take place for the hospital social workers.

"*I think consultation and supervision it helps…We do have case discussions and then we end up discussing even our experiences in the hospitals and then as a group like, as colleagues we support each other. And then we even help each other where we see that there is a need for help. And we always discuss our worst experiences in the wards so that you can see that you are not the only one who is going through that and that. That is why I am saying if you do have that support you will end up being a resilient person and you end up knowing your standing, you end up knowing how to overcome other issues that are difficult to overcome, through your colleagues' support…*" [Indira 286-295].

"*Maybe perhaps if we can have some sessions whereby we can just go sit, relax and just ventilate and offload whatever that is actually…it's a kind of debriefing sessions. If we can just have…one debriefing session as a group as social workers working in one environment I think that also it can help us in terms of taking away this stressful and tiring behaviour of compassion fatigue*" [Dudu 219-224].

"*I am hoping we have supervision dates…for quite some time we haven't been having supervision sessions…so we wish our manager, our manager supervisor just one day comes to us. Engages with us in that way; but for us we do it every Friday. For the supervision she still has to come back to us for consultations so we wish she would arrange consultations for us*" [Amahle 268-273].

"*The supervision system we have in the hospital, especially in a hospital setting…it is on a consultation basis or a formal supervision structure, never, never, never neglect that. Take this from an old social worker and I mean I have been there myself. After a few years in practice you think ah I can do this. But never neglect supervision; that is important…*" [Helen 278-282].

Eshe added that group sessions should include learning about specific topics: *"…hold groups maybe to teach your staff members about fatigue. Create an environment where you can learn about different things like stress, burnout or compassion fatigue so I think is very important for supervisors to create that platform for their staff to come and to be able to reflect on their cases or, their mental wellbeing on how are you doing*" [Eshe 233-238].

Lerato supported Eshe when she said: *"…I can say more training needs to be implemented…Stress management, burnout…those kind of training that can assist us social workers to cope and deal with whatever that is causing this stress because we are assisting people who are stressed. So I believe trainings and need to be more implemented…and then I think also capacity can also help us maybe to do something that is not even work related or…something that we can enjoy as the social worker in the working environment while we are here but we don't talk about patients and work, just to talk about our life. I believe that can also help us…*" [Lerato 168-178].

The storylines are consistent with Poulin and Matis (2021:56) who postulate that in social work practice, supervision is critical since it serves the purpose of nurturing social workers to be able to cope with stressful situations. Kinman and Grant (2020:93) share the same sentiments and assert that since hospital social work requires a lot from social workers, it is important that supervision is made a priority by hospitals management. Various authors concur with the importance of supervision in terms of dealing with compassion fatigue, that organisations must have an open door policy when it comes to supervision and supervision should be compulsory (Kreitzer et al., 2019:1949; Kheswa 2019:7).

The father of compassion fatigue, Figley (1995:172,173) shares the same sentiments about supervision and states the following:

- Supervision can be done either individually or in a group.
- Group supervision can be used in the form of case conference were support is provided in terms of the cases of patients.
- Group supervision will also assist in identifying symptoms of compassion fatigue and professionals who have personal issues which need to be addressed.
- Social work supervisors must create a conducive environment for supervision. To make social workers feel free and open up during supervision, supervisors must understand that information used during supervision cannot be used when performance appraisals are done. Since this can inhibit social workers from genuinely sharing their true challenges.

In addition, various authors concur that supervision play a significant role in promoting resilient since it empowers social workers with better skills to deal with adversities (Collins, 2017:14; Kapoulitsas & Corcoran, 2015:98).

The researcher is in agreement with the above statement and believes that supervision must be done in a safe space where individuals will feel free to share about anything and supervisors must not use the information shared during supervision to evaluate individuals when they have to score them for their performance appraisals.

4.3.8.2 Sub-theme 8.2: Undertake team building

Supervisor/managers should undertake team building was also suggested by the participants as a means to assist with compassion fatigue.

"*What also is important for me is team building… Our department is not open to team building. But for me spending time away from the desk, with colleagues in a relaxed environment will be a good boost…when we can actually connect and get to know each other better and how we need to be supportive of each other, what the needs are…we have this department where each one of us are alone in each little block and very superficial: 'Hi how are you? No I am fine'. Nobody really knows people went through deep, deep things. And we hear it in gossip at a later stage…this is your colleague, you didn't even know her daughter was being transplanted…so, you don't know how to support somebody, you don't even…know she is going through difficulties; she is not coping, not managing with the load. So for me it will be about openness, about talking, about (being) comfortable. To call it fatigue is how we are gonna deal with it...*" (Femada 414-429].

"*And team building. Maybe it can help like going out as social workers maybe a day or for the weekend out I think it can help*" [Cindi 246-248].

Helen's suggestion related more to team building within the wider scope of the multi-disciplinary team: *"…another thing that you must really take into consideration in a hospital setting is the multidisciplinary team within the hospital. Get to know the different disciplines, respect boundaries and have professional relationships with everybody and use the different resources…if the presenting problem is more a psychological nature then you consult the psychologist. Or if is more of a work-related nature then consult occupation therapy…if you go back to a doctor and you say I am not sure about these physical implications, I am not sure about the medication, ask their advice, ask their help, ask their input. And once you establish that professional boundaries and the professional relationships, it is actually very nice to work in a hospital*" [Helen 282-291].

The findings are consistent with the findings of Masson (2019:71&72) who reports that team building exercises encourage unity among workers which in return assists in the sharing of ideas which boosts the resilience strategies of social workers. The findings of Yi et al., (2018:676) resonate with this and report that team building exercises encourage hospital social workers to be able to share their challenges, support each other and be there for each other in order to deal with compassion fatigue. Various authors concur that resilience among social workers can be promoted by interacting with each other through learning new knowledge (Collins, 2017:13; Kapoulitsas & Corcoran, 2015:98).

4.3.8.3 Sub-theme 8.3: Provide support

The participants emphasised that supervisors/managers should provide support to their supervisees in various ways but also that the social workers should support each other. The storylines below explain further.

"*There needs to be trust in the department…and I think recognition is good…we have the half (day off) every other Friday…but then it is also used as if you don't obey, remember that can be taken away…what sometimes irritates me is we are all mothers in our department and sometimes you're having emergencies at home and nobody remembers if she stayed or she went the extra mile. When I need to leave today and tomorrow to go see to my children…so recognition, support, is important for me…*" [Femada 402-411].

"*…sometimes I don't think that people actually realise that they are stuck there…and we then from the outside we are observing it as this woman has an attitude; this woman is lazy. Not realising that actually…this woman is fatigued and rightly, so let's support her...she is bringing her home issues to work…And now she is at work…we are very quick to judge, not knowing the realness of the situation…We tend to be very harsh towards them…inconsiderate, still demanding, still placing more demands on this person…so sometimes we just need to take a step back and be more understanding and accommodative and to actually listen and support this person*" [Femada 435-446].

Helen had similar suggestions: "*To say I have realised you have been through a time…then just ask everybody if are you okay and maybe suggest take some overtime off, I will be here until the end of the day if you need to take time off you know. So what I am saying is to be on the lookout for each other…Know what is happening in your colleagues' life and especially in the hospital setting to a certain extent, usually within our…consultation sessions we will know in which ward the tough doctor is working at the moment that likes to shout at the social workers or make unrealistic referrals…what the supervisor has done in the past with her*

colleague is okay I am going to work in this ward for a day or two…You take a breather and then to tell the doctor but that is not what we do to staff…be in touch with every social worker" [Helen 301-315].

"*You know here there is so much deaths and so much panicking because remember COVID, it brought lot of panicking…just let people go out and breathe, stay away and switch off from your work…I would also rotate the social workers…I will be like you have been working with (this) ward for quite some time. This month let's change; let somebody work in that ward and you work in this ward…because there are wards that we know that they drain a lot, like medical ward…there is (a) lot of dying. So move, don't be subjected to death at least; go and work with the babies…That is the strategies that I am using at least trying to alleviate this fatigue*" [Galeboe 284-295].

These findings are in agreement with the findings by Cournoyer (2017:41) who posits that support is important to deal with stress and it must come both from the families of social workers and from their working environment. In addition, the findings of research by Ostadhashemi et al., (2019:5) concur and assert that when social workers get adequate support from the people around them, it becomes easy for them to deal with compassion fatigue. In addition, Fronek et al., (2017:678) share the same sentiments and emphasise the importance of peer support in dealing with stress. In addition, various authors are in agreement stating that when social workers have supportive managers and supportive working environments, they become more resilient (Shokane, Makhubele & Blitz, 2018:223-224; Collins, 2017:13; Kapoulitsas & Corcoran, 2015:98).

4.3.8.4 Sub-theme 8.4: Provide more resources

The participants suggested that supervisors/managers should attend to providing more resources. This ranged from appointing more staff to improving salaries.

Cindi referred to appointing more staff, improving salaries and providing cars: *"…increasing staff can help…to have another social worker…I think maybe it can reduce fatigue...better salaries hey, because salary is a challenge…like you don't feel encouraged, you are working hard but you are getting peanuts then…And enough resources like maybe (a) dedicated car for social workers to go out for home visit or maybe petty cash for social workers to assist I think it can help*" [Cindi 244-253].

"*I think they should just come closer to social workers. Talk to us. Listen to our challenges and try to address them. If they feel like they don't know social work, why can't they motivate for an allied manager?...they just have to create a post for an allied manager post, who will*

have time to attend to us. These clinical managers they don't have time to attend us. As allieds, they don't have that. They are so fully booked…I don't blame them, they are hired as doctors. And they can do better in doctoring people not managing other people, other categories. I think the health department has to correct this mistake" [Boitumelo 209-217].

"*…we need more places which we can place patients that are in need. Patients that have no-one to take care of (them)…who don't have documents. If maybe perhaps we can have people who perhaps can start something somewhere because we have been engaging Department of Social Development and even the Department of Health they are aware of the challenge, but nothing is happening*" [Dudu 242-248].

The findings of the research study by Chibonore and Chikadzi (2017:11) confirm the above findings that unless there is the availability of resources, such as finances and materials to provide a good quality service, social workers are not able to provide proper services to their patients. The excerpt of a study by Pentaraki (2019:380) concurs and postulates that even though social workers are willing to help patients, it becomes difficult due to a shortage of resources. In addition, the findings of the study by Yi et al., (2018:676) resonates with the abovementioned and they postulate that in order to ameliorate the issue of the shortage of resources, employers can counteract by ensuring that more hospital social workers are hired to match the caseload, better pay is implemented and ensure a supportive workplace.

4.9 SUMMARY OF THE CHAPTER

This chapter gave an outline of the discoveries that emerged from the transcribed interviews of the twelve participants. The profiles of the participants were also covered together with the eight identified themes. All the themes had sub-themes and categories. The themes, sub-themes and categories were narrated, and supported or opposed by current literature. Theme one discussed the participants' reasons for choosing to work as a hospital social worker. Theme two presented participants' descriptions of their work as a hospital social worker and to whom they report. While theme three focused on participants' accounts of the daily challenges they face as a hospital social worker. Theme four covered hospital participants' explanations of what they understand to be compassion fatigue. Theme five delineated participants' accounts of what causes compassion fatigue. Theme six endowed participants' descriptions of how compassion fatigue affects them personally and professionally. Theme seven delineated participants' explanations of what they do to deal with compassion fatigue. The last theme presented what participants felt that supervisors/managers could do to assist social workers experiencing compassion fatigue.

After meticulous narration of the findings of the research, the next chapter will be the final chapter to summarise the research, and provide recommendations and conclusions for the research.

CHAPTER 5 SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

5.1 INTRODUCTION

The purpose of the study was to explore and gain an in-depth understanding of "the experiences of, and responses to, compassion fatigue among social workers employed in government hospitals". This chapter is curated to encapsulate all the chapters of this research study which include Chapter one (introduction), Chapter two (the literature review), Chapter three (research methodology), Chapter four (the findings of the research), and this chapter, Chapter five which includes: summary, conclusions, limitations, and recommendations together with suggestions for future research.

5.2 SUMMARY AND CONCLUSIONS

A summarised version of each chapter of this research report is presented below, inclusive of conclusions drawn per chapter. Limitations noticed and applicable to this research study will also be discussed. Finally, recommendations will be proffered with regard to social work practice, social work policy review and social work education. Suggestions for further and future research will be highlighted at the end of this research report.

5.2.1 Chapter one: General introduction

Chapter one outlined the general introduction, problem formulation, rationale for the study, and the theoretical framework for the research study.

The chapter outlined the background of social work practice and indicated that hospital social work is practiced in every country in the world. It was further discussed that social workers employed by hospitals, work in different wards of the hospitals such as medical wards, surgical wards, children's wards, and oncology wards. Part of the background of hospital social work practice is the fact that hospital social workers have a variety of roles to play in hospitals. The roles of hospital social workers include; providing counselling, helping patients understand the diseases they are diagnosed with so that they are able to live positively, and linking patients with outside support services. The researcher concludes that having a study background is important to provide a clear history of the subject matter.

The researcher discovered a gap in scientific knowledge, since quantitative and qualitative research studies done about compassion fatigue, were mainly focussed on health care professionals such as nurses. This further increased the researcher's curiosity to conduct the study about the experiences of, and responses to, compassion fatigue among social workers employed in government hospitals. In particular, no research could be found which was

conducted in Gauteng, South Africa in relation to how government hospital social workers experience and respond to compassion fatigue. Therefore, the researcher concludes that the motive to conduct a research study must not only be personal appetite or curiosity, but must be based on paucity of knowledge on a particular subject, so that the findings of a research study can add value in bridging a knowledge gap.

The problem formulation of this research study was also discussed. The problem formulation emanated from the fact that hospital social workers experience a lot of challenges when rendering services to their patients and there is lack of research done on this subject matter. Problem formulation is important and the researcher is of the view that an inability to formulate a research problem will cause a research study to lose direction.

The rationale for conducting this research study was in response to search results that confirmed that a large number of studies on compassion fatigue were conducted internationally and a noticeable lack of indigenous (South African) elements/ knowledge were noted. The international studies however, confirmed that hospital social workers experience compassion fatigue but these studies did not focus on how social workers respond to compassion fatigue. In addition, the researcher was concerned about the wellbeing of hospital social workers and intended to provide recommendations and suggestions in this research report as a significant contribution to how to effectively address compassion fatigue experienced by hospital social workers. The researcher therefore concluded that a rationale provides a logical sense why a particular research must be conducted. Therefore, without a rationale there is no reason why a research must be conducted.

The chapter also proffered resilience theory as the theory which the researcher used to contextualise the experiences of the participants. The theory made it easier for the researcher to understand that although social workers go through rough patches and do experience compassion fatigue, they do become resilient in order to protect their own wellbeing. The theory was used as a microscope to identify the abilities of hospital social workers to rise above the challenges of adversity. The researcher concluded that following a theoretical framework is important in research. Because the researcher is able to test previous theories with his research findings.

The chapter also described the research question which was, “What are the hospital social workers’ experiences of, and responses to, compassion fatigue whilst working in Gauteng government hospitals?” Having a research question played a vital role in ensuring that the researcher only stuck to the topic at hand. The researcher concluded that a research question

serves as a key and as a guideline throughout the process of the research and allowed the researcher to only concentrate on the research question.

The goal of this research study was: “To develop an in-depth understanding of hospital social workers’ experiences of, and responses to, compassion fatigue whilst working in Gauteng government hospitals”. The above goal was attained because the researcher managed to conduct the research and information from twelve hospital social workers was used to describe their experiences and responses to compassion fatigue (findings reported in chapter 4). In order to attain this goal, the following objectives were put together and achieved:

- To explore social workers’ experiences of, and responses to, compassion fatigue whilst working in government hospitals in Gauteng.
- To describe, as findings, government social workers’ experiences of, and responses to, compassion fatigue whilst working in government hospitals in Gauteng.
- To report the findings, draw conclusions, and make recommendations in relation to hospital social workers’ experiences of, and responses to, compassion fatigue whilst working in government hospitals in Gauteng.

Having a research goal and objectives ensured that the researcher remain focused on what he wanted to achieve in the research study. The researcher concluded that having a research goal and research objectives is critical in research and gives a researcher a meaningful purpose to conduct a study.

5.2.2 Chapter two: Literature review

Chapter two focused on the literature review and discussed in detail previous studies conducted by various researchers on compassion fatigue. A literature review is a collection of writings that contain information which critique a particular subject and it may consist of commonalities, differences and shortages of information on a subject matter (Thomas, 2017:320). The review presented an exposition of the history of hospital social work, an overall description of compassion fatigue compared to other terms including vicarious trauma and secondary traumatic stress, compassion satisfaction, causes of compassion fatigue, signs of compassion fatigue, roles of hospital social workers, challenges of hospital social workers, effects of compassion fatigue on personal and professional and how it affects service delivery, hospital social workers strategies to deal with compassion fatigue and lastly, the role of managers or supervisors in ameliorating compassion fatigue among hospital social workers.

The literature review also outlined the main roles of hospital social workers as assessing the needs of patients, providing counselling, discharge planning, supporting patients and their families, and helping patients understand or cope with the illnesses they are diagnosed with. It was further discussed that social workers in hospitals do not work in silos but work in collaboration with other professionals such as doctors, psychologists and nurses. They work in a multidisciplinary teams in order to provide holistic comprehensive services to their patients. In addition, the hospital setting is not their primary environment since it is a primary environment for health care practitioners like nurses and doctors. Social workers work in various wards such as oncology wards, paediatric wards, maternity wards, HIV wards and medical wards.

The concept of compassion fatigue was described as a phenomenon that results from working with patients who have undergone trauma. It was furthermore described as a result of using empathy towards patients. Compassion fatigue was further compared with compassion satisfaction, secondary traumatic disorder, vicarious trauma and burnout. Signs of compassion fatigue were also outlined.

Causes of compassion fatigue among hospital social workers, as stated by various literature, were summarised as being exposed to many ugly situations/ deaths, high caseloads where the focus is on quantity rather than quality, being exposed to emotional cases, a lack of resources, a lack of support, recognition and understanding social workers' roles, working with others with the same problems as their own, working with other people, burnout, use of empathy and a need to self-care and not taking work home.

The literature review explored the effects of compassion fatigue on social workers' personal, professional lives and service delivery. The personal effects of compassion fatigue included; hospital social workers becoming irritable/ angry/moody, feeling fearful/alert, feeling hopeless, tired, pessimistic or numb, having physical symptoms, their family being affected/taking work home, affecting sleep and feeling insecure and uncertain. While the professional effects were outlined as; empathy, energy or motivation diminishes, does not want to/cannot work, affects case evaluation, affects work relationships, inability to be compassionate and caring, affects sympathy and lack of attentiveness. In the review it was also discussed how compassion fatigue affects the quality of service delivery in a way that patients receive poor service.

The literature review further explored the strategies social workers employ to deal with compassion fatigue which were; usage of alcohol, taking time off/ gives time off, talking with/

debriefs/ educates colleagues, engaging in activities/hobbies and trips, self-care, being honest with self/ resilient, does extra things, does not take on others' problems/accept death, relies on faith/social worker training, relies on theory and supervision/consultation, has balance, has boundaries, caring for pets and sticks to ethics.

The literature review covered what managers or supervisors of hospital social workers who experience compassion fatigue can do to support social workers who are experiencing compassion fatigue. In which supervision/ debriefing sessions, provision of more resources, improving salaries, and focusing on education on compassion fatigue and creating a supportive environment were outlined as types of support management can offer to ameliorate the effects of compassion fatigue.

The overall conclusions of the researcher in relation to the literature review were as follows;

- The literature review served as an epiphany on understanding the concept of compassion fatigue and how it manifests.
- The review became a dawn of discovery and put the researcher closer to answering the research question. Since the research question was, "What are the hospital social workers' experiences of, and responses to, compassion fatigue whilst working in Gauteng government hospitals?''. The researcher was one step closer to answering this question because in the literature review the following were discovered; the experiences of hospital social workers working in government hospitals, their daily challenges, an overall review of compassion fatigue, the effects of compassion fatigue on the personal and professional lives of social workers and how it affects service delivery, strategies employed to deal with compassion fatigue and suggestions of how managers can assist hospital social workers dealing with compassion fatigue. Therefore, the researcher concluded that the experiences of hospital social workers employed in government hospitals relating to compassion fatigue in its entirety comprises of many challenges and consists of many negative experiences.
- In addition, the review put the researcher nearer to attaining the research goal which was: "To develop an in-depth understanding of hospital social workers' experiences of, and responses to, compassion fatigue whilst working in Gauteng government hospitals". Emanating from the review the researcher concluded that the experiences and responses of hospital social workers employed in government hospitals in relation to compassion fatigue were as follows; hospital social workers experience a lot of challenges, their proximity to traumatised patients makes them vulnerable to compassion fatigue, they experience lots of factors that lead to compassion fatigue,

compassion fatigue affects them personally and professionally and affects service delivery even though they have strategies to deal with it and lastly, managers or supervisors have a role to play to ameliorate the effects of compassion fatigue.

5.2.3 Chapter three: Research methodology

Chapter three provided a detailed overview of the application of the research methodology, sampling, research population, research design, how data was collected, research interview skills, data analysis, data verification and ethical principles that were employed for the research study.

The researcher chose and used a qualitative research approach to conduct the research. The use of qualitative research produced efficacious results.

The researcher's conclusions on the use of qualitative research are as follows:

- It helped the researcher to have a clear, comprehensive understanding of the experiences of participants.
- It assisted the researcher to understand the importance of collecting data in the everyday environment in which participants are employed. In addition, the researcher is of the view that it is critical to collect data from the daily environment of participants.
- It is necessary to use qualitative research when the topic is new or if there is paucity of knowledge on a subject.
- Since the researcher is the one who collected data, it made things easier.
- When a researcher wants to explore rich descriptions and experiences of study participants, a qualitative approach is the best approach, because the focus is on the quality of information rather than how many participants participated.

The sampling method used for this study was purposive sampling. By making use of purposive sampling, the researcher used his common sense to select only participants he felt shared attributes that would enable him to attain his research goal. The researcher therefore concluded that the use of purposive sampling made it easier for him to attain his research goal. Since he is the one who knows the rationale and purpose of the research, the fact that he selected the participants himself made it easier for him to only select participants that had attributes to help him achieve his research goal.

Chapter three also defined the study population. For the purpose of this study, the population referred to only hospital social workers employed in government hospitals. The researcher concluded that having a population provided guidance for the research study to only focus on

a certain people who shared similar characteristics and who were found in a particular environment. In addition, the researcher is of the view that without a target population, the researcher would have just interviewed whoever he came across even if those people did not have the necessary attributes that would enable the researcher to achieve his research goal.

The research design which the researcher followed was exploratory, descriptive, contextual and phenomenological.

The researcher used a phenomenological research design to identify the lived experiences and perceptions of hospital social workers. The researcher therefore concluded that a phenomenology research design was important because it enabled the participants to share their experiences as they saw them, not how the researcher see them.

A descriptive research design was of significance to the study because it helped the researcher to describe the phenomenon of compassion fatigue as experienced by hospital social workers. The researcher was of the view that a descriptive research design enabled him to narrate the experiences of the participants.

An exploratory design was utilised since little was known about the research topic. The researcher concluded that it was vital to use an exploratory design since the topic was new and there was paucity of knowledge regarding the topic.

The researcher also employed a contextual research design by studying participants in their context, namely hospitals. Therefore, the researcher concluded that it would yield good results studying participants close to their everyday environment because they could easily associate with and link their experiences within their context.

Pilot testing was done with two social workers to test the data collection tools and only one change was made as a result of the pilot test. The original intention was to do face-to-face interviews only and the option to do Microsoft Teams interviews to curb the spread of COVID-19 was added since the pilot study was conducted during the COVID -19 pandemic. The researcher concluded the following regarding pilot testing:

- It assists the researcher to trial if the questions are easily understood.
- It helps to identify gaps and challenges. In addition, it ensures that challenges are identified at an early stage and addressed.
- It set out an experiment to assess the readiness of the researcher to do the actual research.

- It serves as a trial to test if the recording device will suffice in recording the actual interviews. It ensures that the recording device is in good working condition and audible.

Before conducting the interviews, the ethics committee of the University of South Africa issued the researcher with approval to conduct the research. The researcher also observed all protocol to get approval from the gatekeepers. The gatekeepers were the NHRD (National Health Research Database), hospital CEOs, clinical managers and social work managers who granted permission to the researcher to gain access to the hospital social workers. As stated by Silverman (2020:493), a gatekeeper has the authority to allow or not allow a researcher to enter an environment where he can find research participants to interview for a research study.

Chapter three furthermore described ways in which the researcher prepared himself before the data collection process began. Therefore, the researcher concluded that preparation for data collection was necessary to:

- Ensured that participants were provided with all the necessary information and documents before the real interview. In addition, it prepared the participants for the actual interview since the questions were sent ahead of time. This not only prepared participants but ensured that participants provided well-detailed, all-inclusive experiences.
- Ensured that the researcher had a printed list of the questions. In addition, this increased researcher's confidence and ensured that the researcher knew the questions in hand. This in turn paved the way for the researcher to avoid mumbling when asking questions since this could have been viewed by participants as a sign of unpreparedness.
- Showed respect to participants because it allowed them to make their own choices in terms of the environment in which research was conducted, together with the time and date.
- Ensured that the recording device was working.
- Guaranteed that the researcher was presentable and looked professional. Preparation allowed the researcher to make sure that clean presentable clothing was available for the researcher when visiting participants for data collection.

This chapter also outlined the preferred method of data collection and how the researcher prepared for data collection. Therefore, the researcher concluded that it was important to prepare beforehand how the data would be collected. This helped in terms of avoiding making mistakes that could lead to panic. Participants also saw that the researcher took them and the study seriously.

This chapter also gave a full description of the steps which researcher employed to collect the data**.** The researcher used semi-structured interviews to collect data. Therefore, the researcher concluded the following regarding the process of data collection:

- Participants must give consent in writing and sign.
- Participants must be given a choice of their preferred method of data collection. Whether they prefer it to be conducted face-to-face in their offices or via online options. Meaning that it is important to discuss the data collection method with participants rather than imposing the researcher's wishes.
- The principle of confidentiality must be explained to participants to ensure that they are comfortable and free to fully share their experiences.
- During interviews, it is important to let participants decide whether they prefer the door of the interview room to be fully open, partially open or closed.
- It is necessary to ask permission from participants to record them and explain why they are being recorded. The researcher is of the view that failure to do so will raise suspicions among participants as to why the researcher is recording the interviews. In addition, researchers should explain to participants how the recordings will be kept safe.
- Although a tape recorder is used, it is also essential to write down notes. These notes will also assist the researcher to explore non-verbal cues since audio recorder cannot record body kinesics. In addition, for the researcher to avoid being distracted when making notes, only brief notes must be done.
- Participants must be given opportunity to ask questions.

The technique that was employed to gather data in this research study was semi-structured interviews. Semi-structured interviews entailed that participants were interviewed individually. These kinds of interviews also allowed the researcher to ask participants the same questions and allowed the researcher the flexibility to ask follow up questions. Based on the fact that semi-structured interviews were utilised, the researcher concluded that in order to have well-organised, formal interviews, semi-structured interviews were the perfect approach.

The researcher employed a number of research interview skills including building rapport, use of probing and minimal encouragers, asking follow up questions, paraphrasing, and observation of non-verbal behaviour, multi-tasking and listening.

Building rapport was two-fold. During the beginning of every interview to break the ice, the researcher ensured that participants felt free to share their experiences and built trust, and at the end of every interview when the researcher allowed participants to ask questions and make closing remarks. The researcher therefore concluded that if trust was developed in the beginning of the interviews, it paved the way for participants to relax and to get off to an excellent start. In addition, rapport assured the participants that the researcher cared about them and did not only see them as sources of information.

The researcher asked participants open-ended questions. The use of open-ended questions allowed participants to freely provide unique answers without being pressured to provide specific answers. The researcher therefore concluded that open-ended questions were important in making participants comfortable when providing answers and paved the way for participants to fully share their experiences without limits.

The use of probing and minimal encouragers ensured that the interviews flowed without the researcher disturbing the participants when they were talking. The researcher therefore concluded that the use of probing and minimal encouragers was essential to ensure that the researcher paid attention and allowed participants to talk freely without being disrupted in between the conversation.

The researcher used follow up questions to clarify when he did not fully understand what was shared. The researcher therefore concluded that probing was a skill that bridged the gap of misunderstanding during the research interviews. In addition, follow up questions ensured that participants broadened their answers.

The researcher used the interview skill of paraphrasing to confirm what was shared by the participants. The researcher therefore concluded that paraphrasing came in handy to summarise what was shared during the interviews. In addition, it was essential to ensure that the researcher perfectly understood what was shared.

The researcher not only listened to the participants' words but also observed their non-verbal behaviour. The researcher did this to create a link between what was said using words and the facial expressions, body movements and tone of participants' voices. The researcher therefore concluded that there were hidden messages that could be detected from the

participants' facial expressions, voices and body movements that could provide valuable information, therefore researchers must pay attention to non-verbal behaviour.

During the interviews, the researcher used multi-tasking to avoid disturbing participants while talking. The researcher was multi-tasking because when participants were talking he was listening, observing non-verbal behaviour and taking notes at the same time. The researcher therefore concluded that all researchers must have the ability to multitask in order to be able to listen to participants' words, silent gestures and write notes. When all these are combined, the researcher was able to collect valuable information.

The researcher, also used listening as a core skill during the interviewing process. The researcher therefore concluded that if listening is not done attentively, other interviewing skills become futile. Because it is through active listening that a researcher is to ask follow up questions, to seek clarity, to observe non-verbal behaviour and to summarise what was shared during the interviews.

Since the research was done during the COVID-19 era, all COVID 19-protocols to curb the spread of COVID-19 were adhered to. Data was collected until data saturation was reached. As stated by Gray (2018:765) data saturation is the stage in which a researcher stops collecting information due to the fact that no new information is coming from the participants. Bryman (2016:544) concurs and states that a repetition of information coming from participants without emergence of new information calls for a researcher to stop collecting data.

For data analysis, the researcher together with an independent coder, followed Tesch's eight steps in the coding process. For data verification, the researcher utilised Guba's model to ensure the validity and trustworthiness of the results. The approach that the researcher applied to prove that the outcomes of the research were trustworthy were credibility, transferability, dependability, and confirmability.

Credibility was applied to ensure that the results made sense but at the same time they were an accurate reflection of the real experiences of the participants. Therefore, the researcher concluded that it was important that the research findings could be tested to prove that the results were the true everyday lived circumstances of the participants and not of the researcher or other people.

The principle of transferability was applied to ensure that the results would make sense even if tested outside this research. The researcher therefore concluded that the research findings

must be reliable in a way that even if applied to a different study they would still produce similar results.

The principle of dependability was adhered to, since the results are a true reflection of the participants and nothing else. This means that even if the study were repeated with the same participants, similar outcomes would emerge. Therefore, the researcher concluded that the results must be a honest reflection of the participants and must not be altered to ensure that even if repeated it would produce similar findings.

The researcher ensured that the principle of confirmability was observed since the information collected from participants was validated by data from previous research. The researcher therefore concluded that work from previous researchers was used to verify the research findings in order to ensure that the results were honest.

The chapter also described the ethical considerations which the researcher observed for the study which were: informed consent, confidentiality, beneficence, privacy, anonymity, debriefing and management of information.

The researcher adhered to informed consent by ensuring that participants had all necessary information in writing before they decided to participate in the study. The researcher therefore concluded that adhering to informed consent was the first step in showing respect to participants during the research. In addition, it ensured that when participants decided to participate in the study, they were not lured by a researcher based on false incentives tabled before them.

The researcher complied with the principle of confidentiality by assuring all participants that the information shared would be kept private and if shared it would be done in a professional manner. Therefore, the researcher concluded that confidentiality was a requisite to ensure that the rights of participants were always protected.

The researcher obeyed the principle of beneficence when he ensured that participants were guarded against any harm and ensured that the research was done in the best interests of participants. The researcher therefore concluded that research participants must not only be seen as sources of information but every research study must have participants' best interests at heart.

The researcher also complied with the ethical principle of privacy by interviewing participants in a safe environment in which the proceedings of the interviews did not infringe on their basic right to privacy. The researcher therefore concluded that all researchers must adhere to the

principle of privacy with an understanding that privacy is one of the fundamental rights of human beings. In addition, respecting the privacy of participants was another form of showing respect.

Anonymity was ensured by the researcher when he decided to provide each participant with a fictitious name. The researcher did this to ensure that when reporting the findings of the research, no one could link the information shared with the participants. The researcher therefore concluded that the identity of participants must be protected at all times. The researcher furthermore concluded that when the researcher protected the identity of the participants, he laid the first stone for future researchers to be taken seriously by future participants. In addition, it ensured that it was easier for future participants to agree to participate in a study with the assurance that their identities would be guarded at all costs.

The researcher ensured that he complied with the principle of debriefing by having a social worker on standby in case the interviews awakened participants' emotions. The researcher therefore concluded that it was important for the researcher to ensure that research participants were left in a better psychological state when interview concluded.

The last ethical behaviour which the researcher adhered to was the manner in which the information was managed. The researcher ensured that the information provided by participants was kept in a secured environment at all times. The use of false names also ensured that even in unfortunate situations where the security of the storage might be breached, no one would be able to identify the participants. Therefore, the researcher concluded that information shared by participants must be protected at all cost. In addition, this must be done to honour the efforts taken by participants to share their valuable information to contribute towards ensuring that researchers were able to attain their research goals.

In conclusion, the abovementioned helped the researcher to meet the research objectives as outlined below by the researcher:

- Being able to draw a proper sample and select proper population which is social workers employed in Gauteng hospitals put the researcher nearer to attaining his objective because if the researcher didn't draw a proper sample, he was not going to achieve his objectives.
- The process of pilot testing was the first step of meeting the objectives. Because the pilot test provided the researcher clarity that the questions that were drafted are going to help the researcher to meet the objectives.

- The interview skills which the researcher employed, made it possible for the researcher to meet his objectives because they paved a way in which participants felt free to share their experiences which helped the researcher meeting his objectives.
- The process of data analysis which were done by the researcher and independent coder, helped the researcher meeting his objectives because they were able to identify themes that helped the researcher meeting his objectives of the research.
- Being able to follow ethics of research played a pivotal role in helping the researcher to attain his objectives because it guided the researcher by becoming professional in a way that it created conducive environment for participants to share their experiences which helped the researcher to attain his objectives.

5.2.4 Chapter four: Research findings

This chapter summarises the findings of the research study, “The experiences of, and responses to, compassion fatigue among social workers employed in government hospitals”, as presented in chapter four.

The findings of this study emanated from twelve participants who were employed as hospital social workers in different Gauteng government hospitals. The hospitals which they represent were: one regional hospital, three district hospitals and one central hospital. The social workers worked in various wards of the hospitals.

All social workers were females. The literature in chapter four confirmed that social work is a female dominated profession, not only in South Africa but globally. All of them had been working in a Gauteng government hospital for more than two years. Seven participants had been employed for only two years, one participant for four years and four participants had been employed for more than 16 years in a government hospital setting. Although there was a vast difference between the duration of being employed as hospital social workers, the extent to which they were affected by compassion fatigue was not influenced by how long they had been employed in a hospital setting. Therefore, the researcher concluded that compassion fatigue affected young and old social workers the same way.

Emanating from the findings, eight themes emerged namely: Social workers’ choice to work as a hospital social worker, their descriptions of their work as a hospital social worker and to whom they report, their accounts of the daily difficulties they come across, how they understand what compassion fatigue is, their understanding of the root causes of compassion fatigue, their explanation of how it affected them both their personal and professional lives, their description of things they do to deal with it and their suggestions for what

supervisors/managers can do to assist social workers experiencing compassion fatigue. The overall conclusion of the researcher regarding the identified themes in relation to the goal of the research is that it was apparent from the themes that hospital social workers go through a lot of challenges and one major challenge is compassion fatigue. In addition, from the identified themes, the researcher became aware of how hospital social workers respond to compassion fatigue.

All the themes consist of sub-themes and some sub-themes consist of categories which are summarised as follows:

5.2.4.1 Theme 1: Social workers' reasons for choosing to work as a hospital social worker

The first theme resulted from a question asked to participants about their reasons for choosing to work as a hospital social worker. In response to the question, the participants reported the following:

- Wanted to work in the medical field.
- For financial reasons.
- Enjoyed the work.

Researcher's conclusions:

- Based on the extracts of participants, the researcher arrived at the conclusion that not everyone who studied to become a social worker wanted to become a social worker. Some had a passion to help people while others studied social work as a second option if they failed to qualify to pursue another career path.
- In addition, the researcher concluded that choosing a career for becoming a social worker was not only determined by a passion for helping people, but other reasons, such as financial security.
- Taking into consideration that some participants' love for social work increased after being placed or exposed to a hospital environment. The researcher concluded that sometimes being exposed to a particular environment, might increase the chances of ending up enjoying working in that particular environment.

5.2.4.2 Theme 2: Social workers' descriptions of their work as a hospital social workers and to whom they report

This theme emerged from a description of participant's work and whom they report to. Below are descriptions of participants work and whom they report to:

Description of their work as hospital social workers;

- Works in a district hospital
- Works in various wards
- Works in a specific unit/ward

Descriptions of whom they report to;

- Reports to a social worker
- Reports to a non-social worker

Researcher's conclusion:

- Based on the accounts of social workers who report to non-social workers, the researcher concluded that those social workers did not receive the necessary support as compared to those who report to a social worker.

5.2.4.3 Theme 3: Social workers' accounts of the daily challenges they face as a hospital social worker

After being asked to outline the daily challenges they face as hospital social workers, the participants shared the following:

- High workload
- Lack of resources:
- Lack of support
- Other professions do not understand the social worker's role:
- Being pressurised to place patients elsewhere
- The death of patients:

Researcher's conclusions:

- Hospital social workers are faced with numerous challenges in their daily lives. In addition, the fact that all participants experienced and mentioned a shortage of resources, shows the solemnity of the problem.
- With regard to the challenge of other professions not understanding social workers' roles, the researcher concluded that social workers working in hospitals would always face this challenge since a hospital is not their primary environment. The researcher was also of the view that this challenge is inevitable; the only difference will be how they deal with it.

- The researcher also concluded that high workload is one of the major challenges which hospital social workers face.

5.2.4.4 Theme 4: Hospital social workers' explanations of what they understand to be compassion fatigue

When asked to explain their understanding of what compassion fatigue is, the participants articulated the following:

- Feeling overwhelmed by the work
- Being stressed or traumatised by the work. As stated by Todaro-Franceshi (2019:85) being subjected to working with patients who are emotionally wounded on a continuous bases causes compassion fatigue.
- Being tired
- Not doing enough for patients

Researcher's conclusions:

- Based on participant's extracts, the researcher concluded and defined compassion fatigue as a phenomenon whereby social workers are traumatised by the cases that they deal with, in which they end up feeling stressed and tired from the work that they do.

5.2.4.5 Theme 5: Hospital social workers' accounts of what causes compassion fatigue

In their response to the question of what causes compassion fatigue, the participants mentioned the following:

- Experiencing many disturbing situations and deaths.
- High caseloads where the focus is on quantity.
- Lack of support, recognition and understanding.
- Lack of resources.
- Working with clients with the same problems as their own.

Researcher's conclusions:

Emanating from the extracts of the participants, the researcher therefore arrived at four conclusions:

- Compassion fatigue can be caused by numerous factors.
- Losing patients through death causes compassion fatigue

- High caseload causes compassion fatigue. Furthermore, it is the perspective of the researcher that having to attend to a lot of patients in a short period of time does not do justice to patients because the focus woukd be on attending all the cases rather than doing quality work.
- Lack of support from management and colleagues causes compassion fatigue.

5.2.4.6 Theme 6: Hospital social workers' descriptions of how compassion fatigue affects them personally, professionally and in their service delivery

When asked about the effects of compassion fatigue on their personal and professional lives and how service delivery was affected, the participants delineated the following in-depth:

Personal effects

- Does not allow it to affect her
- Becomes irritable, angry or moody
- Feels fearful or alert
- Feels hopeless, tired, numb or worthless
- Has physical symptoms
- Family is affected or takes work home

Professional effects

- Empathy, energy or motivation is reduced and feels worthless
- Becomes irritable, angry or rude
- Cannot or does not want to work
- Questions self and/or profession

Service delivery effects

- All of the hospital social workers asserted that compassion fatigue affected their service delivery negatively. They gave less service, the quality was poorer, they were not so focused and they did not go the extra mile, to cite a few examples.

Researcher's conclusions:

Emanating from the extract of participants, the researcher came to the following eight conclusions:

- Not every social worker exposed to stress and trauma experiences compassion fatigue.

- Although compassion fatigue is caused by stress and traumatic cases at work, it also affects social workers' personal lives.
- Compassion fatigue affected the emotional being of social workers. It is the researcher's perspective that the major emotional effect of compassion fatigue was becoming angry, easily irritated, rude and moody.
- Social workers end up not adhering to the values of social work. They end up just working for the sake of working. Social workers end up being dishonest and, to an extent, faking being sick when they are fatigued.
- Compassion fatigue affects relationships between colleagues.
- Social workers change professions because of compassion fatigue.
- Compassion fatigue affects work performance.
- Compassion fatigue affects the quality of service being provided to patients. Patients who are attended by social workers who are fatigued receive poor service.

5.2.4.7 Theme 7: Social workers' explanations of what they do to deal with compassion fatigue

When requested to describe the strategies they employ to deal with compassion fatigue, the following were mentioned:

- Takes time off
- Talks to or debriefs with colleagues
- Participates in activities, hobbies or takes trips
- Self-care
- Does not take work home
- Does not take on others' problems
- Just does what they can or are expected to do
- Relies on faith or social work training

Researcher's conclusions:

- Although social workers cannot avoid compassion fatigue, there are plenty of strategies they can utilise to ameliorate the impact of compassion fatigue.
- Social workers should engage in self-care activities to deal with compassion fatigue. Self-care must include setting boundaries and being involved in a number of activities to enhance the wellbeing of social workers.
- Social workers must be able to draw boundaries between work and their personal lives.
- Peer support plays a vital role when dealing with compassion fatigue.

- Religion plays vital role when social workers go through difficult times.

The above-mentioned can be linked to resilience theory which underpin this study, because even during difficult times when people face adversities, they can still do better than what is expected by facing those difficulties (Van Breda, 2018:12).

5.2.4.8 Theme 8: Social workers' suggestions on what managers or supervisors can do to assist hospital social workers experiencing compassion fatigue

The last question asked participants to make suggestions on what supervisors and managers could do to support social workers experiencing compassion fatigue and they suggested the following:

- Compassion fatigue to be recognised and accepted as a reality
- Schedule supervision/debriefing sessions
- Undertake team building
- Provide support
- Provide more resources

Researchers' conclusions:

Based on the findings regarding suggestions, the researcher concluded that:

- Compassion fatigue must be recognised as a reality and a challenge that cannot be avoided by social workers.
- Supervision and debriefing sessions must always be in place. The approach must be active rather than proactive. Managers or supervisors should avoid acting only when there is a problem.
- Support from managers is important.
- More social workers must be employed to reduce the workload. In addition, tools of the trade/resources and better salaries must be prioritised.

The abovementioned themes were influential in providing the researcher with a proper foundation to be able to answer the research question, "*What are the experiences of, and responses to, compassion fatigue among social workers employed in government hospitals?"* In view of the themes, the researcher was able to identify that hospital social workers come across many challenges and compassion fatigue is one of them. In addition, the themes gave the researcher a clear picture of the ways in which hospital social workers deal with compassion fatigue. The findings of this research, as comprehensive as they are, are

remarkable and help to bridge the gap in making a contribution to the paucity of indigenous knowledge on compassion fatigue and how it affects hospital social workers.

In conclusion, the above research findings which were categorised in themes and subthemes made the researcher to attain his objectives because through the research findings the researcher was able to:

- Explore social workers' experiences of, and responses to, compassion fatigue whilst working in government hospitals in Gauteng.
- Describe hospital social workers' experiences of, and responses to, compassion fatigue whilst working in government hospitals in Gauteng.
- Report the findings, draw conclusions, and make recommendations in relation to hospital social workers' experiences of, and responses to, compassion fatigue whilst working in government hospitals in Gauteng.

5.3 LIMITATIONS OF THE STUDY

Although the findings of this study provided efficacious, interesting results, the results of this research study might contain a few elements of bias. As stated by Walliman (2016:231), "The unwanted distortion of the results of a survey due to parts of the population being more strongly represented than others". Therefore, the researcher acknowledges some limitations.

5.3.1 Limitation in relation to gender

Although the researcher anticipated having both males and females as participants in the study, he came across only females. As mentioned in Chapter 4: Gender of participants, there was a scarcity of males enrolling to become social workers thus impacting on the shortage of male social workers globally. Having only females participating in the study could bias the results towards one gender. Without the participation of male social workers, the findings cannot be generalised since the results might differ if male social workers had participated. In addition, taking into consideration the nature of the study on compassion fatigue which is related to stress and trauma one cannot ignore the multiple roles which women play in society at large which could also contribute to stressful situations.

5.3.2 Limitation in relation to geographical setting of the study

The researcher also acknowledges that South Africa as a country, consists of nine provinces and the study covered only one, which in addition is the key economic hub of the country. This might also contribute to biased results since a specific region or province can consist of common challenges unlike if compared to other provinces. The fact that Gauteng is the economic hub of the country means that there is an of influx of people to the province which

creates more pressure, even for social workers. Gauteng consists of five regions and the study only covered two regions. This could also lead to bias in the results. Should the study have covered all regions of the province, more detailed results could have been explored.

5.3.3 Limitation in relating to generalisation and number of participants

The sample of the study was small and covered only twelve participants, and the results were generalised from that lesser number of participants. As mentioned in Chapter 3: Sampling, the number of participants was determined by when the researcher reached data saturation. Twelve people is a lesser number to generalise results, taking into consideration the number of social workers employed in government hospitals. In addition, taking into consideration that there are thirty-three government hospitals in Gauteng and 340 government hospitals in the country as a whole (Department of Health Government notices, 2012).

5.3.4 Limitation in relation to number of hospitals

According to the Department of Health Government notices (2012:15) Gauteng consists of 33 government hospitals. However, this study only covered five hospitals in Gauteng. Taking into account the fact that only 5 out of 33 hospitals were covered, this can also lead to bias in the results. This limitation is also a result of the researcher having time and money constraints, since covering a large number of hospitals was have required more time and had further financial implications.

5.4 VALUE OF THE RESEARCH STUDY

Despite the limitations, this study has monumental contributions towards the paucity of literature on the experiences of hospital social workers in relation to compassion fatigue and how they respond or deal with it. It also contributes to a great extent to improving the lives of social workers by creating awareness on acknowledging compassion fatigue and having measures to ameliorate its impact. In addition, these research findings and recommendations have great value and potential for improving the service delivery offered to patients because being able to identify symptoms of compassion fatigue, hospital social workers will able to deal with it and, in turn, provide quality service to patients. The findings of this study are also applicable to social workers who are working in any other specialised environments in which they deal with cases of trauma, such as the police, military, municipalities, adoptions, foster care, domestic violence cases, and hospice. Finally, this research study sheds light on social work supervisors/managers' understanding of the impact of compassion fatigue on the personal and professional lives of social workers and provides recommendations for how they can help social workers who are faced with compassion fatigue to deal positively with compassion fatigue.

5.5 RECOMMENDATIONS

The researcher has some suggestions which have emanated from the research findings. As stated by Harding (2018:287) when researchers are done with their research process, they provide a proposal in the form of advice on what can be considered in the future when research is conducted in relation to what was discovered in previous research.

Below are recommendations for social work practice, policy review, education and further future research:

5.5.1 Recommendations for social work practice in hospital settings and social work profession in general.

With regard to strategies to deal with compassion fatigue it is recommended that:

- Social workers must always use a proactive approach to deal with compassion fatigue as compared to using a reactive approach. Meaning that, social workers must develop strategies in their lives to be able to identify the symptoms of compassion fatigue before it further develops into a crisis, so that they are able to ameliorate the effects of compassion fatigue and before it can lead to other major conditions. As stated by Edwards and Goussios (2021:248) it is important that practitioners must always have a plan in place to stop the signs of compassion fatigue from developing into a serious problem. Dziegielewski and Holliman (2020:322) concur and state that the moment social workers understand that although they assist patients with problems, the more they need to understand that they are still emotional beings like other people.
- Self-care must be regularly used as a tenet in social work and social workers must employ self-care activities to be able to deal with compassion fatigue. Failure to prioritise self-care may worsen the impact of compassion fatigue among hospital social workers. Self-care activities may be practised at work or outside work and may include; meditation, relaxation techniques, prayer, joining a gym, listening to music or using any preferred method of relaxation. As stated by Miller et al., (2017:880) self-care must be seen as compulsory exercise in the helping profession and might include activities such as being able to leave behind work activities at work and having enough proper rest when necessary. Figley (1995:140) concurs and posits that helping professionals should learn to separate between professional activities and personal activities, with an understanding that if boundaries are not set properly, work related stress can cause detrimental damage to the personal lives of professionals.
- Social workers must use peer support to deal with compassion fatigue. By using peer support, hospital social workers must ensure that any time they feel burdened they can

talk with their colleagues at work to be able to overcome the difficulties they are going through.

- Social workers must be able to identify factors that contribute to compassion fatigue and must ensure that they have methods in place at all times to deal with those factors. This can be done by means of self-awareness exercises that can be done individually in their own spaces whereby they are able to identify what will best work for them when they feel emotionally drained. In addition, since it is important to acknowledge the reality of compassion fatigue, it is also necessary to have methods in place to counteract it before it can affect the wellbeing of social workers.
- A decision to pursue a career in social work must be motivated by the love of helping people and not for financial security or other reasons. Because when people pursue a career in social work for the purpose of job security they tend to not care about their jobs or their patients and this in turn might make them more frustrated. In addition, people who pursue a social work career as a passion to help people might do better when faced with challenges since they strive to practice professionalism.

Recommendations pertaining to the role that social work supervisors and managers can play to support social workers who experience compassion fatigue in a hospital setting, are:

- Social work supervisors and social work managers must constantly acknowledge that compassion fatigue not only affects the professional aspects of social workers' lives but their personal lives as well. When a social worker's personal life is affected, it has a bad impact on the workplace as well. So, it is recommended that in hospitals, compassion fatigue must be acknowledged as having a detrimental effect on the lives of social workers. This can be achieved through regular consultations conducted in the workplace between supervisors and social workers. As delineated by Parker (2020:173) charity begins at home and social workers must deal with their personal challenges before they can assist patients to deal with their challenges.
- Social work supervisors and social work managers must provide social workers with enough support, since a lack of support might lead to compassion fatigue. Support must be done continuously in the workplace by means of having an open-door policy for supervision and they must treat each social workers' case as unique because social workers react differently to compassion fatigue. In addition, they must be mindful that not every social worker who is exposed to stress and trauma experiences compassion fatigue.

- Compassion fatigue is endemic in hospital social work practice. Therefore, it must be acknowledged and recognised at all times as a reality that social workers cannot avoid. In addition, managers must understand that compassion fatigue leads to poor service that is delivered to patients. Various authors support this view and assert that social workers who experience compassion fatigue, end up providing poor service to their patients (Cuartero & Campos-Vidal, 2019:286; Xu et al., 2019:20). Social work supervisors and managers must, through workplace supervision, have tools in place to be able to identify when their employees are showing signs of compassion fatigue.
- Supervision and debriefing sessions must be conducted by social work supervisors and managers to ameliorate the effects of compassion fatigue. The approach must be proactive rather than reactive. In other words, there must be a supervision schedule, because if supervision is only done when there is a crisis, it might harm the wellbeing of social workers since they might already have developed severe symptoms of compassion fatigue because it is identified late. Supervision can be done individually or in a group setting. Supervision can also be done outside the working environment and conducted in the form of a seminar or team building exercises in a neutral leisure environment.
- Social work supervisors and managers must regularly organise more training and workshops to educate social workers about compassion fatigue and enhance the resilience of social workers. When educating social workers about compassion fatigue it is important that they are also taught about resilience (Masson 2019:71; Yi et al., 2018:678). It is also recommended that training and workshops are done outside the working environment because the environment in which they work might trigger stress.
- Social work supervisors and managers must advocate for the recruitment of more social workers. Social work supervisors and managers must conduct frequent needs assessments during supervision sessions or through monthly reports to compare if there is a fair patient/social work ratio to be able to identify if their employees are overworked or not. Because a lack of social workers leads to high workloads and brings a lot of impediments. Hiring enough social workers to match the influx of patients will reduce the workload, eliminating working under pressure and therefore reduce the risk of social workers being susceptible to the negative effects of compassion fatigue (Xu et al., 2019:20).
- Social work supervisors and managers must advocate for better salaries. Striving to advocate for better salaries must done annually in accordance with the inflation rate. In addition, they must represent their employees by ensuring that proper rationality is

provided to management or unions to justify the importance of social workers having adequate resources so that enough resources are made available. As postulated by Chibonore and Chikadzi (2017:11) when social workers are employed within environments that have a shortage of resources, they become demoralised.

5.5.2 Recommendation for policy review

Based on whom the hospital social workers report to, the following is recommended:

- Department of Health must review its human resources policy on recruitment of social work supervisors and social work managers. It is recommended that all hospital social workers must report to social work supervisors who are registered as social workers with SACSSP. The Department of Health must ensure that every time a social worker is hired there is a senior social worker to supervise him/her. Reviewing recruitment policy for hiring social work supervisors/managers will provide the Department of Health with an opportunity to comply with the supervision framework for the social work profession of South Africa (2012:18) that all social workers must be managed by registered social workers. In addition, it is essential for all social workers to be supervised by someone who knows the in's and out's of social work and knows exactly what social workers are going through. Failure to ensure that social workers are placed under the supervision of registered social work supervisors/manager deprives them an opportunity for learning and to get proper support. In addition, one of the major functions of social work supervision is education to promote the growth of knowledge of social workers. Therefore, social workers who are supervised by non-social workers will experience challenges in relation to their professional growth. As Engelbrecht (2015:325) states, a person who is equal to the task of being a social work supervisor or manager must be someone who has social work background.

5.5.3 Recommendation in relation to gender equity

- The Department of Justice, the Department of Labour, SACSSP and the Commission of Gender Equity must monitor the recruitment of social workers to ensure that there is a gender balance. The Commission of Gender Equity must ensure that it is persistent in educating the community that there is no single career that is determined by gender. This must be done to avoid the dominance of female social workers.

5.5.4 Recommendation of education system

- Higher learning institutions that teach social work must introduce a module on understanding compassion fatigue. This module must be introduced at the foundation

phase of the social work curriculum to ensure that social work students understand that compassion fatigue is one of the realities of social work practice. This must be done as part of creating awareness on the importance of self-care in social work to empower social workers with the abilities and strategies to overcome compassion fatigue.

- Male social workers must be encouraged to study social work. The Department of Social Development, in collaboration with the Department of Education must ensure that there are available bursaries at all times to prioritise male social workers and to encourage them to study social work. The Department of Social Development, the Department of Education and SACSSP must regularly conduct awareness programmes in high schools to conscientize boys to study social work.

5.5.5 Recommendations for further and future research

In view that there are hardly any studies done on compassion fatigue among government hospital social workers, it is recommended that similar studies be done focusing on the following:

- Based on the fact that this study focused only on social workers employed by government hospitals it is recommended that further similar studies be done with social workers employed in private clinics and hospitals.
- Further, future studies can also explore whether the duration of being a hospital social worker affects how social workers deal with compassion fatigue.
- Since compassion fatigue consists of undesirable emotions resulting from working with traumatised patients and which makes social workers vulnerable to secondary traumatisation it is therefore recommended that a study must be conducted to analyse how social work supervisors or managers, by virtue of them debriefing social workers, are affected by compassion fatigue.
- This kind of research can be extended to other specialised social work environments and the findings can be compared with this study so as to optimally address compassion fatigue.

5.5.6 Recommendations in addressing the limitations identified in this research study

- Provided the fact that only females participated in the study it is recommended that further studies are conducted that include male participants. Separate studies must be conducted with male government hospital social workers and another separate study with the private sector to verify the results.

- In view of the fact that the study only covered Gauteng, it is recommended that other studies be conducted in other provinces to cover a wider population. This will provide an opportunity to include more social workers to share their different experiences. In addition, their experiences will be analysed to verify if they are geographical or common in hospital social work.

5.6 CONCLUSION OF THE CHAPTER

This chapter provided summaries and conclusions for each chapter of the research report. Recommendations proffered in this chapter were based on the research findings and conclusions made in support of answering the overall research question (“What are the hospital social workers’ experiences of, and responses to, compassion fatigue whilst working in Gauteng government hospitals?”) and achieving the research goal (“To develop an in-depth understanding of hospital social workers’ experiences of, and responses to, compassion fatigue whilst working in Gauteng government hospitals ").

In closing, the researcher is of the opinion that the research study achieved what was initially set out which was, “To develop an in-depth understanding of hospital social workers’ experiences of, and responses to, compassion fatigue whilst working in Gauteng government hospitals and promoting”.

BIBLIOGRAPHY

Ab, P.H. 2004. Individualization and prevention: Richard C. Cabot and early medical social work. *Social work in mental health*, *2*(2-3), pp.7-20.

Abukar, I. & Wedin, C. 2016. Male social workers experiences of gender bias. A study of gender biases within the social service in Gävle. BA Degree Thesis, University of Gavle, Sweden.

Ainsworth, K. & Sgorbini, M. 2010. Compassion fatigue: Who cares for the carers? *Transplant Journal of Australia,* 19(2):21-25*.*

Albrithen, A. & Yalli, N. 2016. Social workers: Peer interaction and hospital integration*. International Social Work*, 59 (1):129–140.

Aléx, L. 2010. Resilience among very old men and women. *Journal of Research in Nursing*, *15*(5), pp.419-431.

Anderson, E.E. & Corneli, A. 2018. *100 questions (and answers) about research ethics.* Volume 5. Thousand Oaks, CA: Sage.

Armes, S.E., Lee, J.J., Bride, B.E. & Seponski, D.M. 2020. Secondary trauma and impairment in clinical social workers*. Child Abuse & Neglect*, 10:104540.

Babbie, E. 2021. *The practice of social research*. 15th edition. Boston, MA: Cengage Learning.

Barbour, R.S. 2014. *Introducing qualitative research. A student's guide*. 2nd edition. Britain: Sage.

Barmawi, M.A., Subih, M., Salameh,O., Sayyah, N.S.Y., Shoqirat, N. & Jebbeh,R.A.E.A. 2019. Coping strategies as moderating factors to compassion fatigue among critical care*. Brain and Behaviour*, 9 (4): 01264.

Baum, N. 2016. The unheard gender: The neglect of men as social work clients. *British Journal of Social Work,* 46:1463–1471.

Beder, J.C. 2012. Social Work in the Department of Defence hospital: Impact of the work. *Advances in Social Work,* 13(1):132-148.

Bernard, H.R. 2013. *Social research methods: Qualitative and quantitative approaches*. 2nd edition. USA: Sage.

Berzoff, J., Kitsen, J., Klingensmith, J. & Cohen, L.M. 2020. Advance care planning training for renal social workers. *Journal of Social Work in End-of-Life & Palliative Care*, *16*(1), pp.5-18.

Birt, L., Scott, S., Cavers, D., Campbell, C. & Walter, F. 2016. Member checking: a tool to enhance trustworthiness or merely a nod to validation? *Qualitative health research*, *26*(13), pp.1802-1811.

Blaikie, N. & Priest, J. 2019. *Designing social research*. 3rd edition. Cambridge, UK: Polity Press.

Bolton, K.W., Praetorius, R.T. & Smith-Osborne, A. 2016. Resilience protective factors in an older adult population: A qualitative interpretive meta-synthesis. *Social Work Research*, *40*(3), pp.171-182.

Brill, M. & Nahmani, N. 2017. The presence of compassion in therapy. *Clinical Social work Journal,* 45(1):10-21.

Brown, J.L.C., Ong, J., Mathers, J. & Decker, J. 2017. Compassion fatigue and mindfulness: Comparing mental health professionals and MSW student interns*. Journal of Evidence-Informed Social Work,*14 (3):119-130.

Bryman, A. 2012. *Social research methods*. 4th edition. New York, NY: Oxford University Press.

Bryman, A. 2016. *Social research methods: International edition*. Oxford, United Kingdom: Oxford University Press.

Bukuluki, P., Hojer, S. & Jansson, B. 2019. Motives and career choices among Ugandan social work students. *European Journal of Social Work, 22(4):712–724*.

Calitz, T., Roux, A. & Strydom, H. 2014. Factors that affect social workers' job satisfaction, stress and burnout. *Social Work/ Maatskaplike Werk*, 50 (2); issue 1.

Campbell, A., Taylor, B.J. & McGlade, A. 2017. *Research design in social work: Qualitative and quantitative methods.* London; Thousand Oaks, CA: Sage.

Carey, M. 2012. Qualitative research skills for social work: Theory and practice. England: Ashgate Publishing.

Cavanagh, N., Cockett,G., Heinrich ,C., Doig, L., Fiest, K., Guichon, J., Page, S., Mitchell, I. & Doig, C.J. 2020. Compassion fatigue in healthcare providers: A systematic review and meta-analysis*. Nursing Ethics*, 27 (3): 639-665.

Chan, Z.C., Fung, Y.L. & Chien, W.T. 2013. Bracketing in phenomenology: Only undertaken in the data collection and analysis process. *The qualitative report*, *18*(30), pp.1-9.

Cherny, N.I., Fallon, M.T., Kaasa, S., Portenoy, R.K. & Currow, D.C. 2018. *Impact of compassion fatigue: Oxford textbook of palliative medicine.* 5th edition. UK: Oxford University Press.

Chibonore, W. & Chikadzi, V. 2017*.* Enablers and barriers faced by social workers in undertaking advocacy in Johannesburg, South Africa*. Southern African Journal of Social Work and Social Development,* 29 (2).

Cleak, H.M. & Turczynski, M. 2014. Hospital social work in Australia: Emerging trends or more of the same? *Social Work in Health Care,* 53(3): 199-213.

Cleveland, M., Warhurts, A. & Legood, A. 2019*.* Experiencing resilience through the eyes of early career social workers. *British Journal of Social Work*, 49:1434–1451.

Coles, T.B. 2017. Compassion fatigue and burnout: History, definitions and assessment. *Veterinarian's Money Digest,* 1(4):10-15.

Collins, S. 2017. Social workers and resilience revisited. *Practice*, *29*(2), pp.85-105.

Corbin, J. & Strauss, A.2015. Basics of qualitative research. Techniques and procedures for developing grounded theory. 4th edition. USA: Sage.

Cordoba, S. 2022. Scope of social work practice: Hospitals. *Australian association of social workers.*

Cournoyer, B.C. 2017. *The social work skills workbook*. 8th edition. Boston, MA: Cengage Learning.

Crabtree, S.A. & Parker, J. 2014. Being male in female spaces: Perceptions of masculinity amongst male social work students on a qualifying course. *Social Work Review*,13(4).

Craig, C.D. & Sprang, G. 2010. Compassion satisfaction, compassion fatigue, and burnout in a national sample of trauma treatment therapists. *Anxiety Stress & Coping,* 23(3): 319-339.

Creswell, J.W. 2013. *Qualitative inquiry & research design: Choosing among five approaches*. 3rd edition. Thousand Oaks, California: SAGE Publication.

Creswell, J.W. 2014. Research design: Qualitative, quantitative & mixed methods approaches. 4th edition. United Kingdom: Sage.

Creswell, J.W. & Creswell, J.D. 2018 . *Research design: Qualitative, quantitative and mixed methods approaches*. 5th Edition. Thousand Oaks, CA; London: Sage.

Creswell, J.W. & Poth, C.N. 2018. Qualitative inquiry and research design. Choosing among five approaches. 4th edition. UK: Sage.

Cuartero, M.E. & Campos-Vidal, J.F. 2019. Self-care behaviours and their relationship with satisfaction and compassion fatigue levels among social workers. *Social Work in Health Care*, 58 (3): 274-290.

Cummings, C., Singer, J., Hisaka, R. & Benuto, L.T. 2021. Compassion satisfaction to combat work-related burnout, vicarious trauma, and secondary traumatic stress. *Journal of Interpersonal Violence, 36:9-10*.

Curtin, M. & Fossey, E. 2007. Appraising the trustworthiness of qualitative studies: Guidelines for occupational therapists. *Australian occupational therapy journal*, *54*(2), pp.88-94.

Daphna-Tekoah, S. 2021. On the front line: Narratives of social workers at hospitals. *Qualitative Psychology*, 8, (2): 244–254.

Denne, E., Stevenson, M. & Petty, T. 2019. Understanding how social worker compassion fatigue and years of experience shape custodial decisions*. Child Abuse& Neglect,* 95.

De Vaus, D.A. 2013. *Research design in social research*. London: Thousand Oaks, CA: Sage.

Doel, M. 2012. *Social work: The basics.* Abingdon, Oxon; New York, NY: Routledge.

Doka, K.J. 1989. *Disenfranchised grief: Recognizing hidden sorrow*. Massachusetts/Toronto. Canada: Lexington books.

Dubois, A.L. & Mistretta, M.A. 2020. Overcoming burnout and compassion fatigue in schools: A guide for counsellors, administrators, and educators. New York, NY: Routledge, Taylor & Francis Group.

Durand, M.A. & Chantler, T. 2014. *Principles of social research. Understanding public health.* 2nd edition. Berkshire, England: Open University Press.

Dziegielewski, S.F. & Holliman, D.C. 2020. *The changing face of health care social work: Opportunities and challenges for professional practice.* 4th edition. New York, NY: Springer Publishing Company, LLC.

Edwards, K. & Goussios, A. 2021. Who is responsible for compassion satisfaction? Shifting ethical responsibility for compassion fatigue from the individual to the ecological. *Ethics and Social Welfare*, 15, (3): 246-262.

Efron, S.E. & Ravid, R. 2019. *Writing literature review: A practical guide*. New York, NY: The Guilford Press.

Ehfad, B. 2020. Job stress and compassion fatigue among mental health professionals: How can psychological detachment from work during non-work hours help? Dissertation presented on the faculty of the California School of Professional Psychology. DPhil Thesis. Alliant International University, Los Angeles.

Engelbrecht, L. 2015. Revisiting the esoteric question: Can non-social workers manage and supervise social workers? *Social Work/Maatskaplike Werk*, 51 (3): Issue 1.

Engler-Gross, A., Goldzweig, G., Hasson-Ohayon, I., Laor-Maayany, R. & Braun, M. 2019. Grief over patients, compassion fatigue, and the role of social acknowledgment among psycho-oncologists*. Psycho Oncology*, 29:493-499.

Faulkner, S.S. & Faulkner, C.A. 2019. *Research methods for social workers: A practice-based approach.* 3rd edition. New York, NY: Oxford University Press.

Feist, J. & Feist, G.J. 2008. *Theories of personality*. 7th edition. New York, NY: McGraw-Hill Higher education.

Figley, C.R. 1995. Compassion fatigue. Coping with secondary traumatic stress disorder in those who treat the traumatized. New York, NY: Brunner/Mazel Publishers.

Figley, C.R. & Ludick, M. 2017. Secondary Traumatization and compassion fatigue. *APA Handbook of trauma psychology,* 1.

Flick, U. 2018. *An introduction to qualitative research*. 6th edition. Los Angeles: Sage.

Flynn, C. & McDermott, F. 2016. Doing research in social work and social care: The journey from student to practitioner researcher. London: Sage.

Fox, M. 2019. Compassion fatigue and vicarious trauma in everyday hospital social work: A personal narrative of practitioner-researcher identity transition. *Social Sciences,* 8 (313): 1-9.

Fox, M., McIlveen, J. & Murphy, E. 2021. Death, dying and bereavement care during COVID-19: Creativity in hospital social work practice. *Qualitative Social Work*, *20*(1-2), pp.131-137.

Frankfort-Nachmias, C., Nachmias, D. & DeWaard, J. 2015. *Research methods in the social sciences.* 8th edition. New York, NY: Worth Publishers, a Macmillan Education Company.

Fronek, P., Briggs, L., Kim, M.H., Han, H.B., Val, Q., Kim, S. & McAuliffe, D. 2017. Moral distress as experienced by hospital social workers in South Korea and Australia. *Social Work in Health Care,* 56 (8): 667-685.

Galley, D.2020. Social Work is women's work, right?" Amplifying the voices of male social work students entering into a female majority occupation: applying qualitative methods. DPhil thesis, Bournemouth University, England.

Gaudet, S. & Robert, D. 2018. A journey through qualitative research: From design to reporting. Los Angeles: Sage.

Gehlert, S. 2019. The conceptual underpinnings of social work in health care. *Handbook of health social work*, pp.1-19.

Gehlert, S. & Browne, T. 2012. *Handbook of health social work*. 2nd edition. USA: John Wiley & Sons.

Giles, R. 2016. Social workers' perceptions of multi-disciplinary teamwork: A case study of health social workers at a major regional hospital in New Zealand. *Aotearoa New Zealand Social Work*, 28(1):25-33.

Giri, A. & Biswas, D. 2019. *Research methodology for social sciences*. New Delhi ,India: SAGE Publications India Pvt Ltd

Gournelos, T., Hammonds, J.R. & Wilson, M.A. 2019. *Doing academic research: A practical guide to research methods and analysis.* Milton Park, Abingdon, Oxon; New York, NY: Routledge, Taylor & Francis Group.

Grant, C. & Osanloo, A. 2014. Understanding, selecting and integrating a theoretical framework in dissertation research: Creating the blueprint for your "house". *Administrative Issues Journal: Connecting Education, Practice, and Research*, 4(2):12-26.

Grant, L. & Kinman, G 2014. *Developing resilience for social work practice.* 1st edition. Red Globe Press: England,UK.

Gray, D.E. 2014. *Doing research in the real world*. 2nd edition. London: SAGE.

Gray, D.E. 2018. *Doing research in the real world*. 4th edition. London; Thousands Oaks, CA: Sage.

Gunderman, R. 2018. Medical social workers are essential, but underappreciated. *Pacific Standard*, 6 July. Available: https://psmag.com/social-justice/more-support-for-medical-social-workers (Accessed: 6 July 2019).

Hammond, M. & Wellington, J. 2013. *Research methods: The key concepts.* London; New York, NY: Routledge.

Hansen, E.M., Eklund, J.H., Hallen, A., Bjurhager, C,S., Norrstrom, E., Viman, A. & Stocks, E.L. 2018. Does feeling empathy lead to compassion fatigue or compassion satisfaction? The role of time perspective*. The Journal of Psychology,*152 (8):630-645.

Harding, J. 2018. *Qualitative data analysis: From start to finish*. 2nd edition. Los Angeles: Sage.

Harslof, I., Nielsen, U.S. & Feiring, M. 2017. Danish and Norwegian hospital social workers' cross-institutional work amidst inter-sectoral restructuring of health and social welfare. *European Journal of Social Work,* 20(4):*584-595*.

Harvey, E. & Jones, M. 2022. Using complex adaptive systems theory to understand the complexities of hospital social work practice in rural and remote South Australia. *The British Journal of Social Work*, *52*(5), pp.2669-2688.

Hassan, S.M. 2016. Medical social work: Connotation, challenges and prospects. *Pakistan Journal of Social Sciences,* 36(1):495-504*.*

Heenan, D. & Birrell, D. 2019. Hospital-based social work: Challenges at the interface between health and social care. *British Journal of Social Work,* 49:1741–1758.

Hempel, S. 2020. Conducting your literature review: Concise guides to conducting behavioural, health, and social science research. Washington, DC: American Psychological Association.

Hunt, P., Danieffe, S. & Gooney, M. 2019. Running on empathy: Relationship of empathy to compassion satisfaction and compassion fatigue in cancer healthcare professionals. *European Journal of Cancer care,* 28, no. 5.

Imes, R.S., Omilion-Hodges, L.M. & Hester, D.B. 2021. Communication and care coordination for the palliative care team. A handbook for building and maintaining optimal teams. New York, NY: Springer Publishing Company.

International Federation of Social Work (IFSW). 2014. Definition of Social Work. [Online]. Available: http://ifsw.org/policies/defition-of-social-work/ (Accessed: 10 February 2020).

Jensen, E.A. & Laurie, C. 2016. *Doing real research: A practical guide to social research*. Los Angeles: Sage.

Kaplan, D.B & Berkman, B. 2016. *Oxford handbook of social work in health and aging*. 2nd edition. Oxford; New York, NY: Oxford University Press.

Kapoulitsas, M. & Corcoran, T. 2015. Compassion fatigue and resilience: Qualitative analysis of social work practice. *Qualitative Social Work: Research and Practice,* 14(1):86-101.

Kent, M., Davis, M.C. & Reich, J.W. 2014. *The resilience handbook. Approaches to stress and trauma*. New York, NY: Routledge, Taylor & Francis.

Kheswa, J.G. 2019. Factors and effects of work-related stress and burnout on the well-being of social workers in the Eastern Cape province, South Africa*. SA Journal of Industrial Psychology/SA Tydskrif vir BedryFsielkunde,* 45(1):1-10.

Kinman, G. & Grant,L. 2020. Emotional demands, compassion and mental health in social workers. *Occupational Medicine,* 70(2):89-94.

Kinsey. 2010. *Cavendish's encyclopaedia of health.* Tarrytown, New York, NY: Kinsey Square

Klenke, K. 2016. *Qualitative research in the study of leadership*. 2nd edition. UK: Emerald Group Publishing Limited.

Kohli, D. & Padmakumari, P. 2020. Self-care, burnout, and compassion fatigue in oncology professionals. *Indian Journal of Occupational and Environmental Medicine*, 24(3):168.

Kothari, C.R. & Garg, G. 2019. *Research methodology. Methods and techniques*. 4th multi-colour edition. New Delhi, India: New Age International Publishers.

Krathwohl, D.R. 2009. *Methods of educational and social science research: The logic of methods*. 3rd edition. Long Grove, IL: Waveland Press.

Krefting, L. 1990. Rigor in qualitative research: The assessment of trustworthiness. *American Journal of Occupational Therapy*, 45:214-222.

Kreitzer, L., Brintnell, S.E. & Austin, W. 2020. Institutional barriers to healthy workplace environments: From the voices of social workers experiencing compassion fatigue. *British Journal of Social Work*, 50 (7):1942-1960.

Kumar, R. 2014. *Research methodology: A step-by-step guide for beginners*. 4th edition. Los Angeles, CA: Sage.

Kumar, R. 2019. *Research methodology: A step-by-step guide for beginners*. 5th edition. London: Sage.

Kurevakwesu, W. 2021. COVID-19 and mental health services delivery at Ingutsheni Central Hospital in Zimbabwe: Lessons for psychiatric social work practice. *International Social Work*, *64*(5), pp.702-715.

Lahman, M.K.E. 2018. *Ethics in social science research: Becoming culturally responsiv*e. Thousand Oaks, CA: Sage.

Lee, E., Daugherty, J., Eskierka, K. & Hamelin, K. 2018. Compassion fatigue and burnout, One institution's interventions. *Journal of PeriAnesthesia Nursing,* 34(4):767-773.

Leedy, P.D. & Ormrod, J.E. 2015. *Practical research: Planning and design*. 11th edition. England: Pearson Education Limited.

Leedy, P.D. & Ormrod, J.E. 2019. *Practical research: Planning and design*. 12th edition. New York, NY: Pearson.

Lewis, M.L. & King, D.M .2019.Teaching self-care: The utilization of self-care in social work practicum to prevent compassion fatigue, burnout, and vicarious trauma. *Journal of Human Behaviour in the Social Environment*, 29, (1): 96-106.

Limon, E. 2018. *Challenges medical social workers face that lead to burnout.* Master of social work, California State University, San Bernardino.

Lune, H. & Berg, B.L. 2017. *Qualitative research methods for the social sciences.* 9th edition. Harlow, England: Pearson.

Maja, B.K. 2016. Exploring palliative caregivers' experience of compassion fatigue in a hospice. MA dissertation, University of South Africa, Pretoria.

Manning, J. 2022. Hospital palliative social worker's reflection of working during the pandemic. *Journal of Social Work in End-of-Life & Palliative Care*, *18*(4), pp.298-301.

Mantell, A. 2013. *Skills for social work practice*. 2nd edition. London: Learning Matters.

Maree, K. & Van der Westhuizen, C. 2009. *Head start in designing research proposals in the social sciences*. Lansdowne, Cape Town: Juta.

Maree, K. 2016. *First steps in research.* 2nd edition. Pretoria: Van Schaik.

Masson, F. 2019. Enhancing resilience as a self-care strategy in professionals who are vicariously exposed to trauma: A case study of social workers employed by the South African Police Service. *Journal of Human Behavior in the Social Environment,* 29 (1):57–75.

Matsea, T.C. 2017. Strategies to destigmatize mental illness in South Africa: Social work perspective. *Social Work in Health Care* ,56 (5):367-380.

Matthews, B. & Ross, L. 2010. *Research methods: A practical guide for the social sciences*. New York, NY: Pearson Longman.

Mcmahon, M.F. 2021. Say goodbye to compassion fatigue and hello to resilience. *Journal of Trauma Nursing,* 28 (1):1-2*.*

McMillan, K. & Weyers, J. 2014. *How to complete a successful research project*. UK: Pearson Education Limited.

Merriam, S.B. & Tisdell, E.J .2016. *Qualitative research: A guide to design and implementation.* 4th edition. San Francisco, CA: Jossey-Bass & Pfeiffer Imprints, Wiley.

Merriam, S.B. & Grenier, R.S. 2019. *Qualitative research in practice: Examples for discussion and analysis*. 2nd edition. San Francisco, CA : Jossey-bass Publisher.

Miles, M.B., Huberman, A.M. & Saldana, J. 2014. *Qualitative data analysis: A methods sourcebook.* 3rd edition. Thousand Oaks, CA: SAGE Publications, Inc.

Miller, J.J., Lianekhammy, J., Pope, N., Lee, J. & Grise-Owens, E. 2017. Self-care among healthcare social workers: An exploratory study. *Social Work in Health Care,* 56 (10):865-883.

Moon, F., Fraser, L. & Mcdermont , F. 2019. Sitting with silence: Hospital social work interventions for dying patients and their families. *Social Work in Health Care,* 58(5) :444-458.

Mwansa, L.K.J. & Kreitzer, L. 2012. *The SAGE handbook of international social work: Social work in Africa*. London: Sage.

Ostadhashemi, L., Arshi, M., Khalvati, M., Eghlima, M. & Khankeh, H.R. 2019. Social workers' resilience: Preventing burnout and compassion fatigue in pediatric oncology. *International Journal of Cancer Management,* 12(7).

Parker, J. 2020. *Introducing social work*. London: Learning Matters, an imprint of Sage.

Parveen, S. 2017. *Social work in health care*. Delhi, India: Bharati, Prakashan.

Patten, M.L. & Newhart, M. 2018. *Understanding research methods: An overview of the essentials.* 10th edition. New York, NY: Routledge.

Pelon, S.B. 2017. Compassion fatigue and compassion satisfaction in hospice social work. *Journal of Social Work in End-Of-Life & Palliative Care,* 13(2-3):113-150.

Pentaraki, M. 2019. Practising social work in a context of austerity: Experiences of public sector social workers in Greece. *European Journal of Social Work, 22(3):376–387*.

Pillay, Y. 1994. The National Health Services Commission Report of 1994: Lessons from the past for the reconstruction of social services in a post-apartheid South Africa. *Psychology in Society*, *18*, pp.34-46.

Plooy-Cilliers, F.D., Davis, C. & Bezuidenhout, R. 2014. *Research Matters*. Claremont South Africa: Juta & Company Ltd.

Pockett, R. & Beddoe, L. 2017. Social work in health care: An international perspective. *International Social Work,* 60(1):126-139*.*

Portnoy, D. 2011. Burnout and compassion fatigue: Watch for the signs. *Health Progress (Saint Louis, Mo.)*, *92*(4):46-50.

Portoghese, I., Galletta, M., Larkin, P., Sardo, S., Campagna, M., Finco, G. & D'Aloja, E. 2020. Compassion fatigue, watching patients suffering and emotional display rules among hospice professionals: A daily diary study. *BMC palliative care*, 19 (1) :1-7.

Poulin, J. & Matis, S. 2021. *Social work practice. A competency–based approach*. New York, NY: Springer Publishing Company.

Price, A. & Kelly, S. 2021. Qualitative research: Caught between a rock and a hard place: Social work in non-government organizations. *Aotearoa New Zealand Social Work* , 33(1): 67–80.

Punch, K.F. 2014. *Introduction to social research: Quantitative & qualitative approaches*. 3rd edition. Los Angeles, CA: SAGE.

Regoniel, P.A. 2014. *Research goal: Its importance in designing a study*. Available: https://simplyeducate.me/author/patsem/ (Accessed: 7 September 2019).

Roh, C.Y., Moon, M.J., Yang, S.B. & Jung, K. 2016. Linking emotional labor, public service motivation, and job satisfaction: Social workers in health care settings. *Social Work in Public Health,* 31(2):43-57.

Rojon, C. & Saunders, M.N.K. 2012. Formulating a convincing rationale for research study. *Coaching: An International Journal of Theory, Research and Practice,* 5(1):55-61.

Rose, H., Mckinley, J. & Baffoe-Djan, J.B. 2020. *Data collection research methods in applied linguistics*. London: Bloomsbury Publishing.

Rose, S. & Palattiyil, G. 2020. Surviving or thriving? Enhancing the emotional resilience of social workers in their organizational settings. *Journal of Social Work,* 20(1):23-42.

Ruane, J.M. 2016. *Introducing social research methods. Essentials for getting the edge*. West Sussex, United Kingdom: John Wiley and Sons Ltd.

Ruiz-Fernandez, M.D., Ramos-Pichardo, J.D., Ibanez-Masero, O., Cabrera-Troya, J., Carmona-Rega, M.I. & Ortega-Galan, A.M. 2020. Compassion fatigue, burnout, compassion satisfaction and perceived stress in healthcare professionals during the COVID-19 health crisis in Spain. *Journal of Clinical Nursing,* 29 (21-22):4321-4330.

Ruth, B.J. & Marshall, J.W. 2017. A history of social work in public health. *American journal of public health*, *107*(S3), pp. S236-S242.

Saldana, J. & Omasta, M. 2018. *Qualitative research: Analysing life*. 1st edition. Los Angeles, CA: Sage.

Salsberg, E., Quigley, L., Mehfoud, N., Acquaviva, K., Wyche, K. & Silwa, S. 2017. *Profile of the social work workforce*. Available: https://hsrc.himmelfarb.gwu.edu/_sphhs_policy workforce_facpubs/16/ (Accessed: 7 September 2019).

Schaub, J. 2015. Issues for men's progression on english. Social work honours and postgraduate degree courses. *Social Work Education,* 34(3):315–327.

Schenk, R., Mbedzi, P., Qalinge, L., Schultz, P., Sekudu, J. & Sesoko, M. 2015. *Introduction to social work in the South African context*. South Africa: Oxford University Press Southern Africa:

Seekles, M.L. & Ormandy, P. 2022. Exploring the role of the UK renal social worker: The nexus between health and social care for renal patients. *Plos one*, *17*(9), p.e0275007.

Segev, E. & Lander, A. 2019. The gender-related experience of frontline Israeli male social workers. *Journal of Social Work,* 19(4):529-544.

Shepherd, M.A. & Newell, J.M. 2020. Stress and health in social workers: Implications for self-care practice. *Best Practices in Mental Health,*16 (1):46-65.

Shokane, A.L., Makhubele, J. & Blitz, L.V. 2018. *Issues around aligning theory, research and practice in social work education* (p. 418). AOSIS.

Silverman, D. 2020. *Interpreting qualitative data.* 6th edition. London, Thousand Oaks, CA: Sage.

Skhosana, R.M. 2020. The dilemma faced by NPO's in retaining social workers: A call to revisit the retention strategy. *Social Work/Maatskaplike Werk,* 56 (2):109-124.

Smith, P., Vasileiou, K. & Kagee, A. 2020. Experiences of work-related stress and coping among palliative care staff in South Africa: A qualitative study. *South African Journal of Psychology,* 1–13.

South Africa. The Social Services Profession Act South Africa, Act 110 of 1998.

Social Work Indaba. 2015. *Revitalising the Social Work Profession in South Africa.* 24-26th March 2015 Durban ICC.

Sorsa, M.A., Kiikkala, I. & Åstedt-Kurki, P. 2015. Bracketing as a skill in conducting unstructured qualitative interviews. *Nurse researcher*, *22*(4).

South Africa. 2012. Policy on the management of hospitals. *Government Gazette* No 35101, 2 March 2012.

South African Government notices. Department of Health. 2012. No 35101. No. R. 185.

South Africa. 2020. Regulations relating to covid-19 occupational health and safety measures in workplaces. (Government Notice NO.479). *Government Gazette* 43257, 29 April 2020.

South Africa. 2020. Regulations relating to the requirements and conditions for registration of a speciality in social work in health care. *Government Gazette No 11116, Vol. 659(43343),22 May 2020.*

South Africa. 2012. Supervision framework for the social work profession in South Africa February 2012.The department of Social Development (DSD) and the SA Council for social service professions (SACSSP).

Spickard, J.V. 2017. *Research basics. Design to data analysis in 6 steps*. USA: Sage.

Statistics SA. 2018. Mid-*year population estimates 2018*. Available: http://www.statssa.gov.za/? p=11341 (Accessed: 7 September 2019).

Stoewen, D.I. 2020. Veterinary wellness. Moving from compassion fatigue to compassion resilience part 4: Signs and consequences of compassion fatigue. *The Canadian Veterinary Journal*, 61 (11):1207.

Stoltzfus, K.M. 2017.The motivation of Russian Federation social work students for pursuing a social work degree. *International Social Work,* 60(4):847–860.

Terre Blanche, M., Durrheim, K. & Painter, D. 2014. *Research in practice: Applied methods for the social sciences*. 2nd edition. Cape Town: Juta & Company Limited.

Thomas, G. 2009. *How to do your research project: a guide for students in education & applied social sciences*. Los Angeles: SAGE

Thomas, G. 2017. *How to do your research project: A guide to students in education and applied sciences.* 3rd edition. London: Sage.

Todaro-Franceshi, V.2019. *Compassion fatigue and burnout in nursing. Enhancing professional quality of life*. 2nd edition. New York, NY: Springer Publishing Company.

Tracy, S.J. 2013. *Qualitative research methods: Collecting evidence, crafting analysis, communicating impact*. Chichester, West Sussex: Wiley-Blackwell.

Truebridge, S. 2014. *Resilience begins with beliefs: Building on student strengths for success in school.* New York, NY: Teachers College Press, Teachers College, Columbia University.

Truter, E. & Fouche, A. 2019. Living resiliently: The voices of a group of child protection social workers in South Africa. *Health & Social Care in the Community*, 29 (1):135-144.

Turnbull, J. & Hornby, A.S. 2013. *Oxford advanced learner's dictionary*. 8th edition. United Kingdom: Oxford University Press.

Turner, F.J. 2017. *Social work treatment: Interlocking theoretical approaches*. 6th edition. USA: Oxford University Press.

Urban, J.B. & Eeden-Moorefield, B.M.V. 2017. Designing and proposing your research project: Concise guides to conducting behavioural, health, and social science research. Washington, DC: American Psychological Association.

Van Breda, A.D. & Dickens, L. 2017. The contribution of resilience to one-year independent living outcomes of care-leavers in South Africa. *Children and Youth Services Review*, *83*, pp.264-273.

Van Breda, A.D. 2018. A critical review of resilience theory and its relevance for social work. *Social Work*, *54*(1), pp.1-18.

Van Rensburg, H.C.J. 2012. *Health and health care in South Africa*. 3rd edition. Pretoria: Van Schaik.

Van Wormer, K., Sudduth, C. & Jackson, D.W. 2011. What we can learn of resilience from older African American women: Interviews with women who worked as maids in the deep south. *Journal of Human Behavior in the Social Environment,* 21(4):410-422.

Waite, M. & Hawker, S. 2009. *Compact Oxford dictionary & thesaurus*. 3rd edition. Einbeck: Oxford University Press.

Waller, V., Farquharson, K. & Dempsey, D. 2016. *Qualitative social research: Contemporary methods for the digital age*. London: Sage.

Walliman, N. 2016 *Social Research Methods*. 2nd edition. Los Angeles, CA: Sage.

Walter, M. 2019. *Social research methods*. 4th edition. Australia: Oxford University Press.

Warren, C.A.B. & Karner, T.X. 2015. *Discovering qualitative methods. Ethnography, interviews, documents, and images*. New York, NY: Oxford University Press.

Warria, A. 2016. Social workers offer great good to society. *The New Age,* March 15:18.

Wentzel, D.L. & Brysiewicz, P. 2018. A survey of compassion satisfaction, burnout and compassion fatigue in nurses practicing in three oncology departments in Durban, South Africa. *International Journal of Africa Nursing sciences,* 8:82-86.

Whitney, E. 2017. Resilience for social workers: How to increase flexibility, energy and engagement in the face of challenge. *MSW, LICSW.*

Williamson, K. & Johanson, G. 2018. *Research methods. Information, systems, and contexts*. 2nd edition. UK: Chandos Publishing, Elsevier Ltd.

Wirth, T., Mette, J., Prill, J., Harth, V. & Nienhaus, A. 2019. Working conditions, mental health and coping of staff in social work with refugees and homeless individuals: A scoping review. *Health & Social care in the Community*, 27 (4):257-269.

Xu, Y., Harmon-Darrow, C. & Frey, J.J. 2019. Rethinking professional quality of life for social workers: Inclusion of ecological self-care barriers. *Journal of Human Behavior in the Social Environment,* 29(1):11-25*.*

Yin, R.K. 2016. *Qualitative research from start to finish*. 2nd edition. New York, NY: The Guilford Press.

Yi, J., Kim, J., Akter, J., Molloy, J.K., Kim, M.A. & Frazier, K. 2018. Paediatric oncology social workers' experience of compassion fatigue. *Journal of Psychosocial oncology,* 36(6):667-680.

Yi, J., Kim, M.A., Choi, K., Droubay, B.A. & Kim, S. 2019. Compassion satisfaction and compassion fatigue among medical social workers in Korea: The role of empathy. *Social Work in Health Care,* 58(10):970-987.

ADDENDUM A: RESEARCHER ACKNOWLEDGEMENT LETTER

UNISA university of south africa

RESEARCHER ACKNOWLEDGEMENT

Hereby, I Sebedi Clement Motshana, ID number 880626563008 in my personal capacity as a researcher, acknowledge that I am aware of and familiar with the stipulations and contents of the

- Unisa Research Policy
- Unisa Ethics Policy
- Unisa IP Policy

and that I shall conform to and abide by these policy requirements

Signature: .....

Date: 07/10/2019

ADDENDUM B: PERMISSION LETTER TO COMPANY/ DEPARTMENT

2021-05-28

The Hospital CEO

Dear Sir/Maddam

I, Sebedi Clement Motshana, am doing research with Prof. HM Williams, associate professor at the Department of Social Work, towards a Master's Degree at the University of South Africa. I am requesting permission to invite social workers employed at your hospital to participate in a study entitled: **The experiences of and responses to compassion fatigue amongst social workers employed in government hospitals**

The aim of the study is to find out about the social workers' wellbeing and to explore their resilience strategies in response to compassion fatigue. Your organisation has been selected because it is a government hospital and the research will be focusing on Gauteng government hospitals.

The study will entail a semi-structured interview with each participant. In order to mitigate the risk of spread of COVID-19 the interviews will be done via Microsoft Teams and digitally recorded. The benefits of this study will be of an academic nature and havr practical benefits, since it will assist in theoretical and practical knowledge application.

Feedback procedure will entail an academic report.

Yours sincerely

Clement Motshana

University of South Africa
Preller Street, Muckleneuk Ridge, City of Tshwane
PO Box 392 UNISA 0003 South Africa
Telephone: +27 12 429 3111 Facsimile: +27 12 429 4150
www.unisa.ac.za

ADDENDUM C: INVITATION LETTER TO PARTICIPATE IN THE STUDY

11/08/2021

Title: The experiences of and responses to compassion fatigue amongst social workers employed in government hospitals

Dear Prospective Participant

My name is Sebedi Clement Motshana and I am doing research with Prof. HM Williams, associate professor at the Department of Social Work, towards a MA of Social work at the University of South Africa. I am inviting you to participate in a study entitled: **The experiences of and responses to compassion fatigue amongst social workers employed in government hospitals**.

WHAT IS THE PURPOSE OF THE STUDY?

I am conducting this research to find out about the social workers' wellbeing and to explore their resilience strategies in response to compassion fatigue.

WHY AM I INVITED TO PARTICIPATE?

I have chosen you because you are a social worker based in Gauteng government hospital, which is the target group for my research study.

WHAT IS THE NATURE OF MY PARTICIPATION IN THIS STUDY?

The research will be done by means of semi-structured interviews either via Microsoft Teams or face-to-face. The interview will be recorded with your permission. If the

interview is done via Microsoft Teams ,the researcher will provide the participant with enough data to connect for the interview if there is a challenge with connecting.

WHAT ARE THE POTENTIAL BENEFITS OF TAKING PART IN THIS STUDY?

This research will have an academic and practical benefit since it will assist in theoretical and practical knowledge application.

ARE THERE ANY NEGATIVE CONSEQUENCES FOR ME IF I PARTICIPATE IN THE RESEARCH PROJECT?

There are no negative consequences for participating in the research study. If a need should arise that a participant needs debriefing, the researcher will have a social worker who is a colleague on standby to provide debriefing.

WILL THE INFORMATION THAT I CONVEY TO THE RESEARCHER AND MY IDENTITY BE KEPT CONFIDENTIAL?

Your name will not be recorded anywhere and no one will be able to connect you to the answers you give. Your answers will be given a code number or a pseudonym and you will be referred to in this way in the data, any publications, or other research reporting methods such as conference proceedings. Your answers may be reviewed by people responsible for making sure that the research is done properly, including the transcriber, external coder, and members of the Research Ethics Review Committee. Otherwise, records that identify you will be available only to people working on the study, unless you give permission for other people to see the records.

Your anonymous data may be used for other purposes, such as a research report, journal articles and/or conference proceedings. A report of the study may be submitted for publication, but individual participants will not be identifiable in such a report.

HOW WILL THE RESEARCHER(S) PROTECT THE SECURITY OF DATA?

Hard copies of your answers will be stored by the researcher for a minimum period of five years in a locked cupboard/filing cabinet *in a locked office* for future research or academic purposes. Electronic information will be stored on a password protected computer. Future use of the stored data will be subject to further Research Ethics Review and approval, if applicable.

WILL I RECEIVE PAYMENT OR ANY INCENTIVES FOR PARTICIPATING IN THIS STUDY?

There will not be any payment or reward offered, financial or otherwise for participating in the study. In addition, no cost will be incurred by participants to participate in the study. If the interview is done via Microsoft tTeams, the researcher will provide the participant with enough data to connect for the interview if there is a challenge with connecting.

HAS THE STUDY RECEIVED ETHICS APPROVAL

This study has received written approval from the Research Ethics Review Committee of the Social Work department at Unisa.

CAN I WITHDRAW FROM THIS STUDY EVEN AFTER I HAVE AGREED TO PARTICIPATE?

Participating in this study is voluntary and you are under no obligation to consent to participation. If you do decide to take part, you will be given this information sheet to keep and be asked to sign a written consent form. You are free to withdraw at any time and without giving a reason. Should you want to participate in this study please sign the consent form provided .The interview will be conducted at any date, time and venue that is suitable to you, either face-to-face or via Microsoft Teams .If done via Microsoft Teams a link will be sent to you to log in. It is estimated that the interview will take approximately 30 minutes. During and after the interview, if the researcher is of a view that the interview could have affected your emotions, the researcher will, with your permission, refer you to a professional counsellor to receive counselling.

Below are questions which will be asked:

Biographical & research interview questions

Kindly confirm that you are appointed as a hospital social worker in a Gauteng government hospital

How long have you been employed as a hospital social worker?

Please share your reasons for choosing to work as a hospital social worker

What are the challenges you face daily as a hospital social worker?

What is your understanding of compassion fatigue?

What causes compassion fatigue in relation to the job you are doing?

How does compassion fatigue affect you as a person?

How does compassion fatigue affect you as a professional?

How does compassion fatigue affect your standard of service delivery?

Tell me about your experiences in relation to compassion fatigue.

Share he strategies you apply to cope with compassion fatigue with me.

What can your manager/ supervisor do about hospital social workers experiencing compassion fatigue?

HOW WILL I BE INFORMED OF THE FINDINGS/RESULTS OF THE RESEARCH?

If you have any questions or want further information regarding this study please feel free to contact me on 0792324816/ 0119998553 or email clement.motshana@ekurhuleni.gov.za. In addition, the findings of this research will be made readily available to you. Should you require more further information regarding any aspect of this study, please contact Prof. HM Williams, telephone number 0124294269 and email address: willihm@unisa.ac.za. Thank you for taking time to read this information sheet and for participating in this study.

Clement Motshana

ADDENDUM D: INFORMED CONSENT TO PARTICIPATE IN THE STUDY

CONSENT TO PARTICIPATE IN THIS STUDY

Title: The experiences of and responses to compassion fatigue amongst social workers employed in government hospitals

CONSENT TO PARTICIPATE IN THIS STUDY

I, …….. (participant's name), confirm that the person asking for my consent to take part in this research has told me about the nature, procedure, potential benefits and anticipated inconvenience of participation.

I have read (or had explained to me) and understood the study as explained in the information sheet.

I have had sufficient opportunity to ask questions and am prepared to participate in the study.

I understand that my participation is voluntary and that I am free to withdraw at any time without penalty (if applicable).

I am aware that the findings of this study will be processed into a research report, journal publications and/or conference proceedings, but that my participation will be kept confidential unless otherwise specified.

I agree to the recording of the interview that will be done either face-to-face or via Microsoft Teams.

I have received a signed copy of the informed consent agreement.

Participant Name & Surname…….

Participant Signature……..Date…….

Researcher's Name & Surname: Clement Motshana

Researcher's signature……..Date:…….

ADDENDUM E: DATA COLLECTION INSTRUMENT

Biographical questions

Kindly confirm that you are appointed as a hospital social worker in a Gauteng government hospital.

How long have you been employed as a hospital social worker?

Please share your reasons for choosing to work as a hospital social worker.

Research interview questions

What are the challenges you face daily as a hospital social worker?

What is your understanding of compassion fatigue?

What causes compassion fatigue in relation to the job you are doing?

How does compassion fatigue affect you as a person?

How does compassion fatigue affect you as a professional?

How does compassion fatigue affect your standard of service delivery?

Tell me about your experiences in relation to compassion fatigue.

Share the strategies you apply to cope with compassion fatigue with me.

What can your manager/ supervisor do about hospital social workers experiencing compassion fatigue?

ADDENDUM F: ETHICAL CLERANCE CERTIFICATE

UNISA university of south africa

COLLEGE OF HUMAN SCIENCES RESEARCH ETHICS REVIEW COMMITTEE

08 April 2021

NHREC Registration # :
Rec-240816-052
CREC Reference # :
40915662_CREC_CHS_2021

Dear Mr SC Motshana

Decision:
Ethics Approval Extension from 08 April 2021 to 08 April 2022

Researcher(s):	**Name: Mr SC Motshana** **Contact details: 40915662@mylife.unisa.ac.za**
Supervisor(s):	**Name: Prof HM Williams** **Contact details: willihm@unisa.ac.za, (012) 429 4269**

Title: ***The experiences of and responses to compassion fatigue among social workers employed in government hospitals.***

Degree Purpose: MSW

Thank you for the application for research ethics clearance by the Unisa College of Human Science Ethics Committee. Ethics approval is granted for one year.

The ***Low risk application was reviewed on the 25 Mayl 2020 by SWREC and extended on the 08 April 2021*** by College of Human Sciences Research Ethics Committee, in compliance with the Unisa Policy on Research Ethics and the Standard Operating Procedure on Research Ethics Risk Assessment.

The proposed research may now commence with the provisions that:

1. The researcher(s) will ensure that the research project adheres to the values and principles expressed in the UNISA Policy on Research Ethics.
2. Any adverse circumstance arising in the undertaking of the research project that is relevant to the ethicality of the study should be communicated in writing to the College Ethics Review Committee.
3. The researcher(s) will conduct the study according to the methods and procedures set out in the approved application.

University of South Africa
Preller Street, Muckleneuk Ridge, City of Tshwane
PO Box 392 UNISA 0003 South Africa
Telephone: +27 12 429 3111 Facsimile: +27 12 429 4150
www.unisa.ac.za

ADDENDUM G: DRAFT REQUEST FOR DEBRIEFER

DRAFT

UNISA university of south africa

REQUEST TO DEBRIEF PARTICIPANTS FOR RESEARCH STUDY

07/10/2019

Dear Mr Wiseman Letspapa

My name is Sebedi Clement Motshana and I am doing research with DR Williams , senior lecturer in the Department of social work towards, MA at the University of South Africa. I am requesting you to be on standby to provide debriefing for my research participants in case a need arise .

WHAT IS THE PURPOSE OF THE STUDY?

I am conducting this research to find out about the social workers' wellbeing and keen to explore their resilience strategies in respond to compassion fatigue.

Your participation will be highly appreciated

Clement Motshana

ADDENDUM H: TURN-IT-IN REPORT

turnitin

Digital Receipt

This receipt acknowledges that Turnitin received your paper. Below you will find the receipt information regarding your submission.

The first page of your submissions is displayed below.

Submission author:	Clement MOTSHANA
Assignment title:	Complete dissertation/thesis submission for examination
Submission title:	THE EXPERIENCES OF AND RESPONSES TO COMPASSION FAT...
File name:	2023-01-23_DISSERTATION_COMPLETE_MOTSHANA_Final_1.d...
File size:	5.85M
Page count:	235
Word count:	71,529
Character count:	387,267
Submission date:	23-Jan-2023 10:01AM (UTC+0200)
Submission ID:	1997595438

THE EXPERIENCES OF AND RESPONSES TO COMPASSION FATIGUE AMONGST SOCIAL WORKERS EMPLOYED IN GOVERNMENT HOSPITALS

by

Sebedi Clement Motshana

Submitted in accordance with the requirements for the degree of

MASTER OF SOCIAL WORK

AT THE UNIVERSITY OF SOUTH AFRICA

Supervisor

Prof. Hill (Mashi) Williams

NOVEMBER 2022

THE EXPERIENCES OF AND RESPONSES TO COMPASSION FATIGUE AMONGST SOCIAL WORKERS EMPLOYED IN GOVERNMENT HOSPITALS

ORIGINALITY REPORT

19%	18%	7%	10%
SIMILARITY INDEX	INTERNET SOURCES	PUBLICATIONS	STUDENT PAPERS

PRIMARY SOURCES

1	uir.unisa.ac.za Internet Source	5%
2	hdl.handle.net Internet Source	1%
3	www.saflii.org Internet Source	1%
4	Submitted to University of South Africa Student Paper	1%
5	scholar.sun.ac.za Internet Source	<1%
6	www.tandfonline.com Internet Source	<1%
7	vdoc.pub Internet Source	<1%
8	core.ac.uk Internet Source	<1%

ADDENDUM I: LETTER FROM THE EDITOR

Kim N Smit Editorial Services

Declaration of Professional Editing

20 January 2023

This letter serves to confirm that Sebedi Clement Motshana submitted a thesis to me for editing.

The thesis is entitled, '**THE EXPERIENCES OF AND RESPONSES TO COMPASSION FATIGUE AMONGST SOCIAL WORKERS EMPLOYED IN GOVERNMENT HOSPITALS**'.

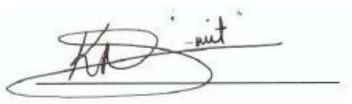
The following aspects were edited:

- Spelling
- Grammar
- Consistency of layout
- Sentence structure
- Logical sequencing
- References (Reference checking involves proofreading and perhaps some editing with regards to the simple formatting of the references into the referencing style required i.e. changing the order of the elements - author, date, title, series, place, publisher, journal, volume, issue, pagination etc.)

My involvement was restricted to language use and spelling, completeness and consistency, referencing style, and formatting of headings, captions and tables of contents. I did no structural re-writing of the content and did not influence the academic content in any way.

Should you have any further queries, please do not hesitate to contact me.

Kind regards,



Kim Smit

Tel: +27 (0)78 493 6554 Email: kimnsmit@gmail.com
Member of the Freelance panel for the University of South Africa
Member of the Freelance panel for the University of Pretoria
Full Member of the Professional Editor's Guild

ADDENDUM J: PERMISSION TO CONDUCT INTERVIEWS

GAUTENG PROVINCE
HEALTH
REPUBLIC OF SOUTH AFRICA

STEVE BIKO ACADEMIC HOSPITAL

Enquiries: Dr JS Mangwane
Tel No: +2712 3452018
Fax No: +2712 354 2151
E-mail: joseph.mangwane@gauteng.gov.za

For attention: Clement Motshana

NHRD Ref Number: GP_202102_012

Re: REQUEST FOR PERMISION TO CONDUCT RESEARCH AT STEVE BIKO ACADEMIC HOSPITAL

TITLE: THE EXPERIENCES OF AND RESPONSES TO COMPASSION FATIGUE AMONG SOCIAL WORKERS EMPLOYED IN GOVERNMENT HOSPITALS

Permission is hereby granted for the above-mentioned research to be conducted at Steve Biko Academic Hospital.
This is done in accordance to the "Promotion of access to information act No 2 of 2000".
Please note that in addition to receiving approval from Hospital Research Committee, the researcher is expected to seek permission from all relevant department.
Furthermore, collection of data and consent for participation remain the responsibility of the researcher.
The hospital will not incur extra cost as a result of the research being conducted within the hospital.
You are also required to submit your final report or summary of your findings and recommendations to the office of the CEO.

Approved

Comment: _____

_____

_____

Date: 2021-03-01

_____

Dr. J S. Mangwane
Manager: Medical Service

GAUTENG PROVINCE
HEALTH
REPUBLIC OF SOUTH AFRICA

Enquiries: Dr. Manei Letebele-Hartell
Tel: +27 12 451 9036
E-mail: Troy.Mashabela@gauteng.gov.za

TSHWANE RESEARCH COMMITTEE: CLEARANCE CERTIFICATE

DATE ISSUED: 15/06/2021
PROJECT NUMBER: 20/2021
NHRD REFERENCE NUMBER: GP_202102_012

TOPIC: The Experiences of And Responses to Compassion Fatigue Among Social Workers Employed in Government Hospitals

Name of the Lead Researcher:	Mr Clement Motshana
Name of the Supervisor:	Prof HM Williams
Facilities:	Mamelodi Hospital Tshwane District Hospital ODI District Hospital Pretoria West Hospital
Name of the Department:	UNISA

NB: THIS OFFICE REQUEST A FULL REPORT ON THE OUTCOME OF THE RESEARCH DONE AND

NOTE THAT RESUBMISSION OF THE PROTOCOL BY RESEARCHER(S) IS REQUIRED IF THERE IS DEPARTURE FROM THE PROTOCOL PROCEDURES AS APPROVED BY THE COMMITTEE.

DECISION OF THE COMMITTEE: APPROVED

.....
Dr. Mpho Moshime-Shabangu **Date** 17/06/2021
Deputy Chairperson: Tshwane Research Committee

.....
Prof. JV Ndimande **Date:** 17/06/2021
Acting Chief Director: Tshwane District Health

GAUTENG PROVINCE
HEALTH
REPUBLIC OF SOUTH AFRICA

Leratong Hospital
Private Bag X2078
Krugersdorp
1740

Enquiries: Dr D P Moloi
Tel: (011) 411-3531
Fax: (011) 410-8421
Email:
Dieketseng.Moloi@gauteng.gov.za
Ref: 9/3/3/1

NHRD REF NO: GP_202103_076

ATTENTION: MR S.C. MOTSHANA

SUBJECT: REQUEST TO CONDUCT RESEARCH: THE EXPERIENCES AND RESPONSES TO COMPASSION FATIQUE AMONG SOCIAL WORKERS EMPLOYED IN GOVERNEMENT HOSPITALS

Permission has been granted to conduct research study entitled: The experiences and responses to compassion fatigue among Social Workers employed in Government Hospitals based on the conditions indicated from Policy Planning and Research Department. For further arrangement contact Dr Phanzu on 011 411 3508/9.

It would be appreciated if you could share your result of the research with the Management of Leratong Hospital.

Thank you for showing interest in our institution.

Kind regards

CHIEF EXECUTIVE OFFICER
/cnk
2020/05/27

LERATONG HOSPITAL
ADCOCK STREET, CHAMDOR
2021 -05- 27
PRIVATE BAG X2078, MOGALE CITY 1740
LERATONG HOSPITAL

City of Ekurhuleni

GAUTENG PROVINCE
HEALTH
REPUBLIC OF SOUTH AFRICA

EKURHULENI HEALTH DISTRICT RESEARCH PERMISSION

Research Project Title: THE EXPERIENCES OF AND RESPONSES TO COMPASSION FATIGUE AMONG SOCIAL WORKERS EMPLOYED IN GOVERNMENT HOSPITALS

NHRD No: GP_202102_012

Research Project Number: 17/06/2021-06

Name of Researcher(s): Mr Clement Motshana

Division/Institution/Company: University of South Africa

Date of review by the EHDRC: 14 June 2021

DECISION TAKEN BY THE EKURHULENI HEALTH DISTRICT RESEARCH COMMITTEE (EHDRC)

- This document certifies that the above research project has been reviewed by the EHDRC and permission is granted for the researcher(s) to commence with the intended research project.
- Facilities approved for the research: Betha Gowa Hospital
- Participants' rights and confidentiality must be maintained throughout the study period and when disseminating the findings.
- No resources (financial, material and human resources) from the health facilities will be used for the study. Neither the district nor the health facilities will incur any additional cost for the study.

GAUTENG PROVINCE
HEALTH
REPUBLIC OF SOUTH AFRICA

ENQUIRIES
Office of the CEO
M | 083 293 1084
T | 011 278 7669
E| Zodwa.Mofokeng@gauteng.gov.za

Date: 17th August 2021

Dear Mr Clement Motshana

Study Title: The experiences of and responses to compassion fatigue among Social Workers employed in government hospitals.

Permission is granted for you to conduct the above-mentioned study as described in your request provided:

- Bertha Gxowa Hospital will not anyway incur or inherit costs as result of the said study.
- Your study shall not disrupt services at the study sites.
- Strict confidentiality shall be observed at all times.
- Informed consent shall be solicited from patients participating in your study.

Please liase with the HOD and Unit Manager in charge of the Department on the agreed dates and time that would suits all parties.

Kindly forward this office with the results of your study on completion of the research.

Supported/ not Supported

Dr. SJ. Mahlangu
Acting Clinical Manager
Date: 18/08/2021

Approved/ not Approved

Mrs. ZPN. Mofokeng.
Acting CEO, Bertha Gxowa Hospital
Date: 2021/08/18

BERTHA GXOWA HOSPITAL
Chief Executive Officer
2021 -08- 1 1
GERMISTON 1400
BERTHA GXOWA HOSPITAL

BERTHA GXOWA HOSPITAL
Angus Street, Germiston, 1401.
T | 011 278 7600

GAUTENG PROVINCE
HEALTH
REPUBLIC OF SOUTH AFRICA

Gauteng Department of Health
Helen Joseph Hospital
Enquiries: Dr. R. Ncha
Chief Executive Officer
Tel :(011) 489-0306/1087
Fax :(011) 726-5425
E mail: Relebohile Ncha@gauteng.gov.za
Date: 10 August 2021

Dear Mr. Clement Motshana

STUDY: The Experiences of and responses to compassion fatigue amaong Social work employed in Government Hospitals.

RESEARCHERS: Mr. Clement Motshana

GP-202102-012

The above the study was discussed at the Research Committee meeting. We recommend that permission be granted for Helen Joseph Hospital to be used as a site for the above research,
The researcher is expected to the following:

- Upon completion of the study, copy thereof should be submitted to Helen Joseph Hospital.
- It is the researcher's duty to collect the data from the relevant department after the Research Committee approved the study.

Thank you

Dr. M.D Mukansi
Helen Joseph Hospital
Research Chairperson
DATE:

Approved

Dr. R. Ncha
Helen Joseph Hospital
CHIEF EXECUTIVE OFFICER
DATE: 13/8/2021