



Article

Compassion Fatigue and Vicarious Trauma in Everyday Hospital Social Work: A Personal Narrative of Practitioner–Researcher Identity Transition

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Abstract: The story of my evolution as a practice-based collaborative researcher is a story that comes full circle. Through exploring my own experiences of compassion fatigue and vicarious trauma as a hospital-based social worker, I am able to investigate the phenomenon across the profession and provide a critique of the needs of practitioners working in the complex environment of hospitals and health care. Parallel to this is an investigation into the need for practice research in this complex environment and in the profession overall as seen through the lens of a collaborative research partnership with social work hospital colleagues that transformed my approach to research. I have drawn on personal narrative, autoethnography and reflexive processing to investigate my own impact on and from this research. I conclude with an understanding of the power of storytelling in participatory action research and in the potential in collaborative research methodologies for authentic reciprocity and relationship to traverse the practice–research divide.

Keywords: compassion fatigue; vicarious trauma; social work; critical reflection; participatory action research; autoethnography

1. Introduction

Compassion fatigue and vicarious trauma are understood to be potential outcomes of working in environments where the primary task of the helping professional is to empathise with those experiencing, or having had experienced, trauma. Compassion fatigue manifests as both physical and emotional exhaustion over time (Dane and Chachkes 2001), while vicarious trauma is the result of hearing stories of trauma from others (Kapoulitsas and Corcoran 2015). Social work, as a profession, has an uneasy relationship with compassion fatigue and vicarious trauma. We know the helping professions are more broadly affected in the everyday by their clinical experiences (Espeland 2006; Killian 2008; Strom-Gottfried and Mowbray 2006; Kapoulitsas and Corcoran 2015), and in the health sector specifically, we know there is a link between stress, burnout and workplace safety culture (Patterson et al. 2010). The physical and emotional symptoms of both compassion fatigue and vicarious trauma are well documented (Figley 1995; Maslach and Leiter 1997; Dane and Chachkes 2001; Espeland 2006), and although the literature validates the phenomenon as being a typical response to working with traumatised peoples (Dane and Chachkes 2001), compassion fatigue and vicarious trauma are also seen within the profession and the literature as being an inevitable side effect of the job. The uneasy relationship therefore manifests in a denial of the impact of practitioner experiences and a lack of understanding about how to support, and work with, those affected.

Personal narratives are lacking in the literature from social workers documenting their lived experience of this phenomenon. The published accounts of the everyday practice of hospital social workers are limited (Cleak and Turczynski 2014), but what is written offers rich insights using poignant case studies (Camacho 2016). Through these works, social work practice in health care

is documented as being responsive to increasingly complex and chronic hospital presentations (Craig 2007; Cleak and Turczynski 2014); more broadly in social work practice as balancing potential risk and individual liberty, with the attribution of professional responsibility and, conversely, personal and professional blame (Green 2007); and as existing in an emotionally charged practice environment complete with emotions, such as fear and shame, being keenly felt by practitioners yet minimally expressed or discussed (Smith et al. 2003).

In this environment of ever-increasing demands and complexities, we also know that compassion fatigue and vicarious trauma does not affect all social workers in the same way, and there is the possibility of post-traumatic growth (Tedeschi and Calhoun 1996; Radey and Figley 2007) and job satisfaction in this work (Hyatt-Burkhart 2014). The definitive answer to job satisfaction in the social work profession is not clear in the literature. However, the mediating of vicarious trauma and compassion fatigue includes a wide variety of both organisational and personal responses (Ashley-Binge and Cousins 2019). In addition, tasks that stretch the social work practitioner's skills whilst providing variety, such as leadership and research activities, can enrich the everyday practice experience (Rapaport and Manthorpe 2017). The challenge for social work practitioners is in the act and art of researching their own practice, the complex presentations that they interact with, and in the writing of personal narratives through which broader professional learning can be gleaned.

2. Methodology

The development of, and impact on, the researcher by way of the research is not new to practice-researchers (Shaw 2005). The recognition of the beginning of inquiry, the impact of hearing another's story, the understanding and analysis of that story, and then the re-telling or representing of that same story, allows for a transmission of sorts to occur. The researcher ceases being an objective ear or a bystander to the experience—they become entwined and a core element of the story's telling (Camacho 2016).

In this personal narrative, I present an account of the practice experiences that shaped and informed my identity development as an academic researcher, and in doing so I confront my own experience of practitioner compassion fatigue and vicarious trauma. The research study I discuss in this essay is a participatory action research project on the topic of compassion fatigue and vicarious trauma. Participatory action research was born from Kurt Lewin's concerns about industry and the effects on workers (Lewin 1946), and for Lewin, group process was the grounding of gaining knowledge about a social situation or condition (Hart and Bond 1995). The link between group process and action stems from the work of John Dewey when examining reform in education (Corbett et al. 2007), and the relationship between action and reflexivity, or a "participatory worldview", allows for a reality where knowledge is interwoven with experience (Reason and Bradbury 2006). The impetus on inquiry from the researcher, a focus on the power differential between the researcher and the researched, and the capacity for the research to be translated into tangible change address the complexity of foci within this methodology (Bradbury and Reason 2003). Throughout this project, I regularly reflected with the research team on the research process as well as the research findings to make meaning of my experiences along the life of the research.

The limitations of participatory action research as needing different validity and reliability measures mean that the generation of useable knowledge becomes a measure of validity, as opposed to the independence of the researcher being the source (Bradbury and Reason 2003). Given that the conflicting roles of researcher and researched are intertwined in participatory action research, there is criticism as to the basis of power in the relationship, with the application of this power having some ethical concerns (Healy 2001). Power is a social construct to be actively negotiated at the beginning and throughout the participatory action research process. Power and the perceived role of the expert are in turn seen as a limitation within this methodology. Ongoing reflection on the nature and impact of power in these relationships is strongly advocated (Healy 2001). The impetus is on the researcher to reflect on the power differential as present, the basis for which this personal narrative has been

written. Although the research discussed here is participatory action research, the analysis and findings that are discussed have emerged through personal narrative, utilising an analytic autoethnographic methodology, complete with the requisite reflexive paradigm (Anderson 2006). Personal narrative and storytelling as a method has a strong history in health-based literature, but are seen less often in accounts of social work practice or research. Although published personal narratives from social work are uncommon, they are well received in the social work practice community due to their capacity for portrayal of the everyday complexities of the work (Craig 2007).

With this context in mind, the writing of this personal narrative utilised methods drawn from autoethnography and participatory action research. These methods included reflective sessions with participants and co-researchers whereby a co-construction of meaning has taken place, as well as autoethnographic journaling throughout the life of the research (Jones and Smith 2017). In addition, in the writing of this personal narrative and constructing my analysis, I am drawing on the history of critical reflection and reflexive writing in both social work practice and social work research (Shaw 2005; Kanuha 2000; Gant et al. 2019). Subjectivity and researcher indulgence potentially limit the reliability and capacity to generalise the findings (Denzin 2006), risking an account of evocative autoethnography (Atkinson 2006).

I am confident that the autobiographical nature of my analysis aids in developing our understandings of not only the lived experience of compassion fatigue and vicarious trauma on the social work profession, but also supports the profession to proactively and critically think through its own well-being. In addition, I am always conscious that my experiences and reflections presented here are my own, albeit having been born from discussions and collaborative relationships with my research partners. This transferable process has been fundamental and inherent to the insider–outsider dynamic present in my involvement in, and enactment of, collaborative research with social work practitioners (Kanuha 2000)—in my case, my esteemed colleagues in hospital social work practice.

3. My Social Work Practice Background

Having dabbled initially in the non-government sector upon qualifying as a social worker, I quickly settled into a practice career that was largely based in acute metropolitan hospitals and in community health. My mother was a general practitioner and would often discuss her everyday work with me, including her patient successes and her organisational frustrations in the health system. When I first started working in the health setting as a qualified social worker, I would go home and discuss my experiences with her. I would reflect on what it was like to work in such a big bureaucracy, and how entering the hospital was like entering a whole new world. Not only was the professional culture different to any I'd known before, the structure and environment was designed to make you believe you were in an important place. One hospital I worked in as a young social worker had an extremely impressive entrance with grand architectural design, however the hospital overall was designed in such a way that there was very little natural light. The staff cafeteria was at the bottom of the hospital next to the morgue, and there were very few sunlit spaces for either patients or staff to sit in. During the winter, I would arrive at work early in the dark, and leave after a long day, again in the dark. This is not uncommon for staff working long shifts in the hospital setting, and the positive impacts of strong architectural design on staff well-being in hospitals has been well documented (Sundberg et al. 2017). The effect of working long days in a closed-in environment was to me as equally challenging as it was professionally validating and exciting. Despite this protected and closed environment, I grew to love working in hospitals over time, and in some ways the privileged position that belonging to a professional subsection of society can afford (Pease 2006). In my years as a practitioner, the hospital became an environment of protection for me, a culture where I could grow and develop my clinical social work skills, supported and nourished by colleagues all living and working together in the same space.

After ten years of practice in this context, I had developed expertise in death, dying, and chronic and complex health. I was interested in further study and embarked on a Masters program, and then slowly

found myself gravitating to educator opportunities in my career, rather than clinical development. I noticed a difference in me in that what was once challenging and nourishing, had become stagnant and crippling. I began distancing myself from clinical discussions with colleagues, as they felt repetitive to my ears. I disengaged from professional opportunities if they were purely clinical and without an educational component, and finally I started to disengage from my patients and their families. I remember being acutely aware that I had started to use my knowledge of micropractice skills against my patients. Instead of using exploratory open questions designed to elicit more information, I was purposefully asking closed questions and not engaging in eye contact, preventing them from connecting with me and telling me their stories. I felt that if I did not hear their story, I would then not have to feel their story, nor take responsibility for their story. I felt that by working in a never-ending cycle of practice complexity, I could no longer care about chronic health, an issue that felt too big and insurmountable to me. I was tired, disengaged and ultimately, my empathy well had run dry. I had my first child and used this as a way to leave practice and enter the university environment. I took a job at a local university, began my PhD study, and put this chapter down to a changing professional focus for me, nothing more.

This story is a common story. Indeed, the story of a practitioner transitioning into higher degree education is an everyday occurrence. What complicates this story are the factors that come into play in making the decision. Hospital social workers leave practice all the time, with no follow-up as to why this occurred. Their colleagues are left wondering after having watched them flounder in their everyday experience of the workplace, with no answers given as to what went wrong, and therefore no way to rectify the concerns. Additionally, their colleagues are left wondering why this didn't happen to them, how had they escaped the same fate? Was there something different about their coping or their resilience? Or the way they interact daily with their work?

When I reflect on my experience working in hospital social work, I am left with the same questions as the practitioners that came before me and continue to practice in this environment. At that time, I was struggling with my capacity to display empathy to my patients and families. I was disconnecting from my colleagues who were having a different experience to me, disengaging from not only their clinical practice, but the entire clinical space. I was seeking out opportunities to engage in teaching, education and research initially as a means of escape, and then as a solace. While still a practitioner, I realise now that I had been struggling with compassion fatigue and vicarious trauma. In order to mediate this, I had unconsciously been seeking out university partnerships through those years. I had developed skills in teaching in partnership and had sought out academic mentorship to begin writing for publication, both activities undertaken whilst working as a hospital social worker. Teaching, writing, and research in the practice environment had been building my resilience and bringing back my job satisfaction. It is from this background that I moved into my doctoral studies on a topic grounded in social work education, and far removed from hospital social work.

Ten years later, I had maintained my hospital networks throughout my university career and had never processed the reasons why I had left my previous practice context. I was approached by my social work colleagues as to whether I would be interested in working with them to research the experience of vicarious trauma and compassion fatigue in hospital social workers. It was to be a six-month-long project and without a second thought, I said yes.

4. My Identity as a Social Work Researcher

My doctoral studies and my entry into becoming a researcher equipped me in qualitative methodologies. I emerged with a clear understanding of the capacity for lived experience to inform new practice understandings, theoretical frameworks and the ensuing translation into improved practice outcomes and the advance of scholarship. However, I had not researched in partnership up until this point; I had not collaborated equally with my participants in the research space. I met with my hospital social work colleagues—all senior managers and educators—and they expressed the desire for themselves and their social work staff to be mentored in research and collaboratively

engaged with throughout the process. We discussed the development of a hierarchy-free research team, an environment where all members could learn from each other, including myself as the academic partner. The final membership of this research team included hospital social workers at all levels, social work students, and myself. At this point, I was keenly aware of the emphasis within this team being on collective learning, however I was unsure still as to what I was learning, or where my learning was situated. I had been firmly positioned as the mentor in the team, the one with the prior knowledge of research and given the position of expert. This did not feel automatically deserved, for although I had the experience of having “done” research, I had not researched collaboratively with a team of social work practitioners before. Indeed, although some of the practitioners had researched with social workers previously, they had not researched in a team before either. Some had only researched in partnership with other disciplines, such as medicine or nursing. In addition, I had not practiced in hospital social work for ten years at this point. Expertise in hospital social work practice was firmly held by my professional colleagues, and so a social work research collaboration that was grounded in authentic reciprocity was formed.

In general, social workers in practice struggle to find the time and confidence to engage with research (Beddoe et al. 2010; Pain 2011; Goel et al. 2018), with a value conflict inherent in organisational culture surrounding research in practice (Shannon 2013). This is particularly true for hospital-based social workers, immersed in a quantitative research culture, dominated by medical and nursing colleagues and driven by evidence-based methodologies (Beddoe et al. 2007). Over time, there has been an increase in nursing and allied health engagement in qualitative methodologies and published research from and with hospital social workers in Australia although now present, is slow to rise (Short et al. 2017; Miller 2018; Harrison et al. 2019). I had many social workers previously ask me to aid them in publishing their case studies or to work with them on issues that had been raised for them in practice. Both lines of practitioner enquiry have strong research and publication histories behind them (Gilgun 1994; Gherardi 2006), but this was not familiar to these social workers working in the hospital setting, and so they struggled with how to approach, then organise, their ideas and investigation.

The research team formed in the way that social workers normally communicate and collaborate—regular meetings with a lot of talking. In fact, the process of collaboration for this social work team embodied the values and principles that I saw them engage with in their daily practice. Principles such as mutual trust and support, combined with values grounded in joint ownership and collaborative expertise, allowed these social workers to create a research space that although challenging and new to them, was in fact a space that was comfortable and somewhat familiar. Clear value alignment is important to social workers when approaching research (Shannon 2013), yet so is the capacity to be reflexive on, and in, their practice. Critical reflection has been embraced by a variety of disciplines and indeed is strong in the health sector more broadly (Gant et al. 2019). Social work has a strong history and relationship with critical reflection in practice, and in a commitment to reflexivity throughout the profession. This is generally seen in supervisory practice or in social work education, both with students and in the early and ongoing professional development space (Cleveland et al. 2019; Watts 2019).

This was affirmed for me after an initial research team meeting where the focus had been on making meaning of the research. One member of the team commented, “This is just like group supervision!” Everyone around the table laughed knowingly. What had emerged for the practitioners was a practice dynamic that the social workers could relate to despite being immersed in a sometimes very different research process. Conversely, what I was experiencing was a shared cultural knowledge being enacted through a practice dynamic that not only my research team could identify with, but one that was innately familiar to me as an ex-hospital social worker (Kanuha 2000). Despite having come into the hospital environment this time as an outsider, my previous background in hospital social work practice, as well as my willingness to explore authenticity within reciprocal relationship, allowed me to equally share in the practice norms present in the room.

When the research team formed, I found myself in the expert role, guiding the development of research questions and a research trajectory for the project. But as the team developed further, the research meetings took on a reflective tone with the hospital social workers sharing their expertise, discussing what vicarious trauma and compassion fatigue meant to them, how their own experiences had led them to this project, and what they hoped the findings from this research would bring to them and their colleagues. In turn, I began to reflect on my role in the team and began to understand that my learning was in working collaboratively with my practice colleagues—not just in understanding their experiences—but in jointly making meaning of it. Imperative in this relationship-building stage was the notion of authentic reciprocity (Anderson 2006; Miller 2018): what could I give to this group of practitioners that would not only sustain them throughout the lengthy period of a research study, but would also motivate them to see the potential outcomes of their endeavours? Not only for them as individuals, but for their colleagues and for their profession? In turn, what could they contribute to a long-term research relationship, complete with the need for academic and scholarly outputs and impact? Overall, given the limitations and ethical concerns of participatory action researchers who strive for the eradication of a power dynamic in the aim of change creation, how can I uphold the need for a flat structure despite being perceived as the expert in the team?

One day soon after we began, I sat down and wrote a briefing paper for our research. In this paper, I outlined how what I saw unfolding around me was, in fact, practice-based research (Miller 2018), complete with research questions arising from practice in order to inform practice (Dodd and Epstein 2012), and that I felt that the fundamental processes needed to successfully co-create meaning and knowledge in this space were grounded in a reflexive paradigm, able to be realised through reflective cycles. I discussed how the practical outcomes of the research would come about through co-construction of research findings, a cycle where critical reflection was as fundamental as formal, or traditional, methods of data collection and in fact would sit in parallel with periods of data collection and analysis. Finally, I provided the research team with a framework in participatory action research, a research methodology with a strong history in health and workplace research (Pasmore 2006; Fox et al. 2007), with relevance to social work practice (Bradbury and Reason 2003), albeit with differing perspectives on application (Healy 2001; Shaw 2005). I described the interconnected relationship between the research team and the data to the practitioners (Gibbs 2001; Corbett et al. 2007), and the opportunity for collaborative enquiry (Reason and Bradbury 2006). I realised through this process that I was just as much a part of the co-construction of meaning as the rest of the team, for my experiences of compassion fatigue and burnout from hospital social work had led me to this research topic. I was now researching myself and my own experiences, despite initially being the outsider brought in to support a research team made up of insider experiences (Gatenby and Humphries 2000). In addition, my role as research mentor was essential to the process, with education being fundamental to the participatory action research reflective paradigm (Corbett et al. 2007).

5. Sustaining the Well-Being of Our Workforce

Compassion fatigue and vicarious trauma are a predictable outcome of undertaking social work practice. This is true across all of the sectors in which social work is practised, and is a by-product of developing relationships with vulnerable peoples everyday. In this account, I have reflected on the complex environment of health and the hospital setting, yet I am aware that this phenomenon does not exist for only social workers in that sector. 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, how the organisations that employ these practitioners are impacted, or indeed how the clients, patients or their families experience these clinicians. Through presenting an autobiographical and autoethnographic account of my transition from social work practitioner to social work academic, I have asked questions of myself and the profession regarding our well-being to help define who is responsible to address this gap.

It is my position that research methodologies that require social workers to enquire about their own practice experiences, and the impact they have on themselves as professionals as well as on those they work with, allows for an opportunity in mutual understanding and the generation of professional knowledge in this field to be realised. Questions in turn demand answers that can, and should, lead us to a richer understanding about this phenomenon from which change can occur for our profession. By considering who is the expert in the room space can be made for the practitioner expert to sit side-by-side with the research expert, as well as offer opportunities to take charge of the research process.

It should be noted that the blame for this lack of understanding about our everyday experience of practice can only fall to our own profession. The literature shows that we do not have enough published accounts of everyday social work practice in the health setting, let alone accounts of the difficulties and challenges that comprise the work. If we were able to access the stories of our practitioners and their everyday struggles, we would not only find insights into what social workers need in order to thrive in our profession, but also how to better equip them throughout their training for the personal and professional demands of the job. Another missing piece of this puzzle, and an opportunity for further research, would then be what can be further developed in our social work curriculum to ensure the professional resilience of our workforce.

Through engaging with my own experiences both in practice and out of practice, and over the life of this collaborative practitioner-academic research team, I have come to see myself as a practice-based researcher. I cannot divorce myself from my practitioner experiences; they are, after all, what has informed both my professional and academic identity. In acknowledging that these are the questions that arise in social work practice that inspire me to seek, know and understand, I acknowledge the unique space that practice-based research holds, and validating the social work practitioner in their role as expert in their practice. I am also able to recognise that social work practice is about stories—it is the individual stories that allow social workers to find the space to connect and build relationships with those in need. Similarly, moving forward, my research must now be grounded in stories and the art of storytelling, and my research partnerships in collaborative and authentic reciprocal relationship. Without this, my research identity risks being disconnected from practice concerns and the everyday enactment of social work practice.

When this research study into compassion fatigue and vicarious trauma was first discussed with my hospital social work colleagues, it was to be a six-month-long project. It is now more than three years later, and the research has uncovered findings into the acute emotional state in which social workers practice daily, the strengths with which they meet their vulnerable patients and families, and highlighted the vulnerabilities they bring to those same patients and families. I find myself regularly visiting the hospitals involved in the research, some in which I practiced as a clinician many years ago. Once upon a time, the hospital space had felt alien to me, a place I had needed to leave in order to protect my everyday professional satisfaction and personal strength. This feeling has now dissipated, and the old sense of comfort and knowing has returned in its place.

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