



## Hospital social workers and their understanding of compassion fatigue and vicarious trauma

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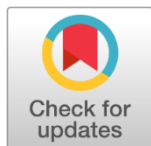
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**Abstract:** Compassion fatigue and vicarious trauma can be consequences of social work practice in all contexts, including the fast-paced, crisis-driven hospital environment. Four metropolitan hospitals collaborated with an academic partner to explore the understandings and awareness that hospital-based social workers have in this area, and to investigate both individual and organisational responsibility. The research utilised a Participatory Action Research methodology with a collaboratively developed survey. The results of the survey showed that social workers' understanding is impacted by their knowledge of compassion fatigue and vicarious trauma, the nature of everyday hospital practice, and the identification and provision of, and engagement in, personal self-care and workplace support strategies. The findings highlighted the dual responsibility that employing hospitals and individuals have to care for themselves and each other, including the capacity for social workers to use supervision and collegial relationships to support their coping and resilience.

**Keywords:** Social Work, Self-care, Compassion Fatigue, Vicarious Trauma, Hospital, Survey

## Introduction

In Australia, the healthcare sector is the largest employer of social workers and has a steadily increasing labour force (Cleak & Turczynski, 2014). Much of hospital-based social work involves complex crisis interventions due to hospital presentations often being of a traumatic and unexpected nature involving multiple competing psychosocial and systemic variables (Cleak & Turczynski, 2014). Hospital-based social

work involves practice in a range of clinical areas (Roberts *et al.*, 2012), with each area involving working with individuals and families at various points of admission, with differing volumes, pace of work and clinical requirements. Social workers in hospitals are primarily located in one clinical unit which can involve working with a concentrated patient demographic or admission characteristics, for example, crisis or short-stay admissions, or

new diagnosis presentations. These clinical areas can include ongoing trauma areas such as oncology clinics (Joubert *et al.*, 2013), or high-trauma presentation areas such as emergency departments (Moore *et al.*, 2017). In this working environment, exposure to repeated types of traumatic presentations and singular types of trauma is increased (Strom-Gottfried & Mowbray, 2006).

Compassion fatigue and vicarious trauma, for hospital-based social workers, result from the cumulative exposure to the stress and distress of those who encounter the health system. However, the experiences of compassion fatigue and vicarious trauma are not unique to the healthcare setting. When examining the wellbeing of the helping professions, the literature identifies multiple terms including “vicarious trauma”, “compassion fatigue” and “burn-out”. Vicarious trauma is linked to the body of trauma-informed literature (Killian, 2008) through the acquisition of trauma-like symptoms obtained vicariously through interacting with, and hearing the stories of, traumatised individuals (Bloom, 2010). Similar to what we know about trauma itself, working with trauma survivors can impact the cognitive schema of the professional (Long, 2020) and can be a contributing factor to social workers exiting the profession (Curtis *et al.*, 2010). Compassion fatigue is sometimes referred to in the empathy literature as secondary traumatic stress disorder and is linked to the ability to empathise with the heard stories of trauma (Cuartero & Campos-Vidal, 2019). Like vicarious trauma, compassion fatigue is referred to as a ‘consequence of stress’ (Kapoulitsas & Corcoran, 2015), or ‘stress resulting’ (Kiley *et al.*, 2018), and as a predictable and treatable consequence of everyday exposure (Ashley-Binge & Cousins, 2020). Burn-out, however, is defined as “emotional exhaustion, interpersonal disengagement, and a low sense of personal accomplishment”, an end point to which vicarious trauma and compassion fatigue may lead (Bohman *et al.*, 2017). These terms are often linked in the literature causing definitional confusion. While the formative experiences that lead to them are similar in the diminished empathic response and the proximity to others’ trauma, compassion fatigue is directly linked to the occupational stress literature with discussions of self-care strategies and initiatives (Sabo, 2011), and is applied as a

global phenomenon with multidisciplinary application, such as to nursing and medical staff (Cuartero & Campos-Vidal, 2019). Criticism of the segregation of these definitions has been aired (Sabo, 2011) and culminates in a pathologising and universal application of the symptoms. To this end, a commonality across the literature when discussing the symptoms of either compassion fatigue or vicarious trauma, or the end point of burn-out, includes both emotional and physical responses, as well as distinct lifestyle behaviours (Espeland, 2006). These symptoms, or impacts from the work, can be mitigated by supportive strategies that can be put in place, both at home and in the workplace.

Self-care is an important prevention strategy, mitigating risk to staff and client wellbeing (Kanter, 2007) and is sometimes referred to as soul care (Radey & Figley, 2007). Bohman *et al.*, (2017) present a framework for well-being that encompasses three domains: culture of wellness; efficiency of practice; and personal resilience. Although developed for medical physicians, this framework highlights the reciprocal nature of each domain’s effect on the others, as well as identifying where organisational responsibility and individual responsibility intersect. This builds on other holistic models of self-care which include physical and mental strategies, such as getting enough sleep, exercising and eating well (Kanter, 2007), guided imagery (Kiley *et al.*, 2018), practising self-forgiveness (Espeland, 2006) and lifestyle approaches balancing the mind, body and spirit (Stebnicki, 2007).

Positive coping strategies and the capacity to implement self-care are as much a quality of a workplace as they are individual (Collins, 2007), but there is a diverse range of opinions regarding who should be responsible for prevention and management. It is established in the literature that organisations should have a salient role in creating an appropriate and safe environment for employees to explore and use various coping mechanisms, yet this is offset by the belief that individuals should be autonomous in their own maintenance of a healthy outlook throughout their career (Espeland, 2006). Safe Work Australia (2013) note that although organisational factors are regarded as the catalyst for stress-related

compensation claims, personality and life circumstances will impact how effectively a person is able to cope with workplace stressors. There are both practical and ethical obligations for employers to reduce the risk for their employees and the obligation to instil organisational measures such as clinical supervision (Bell *et al.*, 2003; Kapoulitsas & Corcoran, 2015), clear organisational structure (Slattery & Goodman, 2009; Walker, 2004), supportive management, and a protected salary (Collins, 2007). Organisations that display and enact values such as transparency and respect play a large role in reducing compassion fatigue and vicarious trauma (Ashley-Binge & Cousins, 2020). When organisations do not implement strong organisational practices, particularly when dealing with internal power dynamics in the supervisory relationship, they can mimic the abuse that clients have faced and, in turn, dramatically impact the social workers' ability to cope with stressors (Walker, 2004).

The notion of self-care can become entwined with self-responsibility, where individuals utilise organisational strategies, such as clinical supervision, to protect themselves from negative consequences of the work (Joubert *et al.*, 2013). Supervision for social workers can be crucial in developing and fostering this organisational resilience (Davys & Beddoe, 2010, p. 21) through identified tasks such as addressing any counter-transference issues or acknowledging professional limitations (Kanter, 2007); and maintaining an awareness of good work-life balance through both personal and professional connections (Stebnicki, 2007). Supervision has a central role in preventing compassion fatigue and vicarious trauma when the supervisor creates a space to explore and process a worker's feelings towards both common and extraordinary cases (Walker, 2004), and can foster quantity, quality and connection in both collegial and supervisory relationships (Slattery & Goodman, 2009).

It is from this environment – a workplace with structured supervision and organisational support mechanisms – that questions were raised regarding the wellbeing of the social work staff and their everyday capacity. A research team consisting of social workers from four metropolitan hospitals (St George Hospital, Sutherland Hospital, Prince of Wales Hospital and Sydney/Sydney Eye Hospital)

partnered with a social work academic from the University of Wollongong to investigate the research question: Is compassion fatigue or vicarious trauma a predominant concern or priority risk for hospital social workers and what is the impact for them? Sub-questions raised by the research team included: How aware were the social work staff of compassion fatigue and vicarious trauma?; and Did they perceive this as an issue of importance? If affected, did they know where they could turn for organisational support? What was the staff perception of who holds *primary* responsibility in this area, themselves or their employing hospital? Was supervision seen to be, and used as, a regular source of support? The study design included two stages of the research. The findings discussed here are from Stage One and focus on staff concerns and perceptions.

## Methodology

### *Participatory Action Research framework*

Ethics approval for this project was granted through both the South East Sydney Local Health District and University of Wollongong Human Research Ethics Committees in 2018. The methodology took the form of a qualitative study, grounded in Participatory Action Research (PAR). PAR is an applied methodology which emphasises the relationship between investigation and outcomes. PAR relies on a participatory process to guide the investigation with in-built reflective cycles for co-analysis and co-construction of shared meanings between, and amongst, research participants and investigators (Kemmis & McTaggart, 2001). PAR cycles typically encompass iterative activities, including “planning, acting, observing and evaluating” (Kjellstrom & Mitchell, 2019), a process particularly well suited to health and community research (Fox *et al.*, 2007) and clinical practice (Koch & Kralik, 2006). PAR has historically been interested in the workplace dynamic as a site for change (Bradbury *et al.*, 2008), and within healthcare has been popular with public health, nursing and education (Cosgrove *et al.*, 2020). Within this methodological approach, it is common for the researchers to be experiencing the phenomenon they are researching, or to be key stakeholders in the issue at hand, appearing as valid co-researchers in the study. This was therefore a suitable methodology

as the research team were personally invested in, and influenced by, the research questions raised.

After undertaking a literature review and drawing on practice experience, the research team identified a number of validated quantitative tools that had been used to measure whether a helping professional had experienced compassion fatigue or vicarious trauma. These included the Compassion Fatigue Self Test, and associated Compassion Satisfaction and Fatigue Test and the Compassion Fatigue Scale (Bride *et al.*, 2007); the Secondary Traumatic Stress Scale (Bride *et al.*, 2004), the Trauma and Attachment Belief Scale (Pearlman, 2003) and the Professional Quality of Life: Compassion Satisfaction and Fatigue Scale (Hudnall Stamm, 2009–2012). These validated tools had been used with a range of healthcare professionals, including nursing and social workers (Tatano Beck, 2011), however, they were not utilised for these reasons:

- To increase participation in the online survey, Stage One of the research was completed anonymously. Including a validated tool would have created an explicit duty of care to respond to individuals with high scores of being at risk of, or actually experiencing, compassion fatigue or vicarious trauma. This duty of care was fulfilled through the Participant Information & Consent Form that all the social workers agreed to sign prior to completing the survey.
- There was agreement to explore a generalised perception of hospital social workers about this issue, whether there was awareness and knowledge of the topic, and whether staff felt that this topic was important to them.
- The survey was designed to both highlight issues some may not have considered part of self-care and to elicit hospital social workers' understandings and perceptions. It was intended that this approach would provide an opportunity for hospital workers to describe their workload environment and experience, increase engagement from hospital social workers on these issues, and inform Stage Two of the research.

A survey that explored perception and understanding of the issue, while increasing knowledge and awareness, was not found in the literature and so the research team designed a survey with qualitative components to address their research question. The research team acknowledged the limitation of self-reported responses, however deemed self-report an important first step in engaging the social work departments in the project.

### *Using PAR to design a survey*

In order to collaboratively design a survey, the research team collectively reflected on the results of the literature and the research question, and assigned research aims and focus within the study scope. The values inherent in PAR, such as researching from within and researching with the affected participant's, align with social work values such as researching in partnership, mutual understanding and striving for social change (Shannon, 2013). In the design of this survey the research team upheld these values by including questions that allowed participating social workers to describe their experiences, and through ensuring a baseline level of knowledge was shared on the topic to encourage identification with, and future involvement in, the research. The survey was to be conducted online to access social workers across the four hospital sites and to ensure anonymity. Questions 1–6 asked for baseline demographic data, such as age, gender, employment status and clinical area of work. Questions 7–19 contained multiple choice, limited response and open-ended questions that aligned with the research aims and focus. Table 1 provides details of the survey questions and their research aims and focus.

The survey was piloted by 10 hospital-based social workers employed in a different Local Health District from the research sites. The research team co-analysed the results of the pilot then finalised the survey questions utilising pilot results and their extensive clinical and research experience. The final survey was then emailed to a purposive sample of 100 hospital-based social workers within the research sites ( $n = 100$  positions).



**Table 1** Survey Questions, Research Aims and Focus

Survey question	Scale	Research aims and focus
How would you describe your workload in your current role as a hospital social worker?	Free text	Social workers being involved in the direction of the research through their descriptions
How would you describe the nature of your workload?	Free text	Social workers delineating between a clinical description and a subjective description of the nature of the work
Please describe the factors that support you in your role as a hospital social worker. Please consider the factors that are present both in your personal life and in your professional setting.	Free text	Social workers being involved in determining whether personal and professional factors are important in the research
What knowledge do you have of compassion fatigue and/or vicarious trauma?	Free text	Establishing baseline knowledge of the issue
In your opinion how important an issue is this in your work as a social worker?	Likert scale	Establishing perception of relevance of the topic
In your opinion is compassion fatigue and/or vicarious trauma a serious issue within the workplace for a hospital social work?	Free text	Establishing perception of relevance of the topic within the workplace
During your career as a hospital social worker, have you conducted any of these self-care strategies? Regular food breaks, regular rest breaks, exercise, meditation, mentoring or debriefing, self-management of workload, further study, other, please specify	Likert scale	Increase awareness of types of self-care for social workers
Do you consider these the responsibility of the individual or the organisation?	Individual, organisation, both, unsure	Establishing perception of responsibility
How important are these workplace strategies to you as a hospital social worker? Supervision, professional development, training, rotation within hospital, workplace culture, monitoring of performance, systems efficiency (IT/eMR),	Likert scale	Identifying areas of importance within workplace responsibility to inform later stages of the research

remuneration, collegial support, other, please specify		
During your career as a hospital social worker, have you ever experienced any of the following physiological or psychological symptoms? Sweating, headaches, sleeplessness, changes in appetite, mood disturbance, anger, sense of helplessness, other, please specify	Likert scale	Increase baseline knowledge of the side effects of the topic to increase awareness
In your experience, is there a relationship between these symptoms and compassion fatigue or vicarious trauma?	Yes/no/unsure	Establish perception and understanding of the topic
If you have experienced any of these symptoms, did you seek out help or support for them? (e.g., Speak to a supervisor, see a GP, etc.)	Yes/no	Establishing perception of individual or organisational responsibility
In your opinion are there any measures the organisation could implement in relation to compassion fatigue or vicarious trauma?	Free text	Identifying areas of importance within workplace responsibility to inform later stages of the research

Inclusion criteria were all social workers employed in the main social work departments. Social workers employed in primarily outpatient units or community settings were excluded. Length of career was not set as an inclusion/exclusion criterion in order to hear from a wide range of social workers in their employment status and history. This included part-time staff and those employed in largely managerial or education positions, to be inclusive of the formative years they had spent in practice prior to this research project. Social Work Department heads emailed the survey link and invitation to participate to social workers in a purposive targeted recruitment strategy. To minimise managerial coercion, they were not permitted to approach staff members directly to complete the survey, however, email reminders were permitted. The survey was open for three weeks and all participant questions were directed to the academic partner.

### *Data analysis*

The survey data were initially coded by the academic partner and external research project assistant, then brought to the larger team. Demographic data, multiple choice and limited option questions were analysed for frequency and numerically presented. Open-ended questions were coded according to thematic groupings, identified as of relevance and importance throughout the literature review and through the research team's initial reflective discussions on the topic and the development of the research question. The aggregated survey data were then presented to the research team who undertook co-analysis and shared meaning-making of the themes through reflective discussion (Corbett *et al.*, 2007). It was at this stage that the research team could engage with the data by asking questions of them while reflecting on their own practice knowledge, which could then be later incorporated into further stages of the research. This co-analysis process was recorded and transcribed, providing

contextual meaning to the findings reported on in this article.

## Key research findings

### *Demographic findings*

A response rate of 48 ( $n = 48$ , 48%) social workers completed the survey from across the four participating hospitals. The participating hospitals had staffing numbers ranging from 3 to 30+ and so, in order to maintain anonymity, social workers were not asked at which hospital they were currently employed. Of these social workers, 92% ( $n = 44$ ) were female and 8% ( $n = 4$ ) were male; the largest group of participants were aged between 31–40 years old (33%,  $n = 16$ ); and 56% ( $n = 27$ ) were employed part-time at their hospital while the remainder, 44% ( $n = 21$ ) were employed full time. The largest group of the social workers who participated (46%,  $n = 22$ ) had over 10 years' experience as practising clinicians, with the next largest group being new graduates with less than two years' experience (21%,  $n = 10$ ). Clinical areas were self-identified with 31% ( $n = 18$ ) working on general medical and surgical wards, 23% ( $n = 14$ ) working in critical care or traditionally crisis areas (emergency departments, trauma or intensive care units), 19% ( $n = 11$ ) working on aged care wards, and 13% ( $n = 8$ ) working in oncology or palliative care. A minority of respondents identified themselves as working in women and children's health (7%,  $n = 4$ ), or in education or management roles within the hospital setting (7%,  $n = 4$ ).

Within the experience of working as hospital social workers, the participants identified three key themes that impacted on their perceptions of compassion fatigue and vicarious trauma: their knowledge of the topic; the nature of hospital social work practice; and the identification, provision of, and engagement in, personal self-care strategies and workplace support measures.

### *Hospital social workers knowledge of compassion fatigue and vicarious trauma*

Most of the social workers (77%,  $n = 37$ ) who participated in the survey reported that they found compassion fatigue and vicarious trauma to be important issues within the workplace. As one social worker stated:

I know I have experienced it at various points – especially when I can feel myself not really caring about what is happening for a patient as much as I used to ... there have been times when I have gone home exhausted and not wanted to listen to anyone else's problems anymore. (survey participant A)

Social workers were asked to describe their knowledge of compassion fatigue and vicarious trauma and they responded to this question in different ways. Almost all (99%,  $n = 47$ ) said they had a level of knowledge in this area ranging from "a little" to "extensive". Most of the social workers mentioned their own clinical experience or their personal experience as being the source of their knowledge, and mentioned training they had undertaken on the topic, either in their current workplace, previous workplace or in their social work training. Some social workers mentioned running training for others on the topic, with one social worker describing a combination of sources for their knowledge:

I have experienced both forms and have burnt out earlier in my career, in addition I have read quite a lot of literature in this area and attended training as well as run training in this area from time to time. (survey participant B).

### *The nature of hospital social work practice*

The open-ended questions in the survey allowed the social workers to explain how they perceived their everyday work. As one social worker clearly stated:

I have seen [social] workers burn out due to the nature of the work they do, and lack of support provided. Particularly when you are looking at persistently demanding caseloads or traumatic cases. We deal with a lot of distressed people in hospital, conflict and death and dying. (survey participant C)

Descriptive words such as "busy", "intense", "heavy", "fluctuates" and "manageable" were repeated, at times brought together, "up and down", "heavy but manageable". Some social workers' voices were quite distinct in their description, "complex and high-risk cases, heavy

workload” and “perfect. Well balanced”. There were also repeated words that described the emotional burden of the work with “complex” and “challenging” being repeated, and “traumatic” or “exhausting” being stated.

### *Supportive strategies: personal self-care and workplace support measures*

The most common self-care strategies identified by the social workers were workplace support measures: mentoring or debriefing (96%,  $n = 45$ ), and self-management of workload (87%,  $n = 41$ ). Personal self-care strategies such as exercise (85%,  $n = 41$ ) and regular food breaks (79%,  $n = 37$ ) followed closely. The participating social workers were asked who should take responsibility for self-care, the individual or the organisation, or both. Most social workers (90%,  $n = 43$ ) perceived responsibility to be shared. Participants were asked to further identify those factors they perceived as the organisations’ responsibility and professional development (100%,  $n = 48$ ), training (100%,  $n = 48$ ), workplace culture (100%,  $n = 48$ ), collegial support (95%,  $n = 19$ ) and supervision (92%,  $n = 23$ ) received the highest responses. The open-ended responses reiterated the importance, not only of peer relationships and supervision, but also of organisation-led, individual, self-care strategies.

Allow for flexibility in supervisor; address problems in supervision thoroughly (don't make the supervisee jump through many hoops before addressing, managers handover situations to be dealt with when new managers come in rather than employee having to start from scratch); allow for rotation between roles if no other strategies working; provide professional development and opportunities to further education; flexible working arrangements; fair distribution of annual leave (not the same person getting in first every time); providing relief when staff members cover others for long periods of time - have a system in place to recognise this and address it; distribute certain types of client presentations that are particularly distressing amongst teams rather than have one staff member specialise in it. (survey participant B)

Some social workers expressed not feeling allowed to ask their colleagues for help if they were overwhelmed, either due to the stigma of not coping with their workload or concern this would increase someone else’s workload and stress. The outcome for some then being a culture of compassion fatigue, uncertainty, denial and guilt.

Clinical supervision does not look at vicarious trauma or compassion fatigue and rarely do I discuss a case with my supervisor as it is more of an admin relationship. I regularly debrief with my peers but that’s all I have. We are understaffed and expected to cover annual leave and sick leave whilst doing our own roles. Ideally there would be a full timer or two that are on cover duties so that I don't have to feel guilt when I am on a sick day or when I'm on a course that other social workers are having to deal with more of a load. (survey participant E)

Some social workers identified cognitive responses as a self-care strategy, including a personal capacity to disconnect from their daily work, “learning to switch off when I leave work” and “[I] tend to compartmentalise life and leave work at work, deal with issues then put them away”. Some saw a personal and professional commitment to their everyday work as being a part of their self-care, stating they had “a passion for public service and public health, a commitment to the profession”. For others, the notion of faith and personal spirituality emerged as a supportive feature. Some social workers referred to their families and friends being a support, including the presence of children in their personal lives. One social worker noted, “having children means you have to take your work hat off as soon as you get home. They don't care about your work they just want you and all your attention”, indicating a sense of freedom from the work upon arriving home, or a shift to other relationships and responsibilities. Alternately, some social workers identified using occupational regulations or workplace systems for their own wellbeing, including the ability to work part-time or having variety in their work, such as rotating between wards or having built-in time for education or management roles.

Finally, the social workers were asked whether they perceived compassion fatigue and



vicarious trauma to be serious issues within the workplace for hospital social work and all 48 respondents answered that they felt it was.

## Discussion

The research team began this project concerned about the extent of compassion fatigue and vicarious trauma amongst hospital social work staff. This included whether or not staff held a low level of knowledge regarding compassion fatigue and vicarious trauma that may, in turn, have meant they were not engaging in self-care strategies either personally or professionally. Encouragingly, in the survey results social work participants demonstrated a baseline knowledge of the terms, some having had formalised training, some having run training sessions for other staff, and some having learnt about compassion fatigue and vicarious trauma through their own lived experiences. The survey findings begin to give verbal expression to the experience of working in this complex setting – resulting from asking social workers to give voice to their experiences in the workplace. Although important, by virtue of being a survey, the language and descriptions are limited in their capacity to explore issues raised by the social workers. The research team noted that, not only is the work variable across clinical areas, it is also variable from social worker to social worker. A sense of what these terms mean to the social workers was needed to understand the qualitative and individualised experience. For example, what did “heavy” mean? What does “balance” feel or look like in an everyday experience of hospital social work? The research team explored the notion that complex caseloads were a core part of hospital social work, and yet the impact of this work on the social worker was still unknown. For example, the expectations on social workers to find resources such as a residential aged care facility when there are limited options available can create a large amount of pressure, as can a large grieving family presenting to the ward. Issues such as high-risk cases, or ethically difficult ramifications resulting from the daily work add to the personal and professional impact and risk.

Despite these experiences, the social workers’ overall response spoke of a culture of engaging in workplace measures that could have a positive impact on their well-being. The high

response rate of social workers accessing supports such as debriefing, mentoring, supervision and training suggest the importance of both formal and informal collegial relationships. The research team stated they felt encouraged that social workers were able to identify and utilise their own self-care strategies, which was an overall positive indicator. However, it was acknowledged that, even with an organisation that is encouraging self-care (for example, taking lunch breaks or leaving work on time) the enactment of self-care practices was still up to the individual. The use of supervision and peer support relationships was also highlighted in the survey findings and raises further questions about how hospital social workers are engaging with their clinical supervisors and the supervision dynamic and process. Collegial relationships are identified by the recipients as important in the mediating of their self-care, but how this relates to the supervision dynamic and dialogue is currently unknown. The clear identification in the survey findings that responsibility for compassion fatigue and vicarious trauma should be a shared one between the employing organisation and the social worker is, therefore, that much more important.

## Limitations of the research

The limitations for this research lie in the relatively low survey participation rate (48%). Given the demand on hospital social workers to juggle a complex workload with high administrative loads the result is somewhat understandable; however, there is therefore little known about those who did not participate (52%). There is the possibility that some social workers did not wish to engage with the topic, either as they did not want to be perceived as not coping or not resilient in the face of their work or that, if they were affected by compassion fatigue or vicarious trauma, there may have been perceived concern they would be identified through their responses. It is the hope of the research team that, by shining a light on these issues, those social workers who did not engage in the research may feel empowered to seek either personal or organisational support. The research findings then would be available more broadly to hospital-based social workers.

## Conclusion

The final outcomes of Stage One of this research were the identification of three key themes that impacted on their perception of compassion fatigue and vicarious trauma: the social worker's knowledge of compassion fatigue and/or vicarious trauma; the nature of hospital social work practice; and the identification, provision of, and engagement in, personal self-care strategies and workplace support measures. The findings highlighted the perception of responsibility for compassion fatigue and vicarious trauma in the hospital setting to be shared equally between the individual social workers and the employing hospital. Descriptive language used by the social workers when discussing their complex workplace identified the need to understand the impact through narratives, highlighting the opportunity for supervision and collegial relationships to assist in the exploring of coping and resilience. Finally, the use of both personalised individual practices and structured workplace arrangements to provide a space for compassion satisfaction or feelings of fulfilment began to be understood and heard.

A further outcome of the collaborative study design was the relevance of a PAR methodology in engaging hospital social workers in research. The research question built on the lived experience of the research team and allowed them to engage with the issues raised, examining it and asking questions of it, regularly. This process mirrored the reflective dialogue that hospital social workers engage with in clinical supervision and so was a natural research space to inhabit. Through co-designing a survey as the initial stage of the project, the research team were able to establish a research identity, reinforced through the design of questions that empowered their colleagues to question not just their work but also their perceptions of the work environment and the impact their work has on them. By engaging in a PAR process, the social workers were able to build capacity in research activity and were able to see how their research can contribute positively to organisational action through evidence-informed policy that improves staff well-being.

Further investigation is needed into the qualitative descriptive experience of working in an acute hospital setting given the varied nature of the clinical areas, the working styles of individual social workers, and the exploration of what "impact" means across individual clinical areas. This will occur in Stage Two of this study. By drawing attention to the experiences of social workers in their clinical work and in their supervision dialogue, there is the potential for an improved connection between these two spaces, and therefore an improved quality of client-centred practice. Finally, by exploring factors that allow hospital-based social workers to flourish, employing organisations, and the overall profession, can continue to support and grow this workforce in the future.

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### Authors contribution

Data collection, analysis and preparation of initial draft (DH, JG, SC, PC, BB, PD, EM, AH, MH & PY); Designing the study, data collection, analysis, preparation and finalizing the manuscript (MF). All the authors read and approved the manuscript.

### Conflict of interest

The authors have no conflicts of interest to declare that they are relevant to the content of this article.

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