COMPASSION FATIGUE AND SELF-CARE: VOICES OF NEWLY QUALIFIED SOCIAL WORKERS

by

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Declaration

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SUMMARY

Existing literature on compassion fatigue and self-care have increased. However, newly qualified social workers receive less attention and are often not the focus of study, with little to no research studies conducted on the plight of social workers in South Africa. They continue to find themselves in stressful and demanding situations which inhibit their ability to conduct their work effectively. This is especially prevalent among newly qualified social workers, who face challenges pertaining to transitioning from student to professional, and this is the reason they are at increased risk of experiencing compassion fatigue compared to more seasoned social workers. In this context, compassion fatigue can be regarded as an ethical concern to be addressed, as it not only negatively affects newly qualified social workers in their personal lives, but also their work performance and service rendering. Despite self-care being recognised as a promising measure to prevent compassion fatigue, newly qualified social workers are not adequately equipped to implement it and thus cannot curb compassion fatigue themselves. Against this backdrop, this research study was aimed at understanding of the compassion fatigue and self-care practices used by newly qualified social workers in the South African context.

A qualitative research approach was utilised in order to capture the rich accounts of newly qualified social workers with regard to their experiences with compassion fatigue and self-care. Descriptive and exploratory research designs were used to substantiate the capturing of various narratives from the participants. To this end, a snowball sampling method was utilised for the purpose of this study. Eighteen participants were interviewed using semi-structured interview schedules. The data gathered was analysed using a thematic content analysis approach. This research document contained three literature chapters, with the first attempting to serve as a framework regarding the conceptualisation of work contexts and working conditions experienced by newly qualified social workers. The second analysed the compassion fatigue experienced by newly qualified social workers, in particular articulating its conceptualisation, symptoms, and relationship with compassion satisfaction, job satisfaction, as well as burnout. Finally, the third identified self-care practices by those prone to compassion fatigue. Building on the background established in the literature chapters, chapter five of this research study contained the

empirical study. In this chapter, results from data collected from participants and literature were presented in an integrated manner. Based on these results, chapter six contained the conclusions and recommendations of the research study.

The main conclusions drawn from the findings established that newly qualified social workers work under extremely harsh conditions which are worsened by challenges related to the transitioning from student to professional social worker. This, along with a lack of organisational support, has increasingly led to the development and experience of compassion fatigue among newly qualified social workers, which is detrimental to them as individuals and professionals. The symptoms of compassion fatigue are far-reaching and impede all aspects of the professional's wellbeing. Owing to the negative impact of compassion fatigue on the quality of service rendering, it should be regarded and addressed as a vital, ethically informed concern in South Africa. In light of the prior mentioned conclusions, it is recommended that self-care not be regarded as the sole responsibility of newly qualified social workers, but rather holistically promoted by training institutions, the South African Council of Social Service Professions, the National Department of Social Development, organisations employing newly qualified social workers, and the managers and supervisors of the social workers concerned.

OPSOMMING

Bestaande literatuur oor deernisuitputting en selfsorg het toegeneem. Nietemin kry gekwalifiseerde maatskaplike werkers minder aandag in die sin dat hulle selde die fokus van navorsingsonderwerpe is, met min of geen studies in Suid Afrika wat handel oor maatskaplike werkers. Hulle is wel deurlopend in stresvolle en uitdagende situasies wat hul vermoë om effektief te werk of presteer beperk. Hierdie is veral heersend onder nuutgekwalifiseerde maatskaplike werkers, wat uitdagings ervaar ten opsigte van die oorskakeling vanaf student tot professionele hoedanigheid. Hierdie verandering is die rede waarom hulle 'n verhoogde risiko het om deernisuitputting te ervaar in vergelyking met ervare maatskaplike werkers. In hierdie konteks kan deernisuitputting gesien word as 'n etiese aangeleentheid wat aangespreek moet word omrede dit nie net nuutgekwalifiseerde maatskaplike werkers in hul persoonlike lewens affekteer nie, maar ook hul werksprestasie en dienslewering. Ten spyte daarvan dat selfsorg erken word as 'n belowende maatreël om deernisuitputting te voorkom, is nuutgekwalifiseerde maatskaplike werkers nie voldoende toegerus om dit te implementeer nie, en hul kan dus nie self deernisuitputting teenwerk nie. Gevolglik het hierdie studie beoog om deernis-uitputting en selfsorgpraktyke wat nuutgekwalifiseerde maatskaplike werkers in die Suid Afrikaanse konteks gebruik te verstaan.

'n Kwalitatiewe navorsingsbenadering is gebruik om die ryk weergawes van nuutgekwalifiseerde maatskaplike werkers se ervaring van deernisuitputting en selfsorg vas te vang. Beskrywende- en verkennende navorsingsontwerpe is gebruik om die narratiewe van deelnemers vas te vang en te ondersteun. Tot hierdie doel is 'n sneeubal steekproefmetode gebruik vir hierdie studie. Onderhoude is met agtien deelnemers gevoer deur middel van semi-gestruktureerde onderhoudskedules. Die ingewinde data is geanaliseer deur 'n tematiese inhoudsanalisebenadering te gebruik. Die navorsingsdokument het drie literatuurstudiehoofstukke bevat. Die eerste literatuurhoofstuk het as 'n raamwerk vir die konseptualisering van werkskontekste en werksomstandighede van nuutgekwalifiseerde maatskaplike werkers gedien. Die tweede literatuurstudiehoofstuk het gepoog om die deernisuitputting wat nuutgekwalifiseerde maatskaplike werkers ervaar te analiseer, met spesifieke verwoording van

konseptualisering, simptome, deernisvervulling, werksbevrediging, asook uitbranding. Laastens het die derde literatuurhoofstuk gemik om selfsorg praktyke van diegene wat geneig is tot deernisuitputting uit te wys. Volgens die teoretiese raamwerk wat in die literatuurhoofstukke uiteengesit is, het hoofstuk vyf van hierdie navorsingstudie die empiriese navorsing bevat. Die data wat ingewin is van die deelnemers en literatuur is op ’n geïntegreerde wyse voorgelê. Volgens hierdie voorlegging het hoofstuk ses die gevolgtrekkings en aanbevelings van die navorsingstudie bevat.

Die hoof gevolgtrekkings vanuit die bevindinge wys dat nuutgekwalifiseerde maatskaplike werkers onder ongenaakbare omstandighede werk, wat vererger word deur uitdagings wat verband hou met die oorskakeling vanaf student na professionele maatskaplike werker. Hierdie, tesame met ’n tekort aan organisatoriese ondersteuning, het toenemend gelei na die ontwikkeling en ervaring van deernisuitputting onder nuutgekwalifiseerde maatskaplike werkers, wat nadelig is vir hulle as individue en professionele persone. Die simptome van deernisuitputting is verreikend, en belemmer alle aspekte van die professionele persoon se welstand. Met inagneming van die negatiewe impak van deernisuitputting op die kwaliteit van dienslewering, moet dit gesien en aangespreek word as ’n essensiële en eties-ingeligte belang in Suid Afrika. Weens die voorgenoemde gevolgtrekkings word dit aanbeveel dat selfsorg nie alleen gesien moet word as die uitsluitlike verantwoordelikheid van nuutgekwalifiseerde maatskaplike werkers nie. Dit moet holisties bevorder word deur opleidingsinstansies, die Suid Afrikaanse Raad vir Maatskaplike Diensprofessies, die Nasionale Departement van Maatskaplike Ontwikkeling, organisasies wat nuutgekwalifiseerde maatskaplike werkers in diens neem, en die bestuurders en supervisors van die betrokke maatskaplike werkers.

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CHAPTER 1: INTRODUCTION TO THE STUDY

1.1. INTRODUCTION AND RATIONALE

Compassion satisfaction and compassion fatigue have been widely studied among human social services since the 1970's (Freudenberger, 1974; Maslach & Schaufeli, 1993; Stanley, Buvaneswari & Arumugam, 2018). Christina Maslach, a prominent American researcher and psychologist, pioneered the knowledge of burnout and compassion fatigue with the focus on social workers (Maslach & Schaufeli, 1993). Within this context, social work is defined as "a practice-based profession and an academic discipline that promotes social change and development, social cohesion, and the empowerment and liberation of people," with "[p]rinciples of social justice, human rights, collective responsibility and respect for diversities" serving as its central tenets (IFSW & IASSW, 2014). Further, the practice is "[u]nderpinned by theories of social work, social sciences, humanities and indigenous knowledge," and it "engages people and structures to address life challenges and enhance wellbeing" (IFSW & IASSW, 2014).

Since social work is a practice-based profession, social workers continue to find themselves in stressful and demanding situations at work, which produces various stressors. According to Stanley *et al.* (2018), these are often identified within three themes, namely organisational factors (a lack of support, limited resources, poor pay and remuneration, high caseloads, and low levels of control), practitioner characteristics (self-esteem, self-efficacy, extraversion, hardiness, and emotional stability), and client attributes (post-traumatic stress, trauma, and disability). Such themes are related to social worker stress and, when predominantly negative, hinders their ability to perform work effectively and eventually causes burnout (Alarcon, Eschleman & Bowling, 2009; Morazes, Benton, Clark, & Jacquet, 2010; Lawson & Myers, 2011; McGregor, 2014; Beer, 2016; Ravalier, 2018). Authors Hussein, Moriarty, Stevens, Sharpe and Manthorpe (2014) agree that such factors contribute to dissatisfaction with work and may ultimately lead to social workers leaving the practice. These circumstances hold true for the South African context, with challenges such as limited remuneration, restricted growth and promotion, health and safety challenges such as exposure to violence, and other

challenges associated with working with difficult and diverse client systems in poor working environments (Department of Social Development, 2009, 2012). Voices on social media corroborate this with statements encouraging newly qualified social workers to work despite it being “draining” and urging them to “forget how little [they] get paid” (Nkosi, 2017). These challenges are intensified when experienced by a newly qualified social worker, typically a professional with 0-24 months of working experience, and may lead to an earlier intention to leave (Hussein *et al.,* 2014). Hunt, Lowe, Smith, Kuruvila and Dreadon (2016) strongly concur that the first years are challenging for social work graduates as they embark on their careers and have identified difficulties relating to the transition, which is further worsened by a lack of organisational support. Therefore, one may be of the opinion that newly qualified social workers are at a higher risk of experiencing compassion fatigue when placed in such circumstances compared to veteran social workers.

Compassion fatigue entails the behaviours and emotions experienced by those in helping professions, and is otherwise understood as encompassing both burnout and secondary traumatic stress (Maslach & Jackson, 1981; Figley, 1995; Stamm, 2010; Audin, Burke, & Ivtzan, 2018). Burnout, a general feeling of emotional exhaustion resulted by frequent exposure to emotionally challenging situations and secondary trauma, as well as symptoms of traumatic stress (resulted from being indirectly exposed to others’ experiences of actual trauma) impact on the ability to maintain compassion for others, which is consequential in helping professions such as social work (Stamm, 2010). It is thus essential that social workers, in particular newly qualified social workers, be assisted in preventing and dealing with compassion fatigue, as it diminishes their empathetic ability, reduces work efficiency, and causes exhaustion and personal distress which is associated with depression. This negatively influences the helping process with vulnerable client systems, which is also in opposition to the Code of Ethics of the South African Council for Social Service Professions (Figley, 2002a; Adams, Boscarino, & Figley, 2006; SACSSP, 2008; Thomas, 2013).

Taking into consideration the challenges faced by social workers, the effect of compassion fatigue on both the professional and the client, as well as the increased risk of newly qualified individuals leaving the practice, attention should be given to self-care.

Self-care, a multidimensional process of strategies that promote healthy functioning and enhance wellbeing, may be a way to mitigate the problematic symptoms and could also alleviate professional burnout (Greville, 2015; Dorociak, Rupert, Byant, & Zahniser, 2017). Several researchers identify a need for institutions to teach students about mindfulness in order to assist them in transitioning more easily into the practice and being able to identify and deal with challenges to ensure their retention in the practice (Gockel & Deng, 2016; Iacono, 2017; Roulston, Montgomery, Campbell & Davidson, 2017). Although knowledge surrounding self-care is mostly generated in Western countries, Stanley *et al.* (2018) retorted that it is universal in nature, although the practice of social work may differ due to contextual factors. As such, one may question whether values and strategies of appropriate self-care may differ in a South African context, and in particular among newly qualified social workers. In South Africa, the Council on Higher Education has developed qualification standards for the Social Work degree and presses for an increase in knowledge and skills related to the "self" (Council on Higher Education, 2015:9-14). It will, however, only be set in motion in 2020 by most universities. This begs the question of how student social workers have previously been prepared to deal with challenges in practice, and more pertinently, whether newly qualified social workers in South Africa are able to effectively deal with such challenges to mitigate the prevalence and effects of compassion fatigue that adversely affects not only them as professionals, but also their client systems.

1.2. PROBLEM STATEMENT

Newly qualified social workers experience a myriad of challenges relating to the transition from student to professional social worker, as well as to the difficulties of working within the social work field (Hunt *et al.,* 2016). As professionals, they may also be affected by compassion fatigue, taking into consideration that they are dealing with difficult and diverse client systems who experience significant trauma. Symptoms of this condition may include an escalation in exhaustion, disinterest, empathy, reduction in work efficiency and personal distress. Apart from adversely affecting the individual, these symptoms also hinder the professional's ability to work effectively with the vulnerable client system during the helping process. Several studies have been done on the topic of compassion fatigue

in South Africa, but these have focused solely on healthcare practitioners (Elkonin & Van der Vuyver, 2011; Mason & Nel, 2012; Mashego, Nesengani, Ntuli & Wyatt, 2016). A single South African study involving job satisfaction and coping strategies of newly qualified social workers and more experienced workers was identified. The study is, however, a decade old and focused only on substance abuse treatment centres in Gauteng (Vermeulen, 2009). There is clearly a remarkable need for insight into the non-western and indigenous values and strategies of self-care (Stanley *et al*. 2018) as a means of mitigating the effects of compassion fatigue. Knowledge relating to the challenges and compassion fatigue experienced by newly qualified social workers within the South African context is imperative due to the impact of compassion fatigue on the retention of social workers. For instance, there is a critical shortage of social workers in South Africa (with the practice classified as a 'scarce skill') and there is a high staff turnover (Calitz, Roux & Strydom, 2014).

1.3. RESEARCH QUESTION

What is the prevalence of compassion fatigue and the self-care practices employed by newly qualified social workers in the South African context?

1.4. GOAL OF THE RESEARCH

The goal of this research was to gain an understanding of the compassion fatigue and self-care practices used by newly qualified social workers in the South African context.

In order to achieve this goal, the following objectives were devised:

- To describe the nature of the social work context for newly qualified social workers in South Africa.
- To analyse the compassion fatigue experienced by newly qualified social workers in the South African context.
- To identify self-care practices by those prone to compassion fatigue in the South African context.

- To explore factors contributing to symptoms of compassion fatigue in newly qualified social workers in South Africa along with the self-care practices that buffer these symptoms.

- To offer conclusions and recommendations to newly qualified social workers, supervisors, managers, and tertiary education institutions pertaining to compassion fatigue and self-care.

1.5. THEORETICAL POINTS OF DEPARTURE

Theoretical conceptualisations of job satisfaction were utilised to add structure and give meaning to the complexities within the social work profession. These included situational theories, which propose that satisfaction is based on the working environment, and dispositional theories that respond that job satisfaction is based on personality and individual characteristics (Judge & Klinger, 2008; Redmond, 2016).

In order to understand the nature and complexity of compassion fatigue, the following models/frameworks were used:

- The compassion stress and fatigue model, which is based on the assumption that empathy and emotional energy are necessary to connect with and respond to clients (Figley, 1995).

- The professional quality of life model which outlines how the client, work, and personal environment of the worker contributes to either compassion satisfaction or compassion fatigue (Stamm, 2010).

Apart from these frameworks, the six-dimensional model of individual wellness was also utilised to understand self-care, which identifies dimensions that are interactive such as social-, occupational-, spiritual-, physical-, intellectual-, and emotional wellness. These contributed to a holistic approach to wellness and an understanding of the multidimensional nature of self-care as a concept (Hettler,1976).

1.6. CONCEPTS AND DEFINITIONS

The following concepts are defined for the goal of the study:

1.6.1. Compassion fatigue

Compassion fatigue involves the behaviours and emotions experienced by those in helping professions and is otherwise understood as encompassing both burnout and secondary traumatic stress (Maslach & Jackson, 1981; Figley, 1995; Stamm, 2010). It is also understood as "the cost of caring," and is a typical response associated with being exposed to others' narratives of trauma and influences one's empathetic response and emotional well-being (Figley, 1995:9; Portnoy, 2011). The term is used interchangeably with other concepts such as secondary traumatic stress, vicarious traumatisation, and burnout, despite nuances in definition (McCann & Pearlman, 1990; Figley, 1995; Stamm, 2009).

1.6.2. Self-care

Bressi and Vaden (2017:34) mention that self-care refers to "activities or processes that are initiated and managed by the worker for the purpose of supporting one's health and well-being, attending to one's needs, or providing stress relief." The authors further add that self-care may involve peers, supervisors, therapists, friends, and family, although it is presumed that it involves caring "by the self and for the self" (Bressi and Vaden, 2017:34).

1.6.3. Newly qualified social worker

The term "newly qualified social worker" is given to social workers who have received their qualification and entered the practice. Authors Moorhead, Bell, and Bowles (2016) indicate that this period begins after graduation and ends 12 months later, but for the purpose of the study, and according to South African scholars, newly qualified social workers were considered as those 0-24 months post-graduation (Cloete, 2012).

1.7. RESEARCH DESIGN AND METHODOLOGY

This section provides an outline of the research approach and design, as well as the sampling, instrument for data collection and data analysis.

1.7.1. Research approach

A qualitative research approach was utilised to reach the research objectives. Bless, Higson-Smith and Sithole (2013) are of the opinion that a qualitative approach is most often utilised by a researcher when a phenomenon has not been thoroughly investigated before. The purpose of this is to understand the phenomenon and to subsequently generate new findings. Accordingly, Bryman (2012) asserts that qualitative research places an emphasis on ways in which individuals interpret their social world, and that it embodies a view of social reality as it is continuously changing. As such, Fouché and Schurink (2011) put forth that qualitative research broadly refers to the research that motivates research participants' narrative of meaning, experience, and perceptions.

Qualitative research is further preferred by many researchers due to its flexible and circular nature, which allows the researcher to refer back and adjust topics of discussions according to the narratives of the participants (Bless *et al*., 2013). This study looked to explore the experiences of newly qualified social workers in South Africa regarding compassion fatigue and self-care. In utilising the qualitative approach, the narratives and voices of the participants were elicited. It gave the researcher the opportunity to probe for in-depth information and discourses regarding the participants' experience of compassion fatigue and self-care.

Moreover, a deductive logic of reasoning was utilised as opposed to inductive. Babbie (2007) explains that deductive reasoning moves from the general to the specific and practically entails conducting the literature study before the empirical study. Inductive reasoning, on the other hand, moves from the specific to the general and practically entails conducting the empirical study first. Therefore, this study's use of deductive reasoning allowed the researcher to gain a broader understanding and knowledge surrounding the compassion fatigue and self-care of newly qualified social workers through theoretical engagement before employing the perspectives of its participants.

This was achieved through conducting a literature study and then deducing the information through the empirical study in order to gain a better understanding of the specific situation of a particular population, in this case, newly qualified social workers. However, although the research was predominantly structured to employ deductive reasoning, a movement between inductive and deductive reasoning occurred as the researcher revisited literature after the empirical study in cases where participants identified and elaborated on aspects regarding compassion fatigue and self-care which the researcher was unaware of prior to the empirical study.

1.7.2. Research design

In joining with the qualitative approach, descriptive and exploratory research designs were utilised for the purpose of the study. A descriptive design, according to Fouché and Schurink (2011), is utilised when information and knowledge regarding a subject exists and the researcher is interested in gaining an understanding of the opinions and thick descriptions of people regarding a specific issue at a specific time, thus expanding existing understanding on the topic. On the other hand, an exploratory design is utilised when there is limited information and knowledge on a subject or phenomenon and enables the researcher to gain insight into a particular phenomenon (Fouché & Schurink, 2011; Bless *et al.*, 2013). Both descriptive- and exploratory designs were deemed appropriate for this study, as they yielded in-depth information and thick descriptive accounts of compassion fatigue and self-care as expressed by newly qualified social workers in South Africa. Ultimately, this combination assisted in generating a stronger knowledge base and in gaining a better understanding of the circumstances of newly qualified social workers.

1.7.3. Sampling

Bless *et al*. (2013) describes a sample as the representatives drawn from a population and studied with the purpose of acquiring knowledge. Snowball sampling, a form of non-probability sampling, was utilised for the purpose of the study. Bryman (2012) explains that this is a technique in which the researcher samples a small group of participants who, in turn, propose other participants who have the same experience or characteristics

relevant to the research. This was done in the study until the required number of participants was reached. Alston and Bowles (2003) express that it is customarily utilised when there is a lack of knowledge regarding the sampling frame, or when there is limited access to the appropriate participants.

Taking this into account, snowball sampling was desirable, as compassion fatigue and self-care practices of newly qualified social workers in the South African context is arguably a relatively unknown area of study. In particular, the fact that the existing knowledge regarding compassion fatigue and self-care is primarily of a Western nature necessitated the need for finding participants from a less represented population group. Accordingly, the study included a varied spread of South African organisations, both public and private.

The criteria for inclusion of participants were that they:

- Be a newly qualified social worker (0-24 months of working experience).
- Be registered at the South African Council for Social Service Professions (SACSSP).
- Be employed in South Africa as a social worker at any organisation at the time of the empirical study.

The sample consisted of 18 participants who shared their own narratives of compassion fatigue and self-care. Interviews were concluded after the saturation of 18 participants was reached. Saturation, simply put, is when information is repeated and no new information emerges (Seidman, 1998). The researcher identified the first participant from her professional network and started collecting data for the empirical study by initiating contact with this individual via telephone. This first participant was then asked to identify other possible participants should they meet the criteria of inclusion. They either asked potential participants for permission to share their contact information with the researcher, or the first participant was asked to share the researcher's information with the potential participants. After each participant was identified and consent obtained, an interview would then be conducted by the researcher, focusing in particular on the newly qualified social worker's perception of symptoms of compassion fatigue experienced by newly

qualified social workers in the South African context along experiences of self-care practices to remedy this strain.

Due to the Covid-19 pandemic, South Africa regulated a strict lockdown procedure and social distancing measures to prevent the widespread disease from worsening (WHO, 2020). This affected the data collection, as participants were given the option to choose between telephonic calls or face-to-face interviews. Of the 18 participants, 17 participants indicated telephonic interviews to prevent contagion and to ensure their health and wellness. In each case, the participant was contacted and interviewed in his/her personal professional capacity. The research neither interfered with the participants' working environments and work hours nor focused on particular organisations, and thus did not require organisational permission. Organisations could not be identified, as this would have hampered both the organisation's and the professional's anonymity.

1.7.4. Instrument for data collection

As the study was qualitative in nature, an interview schedule was implemented for the semi-structured interviews using open and closed-ended questions. Greeff (2011) states that a semi-structured interview is used to give a detailed idea of the perceptions, experiences, opinions, and beliefs of the participants. He further articulates that a semi-structured interview is useful, as it allows one to understand the complexity of a phenomenon due to its flexible nature in which both the researcher and interviewee can guide one another (Greeff, 2011). Regarding the role of the interviewee in this exchange, he states that "participants can be perceived as the expert on the subject and should therefore be allowed maximum opportunity to tell their story" (2011:352). This was vital for the purpose of gaining an understanding of the compassion fatigue experienced by newly qualified social workers in the South African context, and, by extension, the self-care practices employed, since they themselves expressed their narratives and identified and elaborated on aspects not familiar to the researcher.

Themes for the semi-structured interview schedule (annexure 1) included biographical information such as each participant's working experience and nature of employment, age, gender, and marital status. The researcher further probed for information relating to the nature of social work for newly qualified social workers, symptoms of compassion

fatigue, as well as the values and strategies of self-care they employed. The interview schedule was to be refined during the conclusion of the literature study, as this research informed the scope of the interviews. With the participants' consent, a smartphone was used to record the telephonic interviews for the purpose of collecting data. The use of this method allowed the researcher to easily and safely store the data on electronic devices which were password protected to safeguard their privacy. Data was collected by the researcher in April 2020 and the participants were interviewed in their personal professional capacity.

1.7.5. Data analysis

Data-analysis commenced after data collection, wherein interview schedules were edited into appropriate texts and saved electronically. Data analysis is understood as the process whereby the researcher inspects, transforms, and categorises the collected data with the aim of discovering useful information, as well as suggesting conclusions and recommendations (Schurink, Fouché & De Vos., 2011). Schurink *et al*. (2011) further puts forth that data is refined and classified according to themes which comprise the patterns evident across the data. In searching for themes, writers Ryan and Bernard (2003) and Saldaña (2016) recommend looking for repetitions, indigenous typologies or categories, metaphors and analogies, transitions, similarities and differences, missing data, as well as material that is related to theory.

As such, thematic content analysis was performed following a six-phase process of coding to create and establish meaningful patterns. These phases include familiarisation with the collected data, development of initial codes, search for themes, reviewing said themes, and producing a final report of the data (Braun & Clarke, 2006). This included the use of figures and tables for the purpose of illustrating the data visually, and in these cases the contexts were explained. Oliver, Serovich, and Mason (2005) express the need for a denaturalised approach which focuses more on what is said as opposed to how it is said.

The research study also met the criteria established for ensuring the quality of data collected, of which validity and reliability are important constructs. Here, validity refers to the extent to which an empirical measuring instrument reflects the true meaning of that

which it sets out to study. Reliability is the occurrence that a construct acquires the same results when measured more than once (Bryman, 2012). Both Bryman (2012) and Schurink *et al*. (2011) put forth norms of credibility, transferability, dependability, and conformability in order to assess validity and reliability in qualitative research. Concepts are individually discussed as follows:

1.7.5.1. Credibility

Credibility within research refers to the accurate identification and description of the subject within the participants' views and the researchers' representation of them (Schurink *et al*., 2011). Similarly, Bryman (2012) explains it as ensuring that research is carried out with good practice and submitting research to participants for confirmation that what is put forth is accurate to their social reality. This is often otherwise referred to as respondent validation. This is important for the purpose of the study, as an emphasis was placed on the narratives of the newly qualified social workers themselves and their own voices regarding compassion fatigue and self-care. This measure was also used to ensure that the researcher, as a newly qualified social worker, remained unbiased.

1.7.5.2. Transferability

Transferability in research refers to whether the findings of a given study can be transferred from a specific situation to another (Schurink *et al.*, 2011). Bryman (2012), however, states that qualitative research is the intensive study of a particular group sharing certain characteristics, and thus it conveys findings that are contextually unique. Taking this into consideration, Geertz (1973) emphasises the production of thick descriptions and rich accounts of details, as this will allow others to make judgements for possible transferability. As such, the researcher achieved transferability by establishing descriptive and exploratory theoretical chapters accompanied by detailed methodology as to how data would be collected and analysed.

1.7.5.3. Dependability

Schurink *et al*. (2011) describe dependability as a way of determining whether the research process is logical, well documented, and audited. Lincoln and Guba (1985) elaborate that, in establishing trustworthiness of research, an auditing process should be adopted. This auditing process entails that all records of the research process be kept

and that peers should act as auditors during and towards the end of the process to establish to what extent the proper procedures have been followed. For the purpose of the study, this criterion was of great importance, as the researcher stored all of the relevant information and data gathered regarding compassion fatigue and self-care of newly qualified social workers. The research process was also continuously audited by the researcher's supervisor in order to ensure that the research process was followed properly.

1.7.5.4. Conformability

Despite complete objectivity in social research being unattainable, the concern of conformability is that the researcher should be shown to have acted in good faith, not allowing personal values or theoretical inclinations to sway the conduct of the research or its findings (Lincoln & Guba, 1985). To this end, the researcher performed an extensive reflexivity report to substantiate conformability and her stance towards the research topic (see annexure 4).

A further measure the researcher employed to limit the subjectivity was by comparing and corroborating findings from the study with a literature control. Participants were also asked to verify the findings during and after the interview to ensure that the researcher had remained unbiased through member checking with all participants.

1.8. ETHICAL CLEARANCE

Ethical clearance for the study on compassion fatigue and self-care of newly qualified social workers within the South African context was provided for by the Social Work Department of Stellenbosch University's Departmental of Ethical Screening Committee (DESC), and Research Ethics Committee (REC) with the project number 11737. See annexure 3 for the ethical committee approval. This was a medium risk study, as private information, personal issues, and discomfort could have risen from discussing sensitive topics such as compassion fatigue and the nature of social work as experienced by newly qualified social workers. It was thus important that the research be managed properly in order to avoid harm to the participants. With that in mind several ethical considerations were taken into account:

1.8.1. Avoidance of harm

This is understood to encapsulate both physical and emotional harm (De Vos, Strydom, Fouché & Delport, 2011). In considering this, participants were clearly informed of the potential emotional impact of the study, and it was explained that they had the ability to withdraw from the study at any time without any consequences.

1.8.2. Informed consent

Informed consent implies that all possible or necessary information regarding the credibility of the researcher, along with the goal of the investigation, its procedure, advantages, disadvantages and dangers be provided to the participants or their legal representatives (Strydom, 2011). This was necessary, as participants had to understand the research and make an informed decision to partake in the research study. In considering this, written informed consent (annexure 2) was obtained from all of the participants, which stipulated the goal of the study, the proposed time frame, as well as expectations of the participants. This also allowed the participants to gain clarity in case of concerns or uncertainties.

1.8.3. Confidentiality

Confidentiality implies that only the researcher and the supervisor be aware of the identity of the participants to ensure that they remain anonymous to the public (Robinson, 1991). This was of great concern for the purpose of the study, as participants shared intimate and private information regarding their experiences of compassion fatigue and self-care. The researcher thus did not reveal the identities of the participants nor any information that could reveal the identity of a particular participant. The data collected was also stored electronically using password protected devices, which ensured the safety of the data.

1.8.4. Debriefing of participants

This was a medium-risk study, and as a result, participants may have experienced discomfort. Debriefing, which involves working through the experience after the study, is a useful way in which harm can be minimised (Strydom, 2011). This was done through discussing the research study with the participants immediately after conducting the

interview, thereby rectifying any misperceptions that may have occurred during the investigation. The researcher also made use of an external qualified social worker to offer debriefing services to the participants if needed. However, none of them needed or requested this service.

1.9. LIMITATIONS OF THE STUDY

It was imperative that the researcher explain and be aware of the limitations of the study (De Vos *et al*., 2011). Limitations of the study regarding the compassion fatigue and self-care of newly qualified social workers in South Africa entailed it being limited to newly qualified social workers. The implication of this limitation was that student social workers and more experienced social workers were not targeted, and conclusions and recommendations were thus not necessarily applicable to them. Moreover, the sample size of this research study was not large enough to make generalisations. This is accentuated when one considers that the research study was only conducted in one South African province, namely the Western Cape. The researcher, however, meticulously described the research process, which can be adapted to other areas in South Africa with a larger sample size as well.

1.10. PRESENTATION

This research is made up of six chapters. Chapter one serves as an introduction to the research topic. This chapter gives an overview of the rationale behind the study along with its problem statement, describes its aims and objectives, and discusses an overview of the research methodology it utilised. Chapters two, three and four are literature review chapters. Accordingly, chapter two establishes background by through a framework regarding the conceptualisation of work contexts and working conditions experienced by newly qualified social workers. Building on this, chapter three analyses the compassion fatigue experienced by newly qualified social workers, in particular articulating its conceptualisation, symptoms, and relationship to compassion satisfaction, job satisfaction, and burnout. Chapter four takes on the second tier of this study's focus in that it identifies and describes the self-care practices by those prone to compassion fatigue, as well as the role of social work supervision and education in the enhancement

of self-care. In accordance with the qualitative nature of the study, chapter five, as the empirical study accompanying the insights gained from the literature chapters, pertains to data collection and data analysis. Finally, chapter six discusses the conclusions drawn from the analysed data and respective recommendations.

CHAPTER 2: THE WORK CONTEXT OF NEWLY QUALIFIED SOCIAL WORKERS

2.1. INTRODUCTION

Entering the work context is a daunting experience for many newly qualified social workers. They face various challenges such as demanding and laborious working conditions, working with vulnerable and often difficult clients, as well as pressure from the greater society to create change. For this reason, it is no wonder that newly qualified social workers, who themselves are still in a transitioning period, struggle to adapt to and thrive within their new work context. As this study aims to elucidate the compassion fatigue and self-care of newly qualified social workers in South Africa, it is important to first clarify the context of work. This chapter will thus paint an introductory picture of the social service organisations in South Africa, as well as how social workers function in said structures. In so doing, it will serve as a framework regarding the conceptualisation of the working conditions experienced by newly qualified social workers, which are often experienced as challenges. By extension, it will also delineate the client factors and professional attributes that influence the working context of social workers.

2.2. THE NEWLY QUALIFIED SOCIAL WORKER

For the purpose of the study, the term “newly qualified social worker” is utilised to identify social work practitioners who have been in practice for less than 24 months (Janse van Rensburg, 2009). In 2008, 27% of the social work population in South Africa consisted of newly qualified social workers aged 20 to 29 years (Earle, 2008). In South Africa, in particular, there has been a considerable increase in newly qualified social workers following a substantial number of bursaries made available to students from the Department of Social Development as part of their retention strategy (Cloete, 2012). For example, more than 150 newly qualified social workers were placed at various local offices and facilities in the Western Cape Department of Social Development in 2010 and 2011. Regarding current new registrations, 2479 new registrations were made in 2018 at the South African Council for Social Service Professions, a slight decline from 2894 in 2017 (Malamba, 2018).

Although the number of newly qualified social workers that enter the workforce is substantial, researchers like Bates, Immins, Parker, Keen, Rutter, Brown and Zsigo (2010) and Hunt *et al.* (2016:57) put forth that the "complexities of moving from a relatively well-protected position of student to that of a professionally qualified social worker are challenging and often seemingly contradictory." To elaborate on this, Hay, Franklin and Hardyment (2012) study the transition from student to employee, as well as the readiness for practice that accompanies this transition. In so doing, they identify the factors that significantly affect the process as academic and personal attributes, tertiary training (formal education) preparation from the placement agency during education and the structure, function and operation of the new workplace. Building on these challenges, Agllias (2010) and Donellan and Jack (2015) find that the factors assisting a newly qualified social workers in managing their new role include effective supervision, mentoring and coaching, support from colleagues, as well as a staggered increase in volume and complexity of caseload. However, as will be discussed below, this is not always implemented effectively due to various stressors within organisations.

2.2.1. Preparation for practice

Formal education in social work emphasises practice theory in literature, in which knowledge and wisdom from practice is integrated in theoretical knowledge in order to develop expert knowledge (Fook & Gardner, 2007). An increased pressure for social work graduates to be fit and ready for practice by developing this expertise has led to many tertiary education institutions increasing the education period for the BSW degree (Hunt *et al.*, 2016). New Zealand is such an example, with an increase from three to four years, as well as a minimum of 120 field work placement days across the final two placements. Integrating knowledge from practice with theoretical knowledge is not a straightforward transfer, but rather one that is recursive and transforming. As such, Nixon and Murr (2006) advocate more inductive and interpretive habits in order to develop professional knowledge. Bates *et al.* (2010:154) agree and conclude that professional knowledge becomes concerned with 'being' a professional as opposed to simply 'having' the required knowledge, thus making it more complex.

A study conducted by Hussein *et al.* (2014) in England found that three quarters of newly qualified social workers felt that they had been thoroughly prepared in areas including communication skills, social work methods, responding to cultural differences, social work law, evidence and research-based practice, social work values, working in an organisation, inter-professional working, and the role and responsibilities of a social worker. A quarter, however, did not feel prepared in important areas such as assessment, report writing, record keeping, time management, case management, dealing with conflict, or care management and contracting. Half of the participants also did not feel prepared in court skills (Hussein *et al.,* 2014). Engelbrecht and Cronje (1997) did a study on undergraduate social workers' stressors in South Africa more than two decades ago, and more recent studies have complemented this research, with Collins and Van Breda (2010) focusing on the academic support of social work students, and Esau and Keet (2014) studying reflexive social work education. However, none of these studies focused specifically on the perceived readiness of newly qualified social workers for practice. A recent study was conducted regarding the employability of UNISA's newly qualified social workers in which Alpaslan (2019) identified several factors indicating unpreparedness that negatively impacts on their employability. These factors include a lack of passion, self-confidence and the ability to function independently, a lack of exposure to statutory and court work, poor report-writing skills, the inability to integrate theory into practice, a lack of earlier, varied and more practical work exposure, as well as a lack of knowledge regarding the fields of social services and their inability to plan and implement intervention plans. The lack of preparedness is a possible result of there not being sufficient and adequate support available to newly qualified social workers when transitioning from student to professionals.

Nevertheless, there are elements of professional development that cannot be taught in a formal and generalist degree programme. The most evident of these elements include those associated with a particular workplace or activity and those related to the system's rules, tools, norms, objectives, divisions of labour and communities of practice (Knight, 2006). Accordingly, Munro (2011) is strongly of the opinion that, worldwide, not all newly qualified social workers entering practice have the necessary knowledge, skills and expertise for practice. In particular, they are often unprepared for the challenges posed

by child protection work. For this reason, Bates *et al.* (2010:154) advocate that the experience required of social workers are of a situated nature and declare that "a newly qualified social worker's ignorance will become immediately apparent as they become immersed within communities of practice." In short, the theorists are in agreement that the development of the expertise required for a practice such as social work is a "gradual transition from a rigid adherence to taught rules and procedures through to a largely intuitive mode of operation in which learning from experience is the main force of transition" (Bates *et al.,* 2010:154).

2.2.2. Transition into practice

The transition from social work student to newly qualified social worker entering the first year of practice can be described as a "baptism of fire" (Bates *et al*., 2010:152). Moorhead (2019) and Manthorpe, Moriarty, Hussein, Stevens, and Sharpe (2015) explain that this change in identity is epitomised by transitional challenges to graduates who still have to adjust to the organisation's demands, with some describing it as a rite of passage. Donellan and Jack (2015) corroborate this, stating that the first year of social work practice is characterised by sudden and unexpected disruptions and turns as the newly qualified social worker settles into new norms as an employee. Webb (2017) elaborates on this in an international context by explaining that this transition is demanding and intricate as the human service sector is becoming increasingly managerialist with insecure employment arrangements and generic job-roles. This in turn often renders social work, and by extension social workers, less visible in workplaces and multidisciplinary teams. Newberry (2014:45) agrees with the notion that the needs of social workers entering the workforce are seldom met, stating that new practitioners are expected to "[hit] the ground running" and are thus not seen as lifelong learners. A significant stressor for newly qualified social workers transitioning from student to practitioner is thus that they are expected to have a fully developed and coherent professional identity and to have the required knowledge, skills and expertise to practice independently (Moorhead *et al*., 2016; Moorhead, 2019). However, Bates *et al*. (2010) assert that plenty of learning necessary for the development of professional competency and capability only happens after the formal education has been completed.

As newly qualified social workers experience a new set of challenges regarding the integration of theory and overall knowledge learnt in formal education to that of practice, specific role training and informal learning seem to be of great importance (Bates *et al*., 2010; Hunt *et al*., 2016). An induction is normally the first training that newly qualified social workers experience, and this has been shown to assist with immediate technical learning and development needs (Knight, 2006). Bradley (2006) puts forth that adequate induction should meet an individual's personal and professional needs and that supervision be a fundamental component. In this light, Bates *et al*. (2010) found that, in England, three quarters of newly qualified social workers reported to have had a workplace induction, responding that this orientation gave them an explicit idea of the organisation's structure, values, plans and objectives, priorities, processes and procedures, along with people and roles. Nonetheless, only a few were given a structured induction to assist them in moving into their role in a planned and organised way, with many being given a few specific tasks only to be told to organise for themselves anything they felt to be useful (Bates *et al*., 2010). It was, however, indicated that many of the managers did not receive training and support and did not have the necessary resources to follow the induction policy as they would have liked.

2.3. WORK CONTEXT OF A NEWLY QUALIFIED SOCIAL WORKER

Globally, the work context and specifically the structure of the social service organisations have been widely attributed to social workers, particularly newly qualified social workers, leaving their jobs or the social work profession entirely (Bates *et al*., 2010; Jack & Donnellan, 2010; Hussein *et al*., 2014). Similarly, South African authors Calitz *et al.* (2014) confirm this by identifying organisational factors to be a significant influence on social worker retention and loss in South Africa. These writers often attribute the factors to include low levels of control and decision-making within the different organisations, poor management, as well as a lack of work engagement.

2.3.1. Social service organisations

Doel (2012) asserts that the way in which social service organisations are organised is vital, as newly qualified social workers are quickly socialised into the culture of their

employer. He further puts forth that social work has a propensity to be shaped by the nature of its employment, maintaining that the organisation of its services differs from nation to nation. For example, non-government organisations (NGOs) are dominant in developing nations, while the private sector is the most developed in the United States and the public sector in the United Kingdom (Doel, 2012). It is, however, asserted that the nature of social work currently is more dispersed than it was historically.

In South Africa, social service management occupies both non-profit or private sectors and public or governmental sectors. Social service organisations are referred to by various interchangeable terms, such as non-governmental organisations (NGOs), community-based organisations (CBOs), civil society organisations (CSOs), non-profit organisations (NPOs), human services organisations or social welfare organisations (Rankin & Engelbrecht, 2014). All of these provide social services, which refers to the array of programmes made available to individuals, families, groups and communities through public or private organisations. The different social service providers in South Africa will be discussed below.

2.3.1.1. Government sector

The typology of social service organisations first includes the government sector. This is also referred to as the public or statutory sector in the UK as social workers are required to fulfil statutory functions and social workers working in this sector is referred to as civil servants in France. In the UK, local governments employed the vast majority of social workers and accounted for 70% of the employed social workers (Doel, 2012). In South Africa, this sector is structured in terms of the National Department of Social Development, provincial departments, and district offices (Rankin & Engelbrecht, 2014). Social workers are employed by local governments, inter-sectoral, and parastatal organisations. Examples of social service organisations in the government sector include the Department of Social Development (DSD). Johansson (2012) acknowledges the power hierarchy in social organisations that parallel South Africa's government sector and maintains that there is a distribution of power shared by politicians, managers, civil servants and professional social workers. He elaborates that, generally, politicians will decide on policy issues, after which managers and civil servants decide on administrative

issues. Thereafter, professional social workers will decide on the suitable action in solving their clients' problems (Johansson, 2012).

2.3.1.2. Non-government sector

The second typology of social service organisations includes the non-government sector, which is further divided into a profitable and non-profitable sector (Rankin & Engelbrecht, 2014). Doel (2012) indicates that the UK has a voluntary sector which is non-profit, but explains that it is a misleading term, as employed social workers receive the same payment as if they were in the public sector, with some workers even fulfilling statutory obligations. It is, however, noted that substantial funding for voluntary organisations come from the state. In India, this sector is also referred to as the "joint sector" as to reflect a partnership and cooperation between the state and the private sector (Doel, 2012:119).

In South Africa, the profitable sector includes profitable organisations (EAP's) and social workers in private practice. The non-profitable sector, on the other hand, can be further divided into formal and informal organisations. Formal, registered organisations rely on the state for funding and operate within strict bureaucratic procedures and systems. In addition, they have limited autonomy and flexibility in programme development due to it being based on national norms and standards (Patel, 2015). Formal organisations are well-established and generally adhere to the requirements of the Department of Social Development (Rankin & Engelbrecht, 2014). These organisations are governed by a management committee, many of whom tend to be volunteers, and their operations are based on the constitution which may give these formal organisations access to government subsidies. Patel (2015) states that donor funded NPO's and faith-based organisations are also formally registered by the government. Community-based organisations and social networks, on the other hand, are generally unregistered and informally organised using predominantly volunteers. For this reason, such organisations often have limited access to skills or resources (Patel, 2015; Rankln & Engelbrecht, 2014).

2.3.1.3. Private sector

The private sector is comprised of organisations rendering social work services for profit. Private practising social workers are professionals who offer services to individuals,

families, groups and communities/organisations for a fee (South African Association for Social Workers in Private Practice, 2019). Private practitioners not only offer knowledge and skills in different fields, but also flexibility and choice for its consumers. Specialisations include adoption, occupational social work, probation, clinical social work, forensic social work, and social work in health care (SAASWIPP, 2019). Social workers, as registered private practitioners rendering services at fee to those abled to pay, are also contracted by private and public organisations and institutions. Doel (2012) asserts that, in countries like India, the state is often responsible for funding, with the private sector delivering the social services. The Department of Social Development in South Africa maintains responsibility and accountability in all matters relating to developmental social services, which includes access to private services. Lord and Iudice (2012) further argue that social workers, as private practitioners, must comply to regulatory frameworks, norms and standards, and must adhere to the conditions of their registration according to the Council of Social Service Professions.

2.3.1.4. Collaborative partnerships

The social welfare system in South Africa applies principles related to the social development approach. In this context, social welfare is understood as the conditions of social well-being when social problems are managed, and needs are met. In turn, social welfare services are defined as the services and programmes that are provided to meet said social needs (Department of Social Development, 2013). Such services include prevention and promotion; social assistance and social relief; protection; statutory social support; restorative, rehabilitative and therapeutic continuing care and reintegration; and aftercare services. Similarly, developmental social welfare is regarded as the promotion of human rights, use of partnerships to deliver services, integration of socio-economic programmes, and bridging of the micro-macro divides in service delivery (Department of Social Development, 2013). An emphasis on collaborative partnerships between the abovementioned sectors not only plays a crucial role in the provision of equitable services but ensures compliance with legislation.

The government sector, also referred to as the public sector, delivers developmental social welfare services as a constitutional mandate through the Department of Social Development (DSD). The National Department of Social Development provides strategic

leadership, support, and coordination of the implementation of services throughout the welfare sector, and is further responsible for developing norms and standards to ensure uniformity (Department of Social Development, 2013). Moreover, there is also interdepartmental collaboration between government departments who render developmental social welfare services. Such departments include The Departments of Health, Basic Education, Correctional Services, Justice and Constitutional Development, Labour, Cooperative Governance, Traditional Affairs, and the South African Police Service. Each of these departments can ensure integrated developmental social welfare services by developing and aligning programmes and strategies with set out frameworks and legislation and ensuring compliance with standards and professional ethics by employed social service practitioners (Department of Social Development, 2013).

As with interdepartmental collaboration, there is also a close collaboration between the government sector (public sector) and the non-government sector (civil society organisations), as this is critical for an integrated and effective social welfare service delivery system (Department of Social Development, 2013; Manyuchi, 2012). Non-government organisations both require authorisation to render services and ensure compliance to legislation. Resources are a critical aspect of partnership in South Africa due to the limited institutional resource capacity, and NGO's are also subject to funding and subsidisation. This is, however, based on fairness in relation to the costing of services, and NGO's should thus embark on economic development and fundraising initiatives.

Taking into account that there are several different types of social service organisations with different governance, it is evident that there are changes in structure, output and responsibility among the different sectors. Therefore, it is no wonder that social workers, especially newly qualified social workers, struggle with performance targets, frameworks which further require service inspections regarding their contributions, improvements and growth, as well as work engagement (Bates *et al.,* 2010; Penhale and Parker, 2008). This is also evident taking into account the different levels on which social workers render services.

2.3.2. Integrated social welfare services

In South Africa, social welfare services are rendered in various contexts by a range of practitioners. Services may focus on a total population, or only on specific and defined target groups. Social welfare services are also rendered at different levels on a continuum, each with a different proposed outcome. The level on which the service is rendered is determined by the specific needs and challenges to be addressed. Current policy, namely the Integrated Service Delivery Model of the Department of Social Development (2006), refers to levels of prevention, early intervention, statutory intervention/alternative care/residential care, and reunification and aftercare.

2.3.2.1. Prevention

The Integrated Service Delivery Model describes the preventative level as being focused on strengthening and building capacity, self-reliance, and resilience, as well as addressing factors and conditions that enhance wellness (Department of Social Development, 2006;2013). This is further specified as being the most important aspect of social service delivery, with the client in this level functioning at an adequate level while the possibility of being at-risk remains (Department of Social Development, 2006). The White Paper for Social Welfare further refers to service under this category as developmental services, these being the primary prevention of the development of a problem (Republic of South Africa, 1997).

2.3.2.2. Early intervention

Services at an early intervention (non-statutory) level involve developmental and therapeutic programmes to limit the impact of risk and to prevent the progression of problems (Department of Social Development, 2006;2013). These services focus on early identification of risks, behaviour, and symptoms with individuals, families, groups and communities. This is done to ensure that those who have been identified as being at risk are assisted before requiring statutory services. Moreover, this intervention can also be described as secondary prevention (Republic of South Africa, 1997).

2.3.2.3. Statutory intervention/residential/alternative care

At this level the client's social functioning is compromised to the extent that they cannot function adequately or may be involved in some form of court case (Department of Social

Development, 2006;2013). At a statutory level, services may require moving the individual to a more conducive environment, and services are aimed at supporting and strengthening the client. The removal of a client is either done by a court order, or on the recommendation of a service provider, and may involve moving to alternative care (e.g. foster care) or a residential facility in order to ensure the safety of the individual and their well-being. This level also incorporates rehabilitative and continued care services that do not necessarily require statutory intervention. As such, this level may also be referred to as tertiary prevention with the aim of reducing or limiting the negative impact of an existing problem (Department of Social Development, 2006;2013).

2.3.2.4. Reunification and Aftercare

Services rendered at this level are aimed at reintegration and support in order to enhance self-reliance and optimal social functioning (Department of Social Development, 2006;2013). In situations where an individual was moved to alternative care, as seen in statutory intervention, this level includes returning the client to their family or community and rendering reintegration, reunification and aftercare services for continued support.

Social workers and newly qualified social workers alike render a diverse range of services each varying in terms of context, problem and individual. Many social workers not only focus their efforts on one level but render services on multiple levels. This may be challenging for newly qualified social workers who are ignorant and inexperienced when entering the practice, and they may find it overwhelming and daunting to render such a wide range of services which are all inherently different to one another.

2.3.3. Client system

Social workers render services to a diverse range of clients and service users who utilise these services for different reasons. The National Association of Social Workers (NASW, 2019), which is globally applicable despite being in a North American context, clarifies that social workers are present in every aspect of a community, including schools, hospitals, mental health clinics, senior centres, private practices, prisons, corporations, and numerous public and private agencies. Doel (2012) puts forth that the above-mentioned clients utilise the services because they are experiencing some sort of trouble.

Services are rendered to assist clients who face a disability or disease, or social problems such as inadequate housing, unemployment, or substance abuse (NASW, 2019). Moreover, social workers also help with interpersonal issues such as families with domestic conflicts, as well as child or spousal abuse.

The National Association of Social Workers (NASW, 2019) states that globally, several social workers specialise in serving a particular population or working within a specific setting. Doel (2019) confirms this and explains that social work is different to many other public services in that most people have not experienced social work services first-hand, unlike services such as teaching, medicine and policing. Social work service users are often at the margins of society, and it is unlikely that they are well connected or in powerful positions. By extension, their voices are often unheard and frequently represents that which is outside of the norm. Social work is thus neither mainstream nor universal according to Doel (2012), since the individuals it helps are often stigmatised or seen as undesirable.

Rendering services to a diverse range of clients facing unique and complex problems often results in significant challenges for social workers. Most prominently, this includes clients with post-traumatic stress disorder, trauma issues, and disabilities, as these are strongly associated with an increase in burnout by the social worker (Stanley *et al.*, 2018). Calitz *et al.* (2014) confirms this and asserts that social workers often deal with difficult clients and feel unable to adequately help them or change their situation. Doel (2012) elaborates on this, stating that social workers often experience problems with multi-problem clients and complex cases, as boundaries are created by services such as children's services and mental health services, which in turn creates barriers for service users with multiple problems. This is also corroborated by Joseph (2017), who found that many social workers in South Africa dealt with many parties for a single case, with mention also made of professionals such as lawyers and health care practitioners.

Alpaslan and Schenck (2012) found that social workers working in rural areas in South Africa were further weighed down by client-related challenges, including said clients' levels of illiteracy, ignorance about social services rendered, levels of poverty, and lack of motivation, action, and cooperation. This is corroborated by Schenck (2004).

Customary cultural practices and differences, as well as age, gender and language barriers were also found to be client-related challenges. Participants especially noted challenges regarding a difference in age, stating that younger social workers were often not taken seriously in that clients felt that they could not help them. In this sense, young social workers are undermined, since older clients are not comfortable to open up, which may be a significant challenge related to newly qualified social workers (Alpaslan and Schenck, 2012).

The client system itself may be a challenge for newly qualified social workers as it is complex, with each individual client having their own problem, context, and challenges. Newly qualified social workers may especially experience it challenging to relate to and render services to clients who struggle with obstacles such as marginalisation, illiteracy, ignorance about the services rendered, as well as a lack of motivation and action. Those who are inexperienced may not necessarily know how to deal with the client system effectively, which may be considerably stressful.

2.3.4. Ethical code

Social work practice is guided by ethical principles which inform social workers and are designed to facilitate a social worker's aspiration to the highest standards of ethical practice. Further, it is committed to the people and client system with whom the social workers engage (International Association of Schools of Social Work, 2018; International Federation of Social Workers, 2018). To this end, the global statement of ethical principles is developed to ensure accountability towards individuals, families, groups, and communities, along with the social workers themselves, their organisations, societal contexts, education, practice and research (IASSW, 2018).

Taking this into consideration, the first ethical principle that should be adhered to is the recognition of the inherent dignity of humanity, and involves recognising and respecting all persons, their attitudes, beliefs and actions (IASSW, 2018; IFSW, 2018). The second principle promotes human rights, which involves working with people to find balances between competing human rights. The third ethical principle relates to promoting social justice, and involves challenging discrimination and institutional oppression, respecting diversity, challenging unjust policies and practices, and building solidarity. Building on

this, the fourth principle is concerned with promoting the right to self-determination, which involves respecting and promoting people's rights to their own choices and decisions, while the fifth promotes the right to participation, which involves the building of self-esteem and capacities, as well as promoting the involvement in actions and decisions (IASSW, 2018; IFSW, 2018). In turn, the sixth is respect for confidentiality and privacy, which entails adhering to confidentiality unless there is a risk of harm, while the seventh is treating people as whole persons and incorporates that social workers recognise the various dimensions of people's lives (e.g. biological, psychological, social, and spiritual) and using it holistically in assessments and interventions. Finally, the eighth is the ethical use of technology and social media, and entails recognising that the use of digital technology and social media can pose threats to ethical standards including confidentiality and privacy among others (IASSW, 2018; IFSW, 2018), while the ninth is professional integrity, which encapsulates various points including, but not limited to, that social workers should have the required qualifications and maintain the necessary skills. These skills include competencies for the work, that they must act with dignity, that social workers are accountable for their actions, and lastly, that social workers have a duty to take necessary action to care for themselves professionally and personally in both their workplace and their private lives (IASSW, 2018; IFSW, 2018).

Taking all of these factors into account, for newly qualified social workers, following their ethical code can be especially daunting. Walker (2014) explains that newly qualified social workers have to deal with highly complex social problems, along with associated ethical dilemmas. This contributes to the necessity of social work supervision, which will be discussed later in this chapter, as it is the supervisor's responsibility to ensure that the supervisee provides competent, appropriate, and ethical services to the client system (National Association of Social Workers, 2013).

2.4. WORKING CONDITIONS OF A NEWLY QUALIFIED SOCIAL WORKER

The work environment of social workers either impact the employee's working life positively or negatively. A positive working environment may produce productivity, effectiveness, and an improvement in the general well-being of an employee. In essence, this involves not only the direct work of an employee, but also future opportunity for

continued growth and security, adequate and fair compensation, as well as safe and healthy working conditions. Negative working environments, on the other hand, play a significant role in decreasing the retention of social workers, including those that are newly qualified, in the practice (Hussein *et al.,* 2014). While they are sometimes addressed in the private sector, the factors which will be discussed in more depth below are generally lacking in public service, otherwise known as the government and non-government sectors.

2.4.1. Workload

Moving from the position of a well-protected student to that of a qualified social worker is challenging and often contradictory (Bates *et al.*, 2010). Hunt *et al.* (2016) identifies a high workload to be a significant factor in this shift. However, along with Pithouse and Scourfield (2002), they state that it can be difficult to find a balance between offering a quality induction period to a newly qualified social worker while also negotiating workload with the practice pressures of a busy workload.

Social workers worldwide experience pressure regarding their work as a result of high caseloads and tedious administrative duties. A United States study regarding child protection workers indicated that many social workers left their jobs “feeling like work was never done” and experiencing heavy caseloads to the point that they felt “there [were] too many families” for them to make a difference (National Council on Crime and Delinquency, 2006:8). In effect, this research thus showed that social workers were overburdened, which set them up for failure (NCoCD, 2006:11). Similarly, a study conducted by Hussein *et al*. (2014) in England regarding factors contributing to the retention of newly qualified social workers found unmanageable workloads to be a significant issue. Results indicated that social workers in local authority children’s departments reported especially unmanageable caseloads. In the same manner, those working for government organisations in certain geographical areas experienced significantly more stressors than those working in specialist teams.

Extremely high caseloads are also a prevalent issue in South Africa. The Department of Social Development (2009) explained that there is a decline in productivity and quality of services due to high caseloads, high stress levels, and lack of resources. They further

state that social workers are increasingly used for non-professional tasks, which further increases their workloads, adds to their stress levels, and deprives them of professional growth. As can also be seen in the studies conducted in the United States and the UK, several studies conducted in South Africa indicate significantly higher caseloads within the non-government sector (NGO), reporting social workers having between 110 and 400 cases, and child protection social workers in foster care being responsible for as many as 500 cases (Baldauf, 2007; Narsee, 2013; Joseph, 2017). This is despite controlling bodies such as The National Department of Social Development recommending that their workload should not exceed 60 cases (Earle, 2008).

On the contrary, Bakker and Leiter (2010) reported that the negative effects of high workloads were diminished when social workers' work engagement was boosted by a flexibility in professional skills. Nonetheless, they still find that a third of participants felt unsatisfied with their workload, as they felt a reduced work performance due to the level of productivity expected of them and further felt underappreciated. Accordingly, Calitz *et al.* (2014) argue that social workers experience stress and burnout as a direct result of their high workload and time management, as these factors lead to them feeling emotionally drained and unproductive. Several authors assert that newly qualified social workers in particular may experience this issue, especially as they still need assistance in managing workloads and may not always be able to negotiate what is expected of them (Bates *et al.*, 2010; Moriarty, Manthorpe, Stevens & Hussein, 2011; Walker, 2014).

2.4.2. Remuneration

Though a multitude of negative factors relating to job satisfaction would not be nullified by an increase in salary, pay and remuneration remains a substantial predictor of job satisfaction (Smith & Shields, 2013). Joseph (2017) confirms this, and further argues that it is a contributing factor to a sense of self-worth. Although several international scholars indicate low salaries for social workers, Engelbrecht (2006) points out that South Africa represents the extreme.

Social work remuneration is an issue in general but is more dire in the non-government sector (Earle, 2008; Viljoen, 2009). In a study focusing on social workers working in rural areas, Alpaslan and Scheck (2012) found that NGO workers were particularly dismayed

about their remuneration in the sense that they felt that their salaries were not worth it. They also identified that workers were unsatisfied with the pay discrepancy between Department social workers and NGO social workers. Viljoen (2009) confirms this, and states that social workers working for the DSD earn roughly 40% more than their NGO counterparts. This phenomenon is due to the DSD regrading salaries to eventually reflect a four year long professional degree. However, this progression was not widened to include the NGO sector (Earle, 2008). Earle (2008) further elaborates that this difference is what resulted in the substantial disparity in salaries, which is further exacerbated by benefits such as medical aid, pension, housing subsidies and car allowances, which do not exist for social workers employed in NGOs. Despite the current disparity, due to the grading of positions, a newly qualified social worker earns less than a more experienced social worker in both scenarios.

Remuneration is believed to be better for private practising social workers, which has also led to decades of degrading comments, including that private practitioners were sell outs who abandoned the profession's mission of social justice (Specht & Courtney, 1994; Lord & Iudice, 2012). For many years, these workers were critiqued for opting for financial gain and offering services of change to individuals instead of systems (Specht & Courtney, 1994). Despite this, decades ago, Barker (1991) stated that financial gain was not an important motivator for pursuing work in the private sector. This was later corroborated by Brown and Barker (1995), who maintained that many social workers in private practice render services at a reduced rate or for free and are often more accessible than agency services.

2.4.3. Environment

Social workers are plagued by health and safety risks, as well as challenges related to a lack of organisational and community resources. Joseph (2017:42) is thus of the opinion that South Africa is "fraught with social ills" resulting in welfare organisations being "overwhelmed, overburdened and financially under resourced." Numerous authors confirm this statement and indicate that South African social workers experience a lack of basic resources such as clean office spaces, office furniture, stationery, computers and reliable vehicles (Engelbrecht, 2006; Earle, 2008). During one incidence where thousands

of social workers presented a memorandum to the government in 2016, they mentioned a lack of resources, including insufficient and unsafe vehicles that were unroadworthy, a shortage of stationery, inadequate office equipment and space, as well as a lack of basic sanitation on work premises (Madibogo, 2016). On social media, they write about having to buy their own paper, airtime to contact clients, and public transport to reach courts (KaNqcwabe, 2014). The Department of Social Development (2009) affirms this, and states that buildings and service points are often neglected due to funding, which may pose a threat to the social worker and the public. As this suggests, the profession often exposes its workers to dangerous situations and environments that put their health and safety at risk.

Apart from the stressors associated with a lack of resources, social workers are often exposed to dangerous situations when engaging with clients or when going out to conduct home visits. The Department of Social Development (2009) firstly elaborates that social workers have to drive long distances in hazardous weather and bad conditions, which, together with heightened stress levels and fatigue, negatively strain their relationships with their clients. Alpaslan and Schneck (2012) confirm this and state that this is a general concern among workers working in rural areas. Earle (2008) affirms that transport difficulties are also severe in NGOs, where there are a limited number of poorly maintained vehicles, which thus requires workers to share vehicles. Both theorists further argue that there are no mechanisms in place to reduce these risks and to ensure safety of the social workers.

Taking the dangers of unreliable transport and the situations that social workers have to place themselves in into account, the Department of Social Development (2009) acknowledges that the social work profession is predominantly female, which puts its workers at greater risk. With the increase of violence, rape, and gender-based violence, the risk to these professionals is particularly striking. Further, the Department of Social Development (2009:40) refers to social workers having to enter territories of clients, which at times are secluded or risky areas. Apart from the risks associated with the areas they work in, the nature of social work also involves professionals having to work with “emotionally unstable and marginalised persons,” which exacerbates these dangers. As such, the safety of social workers is often compromised (Horowitz, 1998).

A study conducted by the Canadian Union of Public Employees (CUPE) in 1990 found that 52% of social workers working in children's aid had been subject to aggressive acts whilst at work. They further confirmed that those most at risk of violence at work to be social workers employed in shelters or custodial work, as well as those who work alone. This correlates with findings several years later in a study conducted by Kapoulitsas and Corcoran (2015) in Australia, who indicate that participants identified issues of unpredictable and challenging situations along with violence and threats to personal safety, with one participant sharing that she was threatened with a physical attack by a client. Kapoulitsas and Corcoran (2015) maintain that this can have a harmful impact on social workers' emotional well-being.

2.4.4. Supervision

The Department of Social Development (2012:11) define social work supervision as *"*a formal arrangement and an interactive and interminable process in a positive, non-discriminatory relationship." Further, it states that "[t]his process is based on distinct theories, models and perspectives on supervision whereby a social work supervisor supervises a social work practitioner," which "is done by performing educational, supportive and administrative functions in order to promote efficient and professional social work services" (DSD, 2012:11).

The social work supervisor, a registered social worker with the required experience and qualifications to whom authority is delegated, performs numerous functions and tasks for a social work supervisee to flourish (DSD, 2012; Engelbrecht, 2019). Supervisors are held accountable for their supervisees' ethical approach and work performance, and further manage supervisees through a supervision process involving assessment, contracting, developing and operating a personal development plan, performance management and appraisal (DSD, 2012). Supervision is particularly important for newly qualified social workers, predominantly in their first year of employment, and it is important to make time for professional development and caseload management (Bates *et al.,* 2010). However, a participant in a South African study conducted by Brandt (2019) indicated that the newly qualified social worker's supervision seldom involves their health and wellbeing. This

participant also indicated that, although the organisation/supervisor knew that they were struggling to cope, not much was done to remedy this.

Many debates exist around supervision, the most prominent of which is the duration required for this process. A pioneer in social work, Kadushin (1992), advocates that social work supervision is an interminable process due to its accountability, as well as administrative, educational, and supportive functions. The duration and approach to supervision is highly dependent on the perceived goal of supervision. Those who believe the goal to be independence and autonomy will terminate the supervision process once satisfied with the supervisee's performance (Engelbrecht, 2019). This is said to fit with managerial and neoliberal tendencies, in which cost-effectiveness is a motivator. On the contrary, researchers such as Kadushin and Harkness (2002) and Tsui (2005) argue the goal of supervision to be enabling supervisees to render the best possible services to their service users. As such, they see social work supervision as ongoing dependence along with continuous learning and development. One may come to the conclusion that the approach to and implementation of social work supervision is largely determined by the social service organisation despite the supervisor's best intentions. Engelbrecht (2012) puts forth that the structural and organisational issues that impede these intentions include scarce resources, unmanageable workloads, and counterproductive working conditions. It is further asserted that, if supervision is not prioritised within an organisation, these structural and organisational issues will always stand in the way of social workers flourishing (Pullen-Sansfaçon, Spolander & Engelbrecht, 2012).

The quality of supervision received and the social worker's relationship with the supervisor is a crucial ingredient in job satisfaction and a significant motivator in job turnover. Receiving limited or no supervision was also an antecedent factor (Manthorpe *et al*., 2013; Smith & Shields, 2013; Hussein *et al*., 2014; Joseph, 2017). Brandt (2019) found that several newly qualified social workers had a poor relationship with their supervisors and did not trust them to discuss personal issues, as these at times did not remain confidential. Similarly, Wynne (2020) found that many social workers indicated that they are not comfortable with their supervisors due to the nature of the supervision sessions and the supervisor's personality. Redpath, Gill, Finlay, Brennan and Hakkennes (2015:215) concedes that the supervisor-supervisee relationship is the most important

relationship in the social worker's workplace, as it affects the supervisee's emotions, attitudes, motivations, behaviours, health, and workplace retention.

2.5. CONCLUSION

This chapter sought to introduce the newly qualified social worker, as well as describe their work context and working conditions. Entering the workplace is a daunting experience for many newly qualified social workers, which not all are thoroughly prepared for. It is, however, not possible for student social workers to be prepared on all elements of work, as working experiences are highly situational. As such, this transition has been described as a "baptism of fire" which is challenging and often contradictory due the complexities of moving from a relatively well-protected position of student to that of a professionally qualified social worker (Bates *et al.*, 2010:152).

Social workers furthermore deal with organisational issues that are dependent on their social service organisation and system, be it government, non-government, or private. Social workers in the aforementioned sectors render a diverse range of integrated social welfare services and also deal with difficult and often marginalised clients with complex and frustrating cases, which puts them at significant risk of stress. Moreover, the working conditions of social workers are notoriously poor, with many instances of high and unmanageable caseloads, poor remuneration, dangerous and unproductive environments, and ineffective support and supervision. With these limitations, it is no wonder that newly qualified social workers, who themselves are still in a transitioning period, struggle to adapt and thrive within their new work context.

The next chapter will analyse compassion fatigue experienced by newly qualified social workers in South Africa. This will involve the conceptualisation of compassion fatigue, the symptoms thereof, as well as the possible causes relating to their work context and working conditions of newly qualified social workers.

CHAPTER 3: COMPASSION FATIGUE OF NEWLY QUALIFIED SOCIAL WORKERS

3.1. INTRODUCTION

Those working in helping professions, such as social work, provide services to a wide range of clients often experiencing significant issues and trauma. Although social work is described as rewarding, it is also stressful due to its emotionally demanding nature, which is further complicated by the complexity of promoting the client's well-being as well as managing personal emotion. This drive to improve the lives of clients and the greater society is based on altruism and is what eventually exposes social workers to compassion fatigue. Accordingly, this chapter will analyse compassion fatigue, its symptoms and risk factors, the role of job satisfaction as a buffer against compassion fatigue, and finally, the relationship between compassion fatigue and burnout.

3.2. COMPASSION FATIGUE

Social workers render services to vulnerable individuals, families, groups, and communities who are often at risk of trauma (Wagaman, Geiger, Shockley, & Segal, 2015). Being exposed to clients' traumatic events over a period of time directly impacts the social worker's physical, emotional and psychological status (Newell & MacNeil, 2010). Stamm (2010) agrees with this, and elaborates that social workers encounter both positive and negative reactions when rendering services to clients. He also acknowledges that the elicited feelings affect their professional quality of life, which include compassion satisfaction, burnout, and secondary traumatic stress.

3.2.1. Defining compassion fatigue

Radey and Figley (2007) acknowledge that social workers are deeply connected to their work, with students and workers often citing the need to help others and make a difference as their reasons for entering the profession. In so doing, social workers connect and empathise with their clients, and further, feel compassion. Compassion is widely defined as "a deep sense or quality of knowing or awareness of the suffering of another coupled with the wish to relieve it'' (Radey & Figley, 2007:207). Radey and Figley (2007) further

put forth that it is associated with feelings of condolence, pity, sympathy, empathy, and commiseration. These are connected to altruism, which is understood as the concern for the welfare of others. As such, social workers are guided by compassion and altruistic desire to improve the conditions of individuals and society as a whole. To this end, McCann and Pearlman (1990) argue that rapport and empathy must be developed with the clients in order to help and, as Radey and Figley (2007) confirm, compassion is essential to effective social work. Several decades ago, Figley (1995) introduced the concept of compassion stress, which is understood to be the stress related to the exposure to a sufferer. Compassion fatigue is thus developed as a direct result of the exposure to clients' suffering, which is complicated by the lack of support.

The term compassion fatigue was first introduced in a study regarding burnout among nurses, but was later popularised and made more user-friendly by Figley (Joinson, 1992; Figley, 1995). Figley (1995, 2002a) used this construct to describe the cost of caring for traumatised individuals, thus defining secondary trauma stress in a manner that was less pathologised. Consequently, this term emphasises the normative development of chronic stress in caregivers who perform duties for clients for whom crises, suffering and distress is common (Beebe, 2016). It has also been described as the cost of caring (Figley, 1982) and is characterised as the "negative aspects of providing care to those who have experienced extreme or traumatic stressors… [including] feelings of being overwhelmed by the work that are distinguished from feelings of fear associated with the work" (Stamm, 2010:21). As such, compassion fatigue is associated with the cumulative and chronic emotional investment of compassion, and entails the worker's ongoing sense of responsibility for the clients who suffer (Figley, 1995). Many researchers agree that this often transpires when workers do not witness the positive outcomes of their clients' improvement (Cohen & Collens, 2013; Gottfried & Bride, 2018). Stamm (2005) further states that compassion fatigue has been marked by having a rapid onset, and that it is linked to a particular event as opposed to a succession of events.

Gottfried and Bride (2018) indicate that there are numerous understandings of compassion fatigue as a cost of caring, with the three central frameworks being: (a) compassion fatigue as synonymous with secondary trauma stress, (b) compassion fatigue as an extensive phenomenon encompassing a combination of secondary trauma

stress and burnout, and (c) compassion fatigue as distinct from both secondary trauma stress and burnout (Radey, & Figley, 2007; Stamm, 2010). Tyson (2007), on the other hand, integrated the term as a more universal concept to encompass post-traumatic stress disorder (PTSD) symptoms, as well as adverse changes in social workers such as self-identity, cognitive schemas, interpersonal relationships, physical health, job morale, worldview and spirituality. Another universal conceptualisation of compassion fatigue describes it as the conjunction of primary traumatic stress and cumulative stress/burnout of professionals such as social workers (Gentry, Baranowsky, & Dunning, 2002). Gottfried and Bride (2018), however, argue that compassion fatigue is not yet unambiguously defined. Simultaneously, Stamm (2010) argues that, although there are slight nuances among the various terms including vicarious trauma, secondary stress and compassion fatigue, there is no evidence to state that they are truly different to one another.

3.2.2. Symptoms of compassion fatigue

Compassion fatigue has been identified as a leading ethical concern regarding the effectivity of social work service in the sense that it represents a reduced capacity for and interest in being engaged in helping relationships (Figley, 2000b). As stated previously, social workers take on the problems of their clients, and this impacts their mental-, physical- and emotional health (Figley, 1993). Symptoms of compassion fatigue can be classified in terms of cognitive, emotional, behavioural, spiritual, personal relations, somatic and work performance. These symptoms not only affect the social workers' professional lives, but also the quality of their work, the care they offer to clients, and their personal lives (Choi, 2011; Coles & Mudaly, 2010).

3.2.2.1. Cognitive symptoms

Figley (2002b) identified the cognitive symptoms of compassion fatigue, which include decreased self-esteem, rigidity, disorientation and perfectionism, along with trauma, thoughts of self-harm or harm to others. Portnoy (2011) confirms this, and, along with Figley (2002b), states that professionals who suffer from compassion fatigue may likely experience lowered concentration, apathy, minimisation, and preoccupation with trauma. Coetzee and Klopper (2010) have also identified disorderliness to be a symptom of compassion fatigue.

3.2.2.2. Emotional symptoms

Most prominently, emotional symptoms of compassion fatigue include anxiety, guilt, anger/rage, survivor guilt, shutdown, numbness, fear, helplessness, sadness, depletion, and over-sensitivity (Figley, 2002b). Portnoy (2011) and Figley (2002b) also state that individuals with compassion fatigue may feel powerless or depressed and experience distressing dreams. This correlates with the abundance of research that has been done on the emotional symptoms of compassion fatigue, with several noting anger, grief, despair, frustration, emotional- and physical exhaustion, depersonalisation, lower sense of personal accomplishment, excessive stress, and a diminished capacity for empathy and compassion (Newell & MacNeil, 2010; Stamm, 2010; Whitfield & Kanter, 2014). Coetzee and Klopper (2010) confirm the emotional effects to include apathy, and further identify that this often manifests in the professional's desire to quit. All of the abovementioned symptoms are taken into account by Gottfried and Bride (2018), who argue that social workers with compassion fatigue predominantly experience negative changes in their thinking and mood.

3.2.2.3. Behavioural symptoms

Figley (2002b) identified behavioural symptoms of compassion fatigue to include being impatient, regression, sleep disturbances, nightmares, appetite changes, hypervigilance, elevated startle response, accident proneness and losing things. Further, Coetzee and Klopper (2010) and Figley (2002b) identified indicators such as irritability, moodiness, and withdrawal, while Stamm (2010) and Gottfried and Bride (2018) added anger outbursts, reckless or self-destructive behaviour, and difficulty concentrating. Behaviourally, compassion fatigue may also manifest in an increase in substance abuse, compulsive behaviours, and poor self-care (Compassion Fatigue Awareness Project, 2013).

3.2.2.4. Spiritual symptoms

A few spiritual symptoms of compassion fatigue have also been identified. According to Figley (2002b), these include: questioning the meaning of life, loss of purpose, lack of self-satisfaction, pervasive hopelessness, anger at God, questioning of prior religious beliefs, loss of faith in a higher power, and a greater scepticism about religion. Coetzee

and Klopper (2010) also identify spiritual effects of compassion fatigue to include poor judgement and disinterest in introspection.

3.2.2.5. Personal relational symptoms

Figley (2002) identified personal relational symptoms of compassion fatigue, which include withdrawal, decreased interest in intimacy or sex, mistrust, isolation from others, overprotection as a parent, projection of anger or blame, intolerance, loneliness, and increased interpersonal conflicts. Coetzee and Klopper (2010) also indicate unresponsiveness, callousness, and an indifference towards clients as potential social effects.

3.2.2.6. Somatic symptoms

Social workers also experience compassion fatigue physically, with somatic symptoms including shock, breathing difficulties, aches and pains, increased number and intensity of medical maladies, and an impaired immune system among others (Figley, 2002b). In addition, Portnoy (2011), along with Figley (2002b), indicate sweating, rapid heart rate, and dizziness as somatic symptoms, whereas Coetzee and Klopper (2010) mention burnout, absence of energy, as well as being prone to accidents.

3.2.2.7. Work performance symptoms

The effect of compassion fatigue remains a controversial debate, as the symptoms of the social worker suffering from it significantly impact on their work performance. Figley (2002b) identified work performance symptoms of compassion fatigue to include: low morale, low motivation, avoiding tasks, obsession about details, apathy, negativity, lack of appreciation, detachment, poor work commitments, staff conflicts, absenteeism, exhaustion, irritability and withdrawal from colleagues. From an administrative perspective, signs of compassion fatigue at the workplace include absenteeism, chronic tardiness, chronic fatigue, low completion rates of duties, and poor patient care (Maslach & Leiter, 1997; Newell & MacNeil, 2010; Beebe, 2016). This is further worsened by symptoms put forth by the Figley (2002b), which include a decrease in quality and quantity of work, avoidance of tasks, faulty judgement, demoralisation, changes in or poor co-worker relationships, inability to work in a team, aggressive behaviour among staff, negativity towards management, an inability to believe that improvement is possible, as

well as a lack of vision for the future. Here, especially, it is evident that compassion fatigue not only negatively effects the social worker, but also the social service organisation and the client system, which depend on the compassion and performance of the professional.

3.2.3. The compassion fatigue model

The compassion stress and fatigue model developed by Figley (1995,2002b) is based on the theory that empathy and emotional energy are needed for professionals such as social workers to connect with clients and respond to their pain. Figley (1995,2002b) clarifies that the process starts with the exposure to the client, which is then followed by empathetic concern and -response, which is based on the professional's empathetic ability and understood as the aptitude of noticing the pain of others. With this model, it can be determined that the greater the professional's empathetic ability, the greater their empathetic concern (i.e. their motivation to respond to those in need) and the greater their empathetic response (i.e. the effort to reduce the suffering) (Figley, 2002b; Coetzee, 2017). Coetzee and Laschinger (2018) elaborate that the ability of the professional to empathise renders them vulnerable to compassion fatigue.

Figley's compassion stress and fatigue model progresses into residual compassion stress, which is minimised by either a sense of satisfaction or a sense of disengagement (Figley, 1995, 2002b). In particular, he warns that, with prolonged exposure to traumatic memories that elicit an emotional response as well as other life disruptions, the professional is destined to develop compassion fatigue.

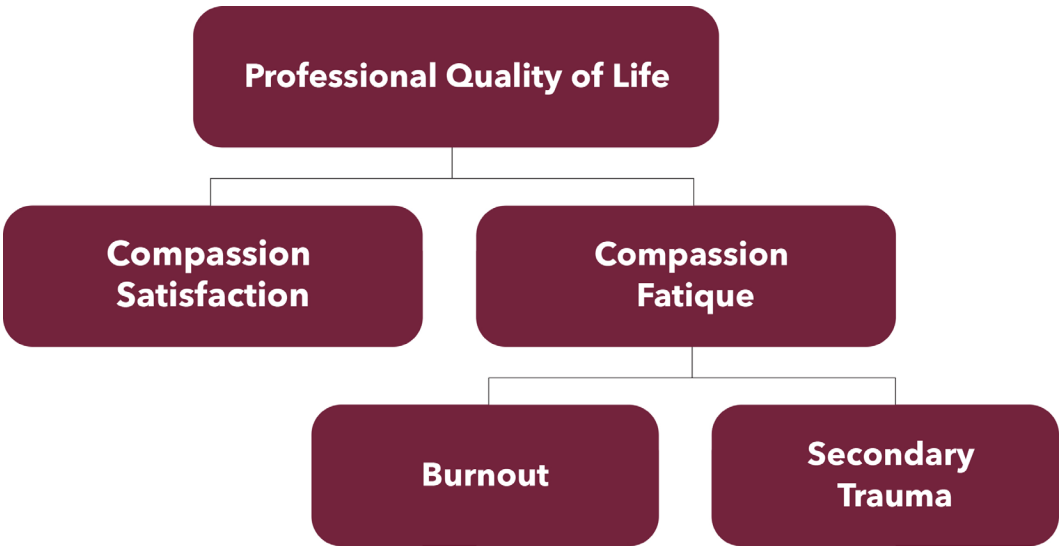

Figure 3.2.1: Diagram of Professional Quality of Life (Stamm, 2010)

As represented in the figure above, professional quality of life consists of two core components, namely: compassion satisfaction and its negative counterpart, compassion fatigue (Stamm, 2010). Compassion satisfaction involves the positive feelings that a professional has about their ability to help others and the pleasure they get from doing it well. This can also be understood as altruism. Compassion fatigue, on the other hand, involves negative effects that are aggravated when the professional is exposed to traumatic material. Stamm (2010) explains that compassion fatigue consists of two components, these being burnout and secondary traumatic stress. In this regard, burnout is associated with feelings of hopelessness and challenges in dealing with work or doing the work effectively (Stamm, 2010). On the contrary, secondary traumatic stress involves the "natural consequent behaviours and emotions resulting from knowing about a traumatizing event experienced by a significant other [i.e.] the stress resulting from helping or wanting to help a traumatized or suffering person" (Figley, 1995:7).

As Coetzee and Laschinger (2018) summarise, this model links empathy with the professional's capability to connect with and help the client, and thus highlights the requirement of emotional energy. Moreover, the development of compassion fatigue is a process that starts with compassion stress, which, if not managed by a sense of satisfaction or disengagement, develops into compassion fatigue if the individual continues to be exposed to stress.

3.2.4. Contributing factors to compassion fatigue

Figley's Compassion Stress and Fatigue Model is based on the assumption that empathy and emotional energy are the driving forces for connecting with and helping others (Figley, 2002a). However, he states that both compassion and empathy require cost and energy which together predict compassion fatigue. In so doing, he identifies 10 variables that contribute to compassion fatigue, these being empathetic ability, empathic concern, exposure to the client, empathic response, compassion stress, sense of achievement, disengagement, prolonged exposure, traumatic recollections, as well as life disruption (Figley, 2002b). The relationship between these variables, which will be unpacked in more depth below, is visually represented in figure 3.2.2.

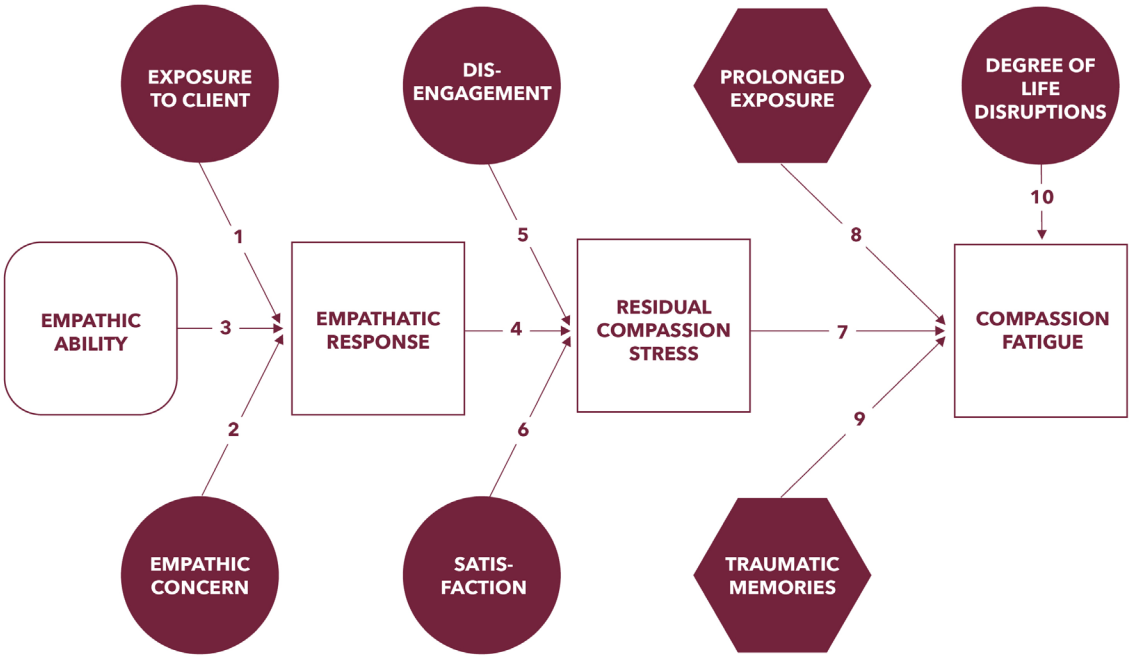

Figure 3.2.2: Compassion Stress and Fatigue Model (Figley, 1995)

Empathetic ability is "the aptitude of the psychotherapist for noticing the pain of others" (Figley, 2002b:1436). Beebe (2016) maintains that this ability is essential, both in connecting with and helping others, and in being vulnerable to the cost of caring. Empathetic concern is "the motivation to respond to the people in need" (Figley, 2002b:1436). Moreover, the ability to be empathetic is insufficient if there is no motivation to help others. Direct exposure to suffering, however, also puts the social worker at risk

for compassion fatigue (Beebe, 2016). Empathetic response is the “extent to which the helping professional makes an effort to reduce the suffering through empathic understanding” (Figley, 2002b:1436). Figley (2002b) explains that this insight into feelings, thoughts and behaviours involve projecting oneself into the perspective of the client, and may result in feelings of hurt, fear, and anger amongst others. Both Figley (2002b) and Beebe (2016) argue that this is where both the benefit and the cost of caring lies, which makes up the foundation of the therapeutic alliance. Furthermore, Figley and Figley (2017) confirm this, and argue that empathetic response directly impacts the level of compassion stress as the professional takes in disturbing information from the client.

Compassion stress is "the residue of emotional energy from the empathic response to the client and is the ongoing demand for action to relieve the suffering of a client" (Figley, 2002b:1437). With enough intensity, it can negatively impact the functioning of the immune system and the professional’s quality of life (Figley, 2002b; Beebe,2016). Figley and Figley (2017) further argue that compassion stress can either aggravate or lessen the other variables.

As mentioned previously, however, Figley (2002b) also identified two buffers to compassion fatigue, which include a sense of achievement and disengagement. This sense of achievement is the extent to which the professional is satisfied with their efforts to help clients. On the other hand, disengagement is the extent to which the professional distances themselves from the misery of the client and involves conscious and rational efforts to let go of the thoughts, feelings, and sensations associated with it.

Prolonged exposure is the “ongoing sense of responsibility for the care of the suffering, over a protracted period of time” (Figley, 2002b:1438). Figley (2002b) maintains that the longer the professional has respite from being compassionate and empathetic, or “a break from being a professional service provider,” the better. Trauma recollections involve the “memories that trigger the symptoms of PSTD and associated reactions, such as anxiety and depressions” (Figley, 2002b:1438), and may occur when a client discloses something or due to an event that transpires during the session. Beebe (2016) elaborates that these memories provoke emotional reactions in the professional and are further associated with emotional distress. This in turn involves life disruptions such as “unexpected changes in

schedule" and "routine," along with difficulty "managing life responsibilities that demand attention" (Figley, 2002b:1438). Other examples of disruptions include illness, or changes in lifestyle or responsibilities. Generally, these would cause a tolerable level of distress, but when combined with the aforementioned factors, the changes increase the chance of the professional developing compassion fatigue (Figley, 2002b; Sprang, Clark, & Whitt-Woosley, 2007).

3.2.5. Other risk factors for compassion fatigue

Apart from the abovementioned contributing variables identified by Figley (2002b), there are several other individual- and organisational factors that place social workers at increased risk for developing compassion fatigue.

3.2.5.1. Individual factors

Gottfried and Bride (2018) put forth that risk factors for compassion fatigue on an individual level include personal history of past trauma, mental health status prior to the exposure to said trauma, the individual's history of anxiety and/or depression, as well as a lower sense of accomplishment. Xu, Harmon-Darrow and Frey (2019) elaborate that personal factors also include lower family income and having fewer coping strategies. The increased exposure to graphic images related to trauma, the length of time providing trauma treatment, as well as the type of trauma of the client are also associated with compassion fatigue (House, 1981). Social workers who view themselves as saviours or rescuers, or who have an increased capacity for feeling and expressing empathy are, according to Gottfried and Bride (2018), also at risk of compassion fatigue. In this regard, empathy is both an important part of caregiving and a risk factor for indirect trauma, a dichotomy which Russel and Brickell (2015) describe as a double-edged sword.

More than any other group, newly qualified social workers are identified to be at risk of compassion fatigue. Originally, Figley (2002a) argued that newly qualified social workers, otherwise referred to as new therapists, are vulnerable to compassion fatigue as they are younger and newer to the work. This correlates with the findings of Pearlman and Madan (1995), which indicate newly qualified therapists having more difficulties in trauma-related work and being more vulnerable to burnout. Smith (2015) and Gottfried and Bride (2018)

confirm this and contend that newly qualified social workers with less experience, especially females, are at heightened risk. This is also confirmed by authors who note that age is positively correlated with the related symptoms, as younger people are often more idealistic, which factors into their vulnerability (Figley, 1995; Bush, 2009).

3.2.5.2. Organisational factors

Predictors of compassion fatigue not only involve the social worker's individual factors and characteristics, but also organisational factors. The most prominent factor mentioned in research is the overwhelming number and nature of caseloads (Beebe, 2016; Gottfried & Bride, 2018; Xu *et al.,* 2019). Other factors include child welfare affiliation, serving clients who have had severely traumatic lives, a lack of resources, bureaucratic restraints, unsafe environments, low work autonomy, role stress, and a lack of control regarding agency policies and procedures (Figley, 1995; Smith, 2015; Gottfried & Bride, 2018; Xu *et al.*, 2019). Unsurprisingly, a lack of support is a significant risk factor for social workers, especially newly qualified social workers, to develop compassion fatigue. Figley (2002a), Accordingly, Gottfried and Bride (2018) and Xu *et al.* (2019) all indicate that insufficient supervision and a lack of team and co-worker support is detrimental to the social worker, and that newly qualified social workers require mentoring relationships by veteran professionals.

3.3. COMPASSION SATISFACTION

Compassion fatigue and compassion satisfaction fall on a continuum and is the result of the transference of energy resulting from compassion stress (Radey & Figley, 2007; Russell & Brickell, 2015). Compassion stress can thus be negative, resulting in compassion fatigue, or positive, resulting in compassion satisfaction. The development of compassion satisfaction, in other words the halting of compassion fatigue before it turns into burnout, is also influenced by job satisfaction.

3.3.1. Compassion stress and compassion satisfaction

Social workers naturally feel compassion because they care and are empathetic (Radey & Figley, 2007). This involves seeing something from the point of view of those who are distressed. This empathy is what motivates altruistic behaviour, and in turn makes the

social worker strive to lessen the suffering of others. Radey and Figley (2007) further explain that in doing so, the experiences of the clients also affect the social worker. This is useful, because it assists the social worker to appreciate the suffering of others and to further empathise with the pain. Decades ago, Figley (1995) defined compassion stress as the stress that is connected with the exposure to a sufferer. Taking this into account, Radey and Figley (2007) argue that compassion stress could also possibly be positive energy that culminates in compassion satisfaction, and should be treated as such. They offer that, if compassion stress is handled effectively, its energy can lead to a sense of flourishing instead of compassion fatigue. In order to flourish, social workers and newly qualified social workers alike should experience joy in helping others and find satisfaction in their work. This joy and satisfaction may lead to compassion satisfaction, as well as a sense of fulfilment (Figley, 1995; Stamm, 2002). With compassion stress, Radey and Figley (2007) put forth that it is possible to transfer the energy into satisfaction with three interrelated ways. These include: (1) increasing the social worker's positive affect or maintaining a positive attitude towards clients, (2) increasing the social worker's resources to manage stress, including compassion stress, and (3) increasing the social worker's self-care in the form of inspiration and happiness in life. It is with these three elements that compassion stress will result in increased positivity and lead to compassion satisfaction. Figley (2002a) also asserts that there is a balance between compassion fatigue and compassion satisfaction, and that those experiencing compassion fatigue may also experience compassion satisfaction.

3.3.2. Professional quality of life

Stamm (2010) put forth another approach, namely the feelings of helping known as professional quality of life, to argue that this involves a balance of compassion fatigue and compassion satisfaction. Here, compassion satisfaction is defined as the enjoyment that helping professionals derive from being able to help others, and is also related to providing care, working with colleagues, the professional's beliefs about themselves, as well as altruism. This is confirmed by Murray (2015), who states that a high degree of compassion satisfaction can be related to the establishment of joy in the social work profession. Pooler, Wolfer and Freeman (2014) further elaborate that there are

interpersonal sources of joy within social work, and that these include connecting to clients and colleagues, making societal changes, as well as intrapersonal sources of joy, which include finding meaning in and making a life in doing services for others. In general, Stamm (2009, 2010) argues that, the more compassion satisfaction the professional has, the less compassion fatigue they have, and vice versa. Compassion satisfaction in turn can be prompted by a sense of achievement, motivation, inspiration and enjoyment from emotionally demanding social work (Wagaman *et al.,* 2015). They also found a significant relationship between empathy and compassion satisfaction. Rumsey (2017) added that empathy may thus be a supportive factor contributing to compassion satisfaction. Radey and Figley (2007) also argue that compassion satisfaction can effectively reduce burnout and secondary traumatic stress, as compassion satisfaction provides motivation, interest, and a sense of accomplishment in helping clients to overcome trauma. In this light, Pooler *et al.* (2014) explain that compassion satisfaction prompts situations where social workers vicariously benefit from their clients' improved functioning, personal growth or therapeutic gains. This is due to social workers and clients sharing positive outcomes of feelings of empowerment, energy, and exhilaration. Moreover, Cieslak, Shoji, Douglas, Melville, Luszczynska, and Benight (2014) identified self-efficacy to be another mediating factor between stress related to the exposure of trauma and the positive changes related to trauma. Social workers' compassion satisfaction is most generally seen in heightened performance, a positive attitude toward their work, enhanced value, as well as a greater hope for positive outcomes (Kulkarni, Bell, & Hartman, 2013).

3.4. JOB SATISFACTION

Simply put, job satisfaction is "how people feel about their jobs and different aspects of it" (Spector, 1997:2). This can be regarded as a general feeling, or as a response to various aspects of the job (Joseph, 2017). Social workers remain in poor paying jobs with serious levels of emotional exhaustion because they are fulfilling needs and values through helping others (Smith and Shields, 2013). Adamson, Beddoe and Davys (2014:526) elaborate on this, and explain that there is a "dynamic and fluid" relationship between the "benefits and strains" of the job. Moreover, from this argument, Joseph (2017) derives that it is fundamental that the negative aspects do not outweigh the positive aspects of

social work, as tipping the balance may ultimately negate the satisfaction from helping others. She also puts forth that, in order to gauge an accurate reflection of job satisfaction, the individual's cognitive and emotional evaluations of the job and the workplace experiences is required (Joseph, 2017). Therefore, for compassion satisfaction to be realised, as previously discussed, there should be an interplay between situational factors within the organisation as well as dispositional factors of the social worker (Joseph, 2017).

3.4.1. Situational factors

Situational theories propose that satisfaction is derived purely from the working environment, be it the nature of the work or the organisation's culture, and that this determines job satisfaction (Judge & Klinger, 2008; Redmond, 2016). These factors include working conditions, remuneration, workload, and opportunities for promotion, as discussed in depth in chapter 2.

Working conditions and environments are significant contributors to job satisfaction, thus rendering poor working conditions and environments as factors for job dissatisfaction. Aspects that often contribute to this include that social workers are plagued by health and safety risks, along with challenges related to a lack of organisational and community resources (Engelbrecht, 2006; Earle, 2008; Alpaslan and Schneck, 2012; Joseph, 2017). Kapoulitsas and Corcoran (2015) maintain that the abovementioned features can have a harmful impact on the social workers' emotional well-being. Remuneration, furthermore, plays a role in predicting job satisfaction, as it is related to a sense of self-worth, with workers often reporting that they are dismayed about poor remuneration, which is accompanied by a feeling that it is not worth it (Alpaslan and Scheck, 2012; Joseph, 2017). In general, social workers experience work-related pressure as a result of high caseloads and tedious administrative duties. With job satisfaction, Calitz *et al.* (2014) argue that high workload and time management directly results in social workers experiencing stress and burnout, as this leads to them feeling emotionally drained and unproductive. This issue is prevalent among newly qualified social workers, as they still need assistance in managing workloads and may not always be able to negotiate workloads (Walker, 2014). Career advancement is acknowledged to be an essential ingredient in job satisfaction, whilst social work remains one of the few professions in

which there is little opportunity for advancement and career growth (Earle, 2008; Redmond, 2016). Newly qualified social workers in particular have no defined prospects of promotion, which creates a stagnation and is furthermore a stressor in itself (Janse van Rensburg, 2009).

3.4.2. Dispositional factors

Contrary to situational theories, the dispositional approach proposes that some people may be predisposed to either higher or lower job satisfaction, regardless of their working environment or nature of work (Judge & Klinger, 2008; Redmond, 2016). Moreover, this approach indicates that there is a bi-directional correlation between job satisfaction and life satisfaction. The factors that play a role in this include empathy and personality traits.

3.4.2.1. Empathy

An essential part of a social worker's disposition should be a high level of empathy (John, 2012). In fact, being an empathetic person is the foremost motivation for entering the social work profession. Clark (2006) similarly posits that a social worker's inner character should instil courage, benevolence, and compassion. A study conducted by Joseph (2017) also found that participants mentioned the ability to develop intense empathy, and thus encourage a strength-based perspective to their clients. This notion of empathy correlates with the benefits that can be gained from resilience, as social workers from disadvantaged backgrounds and challenging pasts managed to overcome their own emotional and social challenges (Earle, 2008; Joseph, 2017). Joseph (2017) also puts forth that previous challenging experiences often gave individual social workers a strong penchant to show natural empathy towards others. In this study, participants indicated that it resulted in a real desire to understand the client and their emotional world. Accordingly, Joseph (2017:133) summates that social workers who had previous challenging experiences and backgrounds had a "palpable passion to understand, act upon and improve the lives of those disempowered in our society." Moreover, she argues that the aforementioned personal characteristics are necessary to be an adept social worker, but that this type of individual would also gain enormous satisfaction and reward from working in social work, as it connects with their personality and interest set (Joseph, 2017).

Personality is not only related to burnout, but also to resilience, which impacts on compassion fatigue and compassion satisfaction. This includes good humour, social responsibility, adaptability and tolerance, a good self-esteem, self-discipline and self-control, as well as skills related to planning, problem-solving, and critical thinking (Werner & Smith, 1992). These personality traits can be regarded as protective factors in the development of resilience.

3.4.2.2. Personality traits

Personality plays a significant role in the experience of stress in the workplace, which directly links with the development of compassion fatigue. In this context. personality is defined as the "relatively enduring combination of traits which makes an individual unique and at the same time produces consistencies in his thoughts or behaviour" (Fincham & Rhodes, 1999:62). According to Statt (2004), personality is also the reason that individuals with similar skill sets might choose different spheres of work including a difference in pace, greater or lesser responsibilities, different nature of rewards and a varied complexity in demands. Caron, Corcoran and Simcoe (1983) argue that differentiations and distinctions in personality affect the way that individuals experience their job and the work they do, as well as the way in which they experience stress.

The first personality trait, according to the five-factor model, is open to experience versus closed to experience (Fincham & Rhodes, 1999). In essence, newly qualified social workers that are open to experiences will seek out new and varied experiences, whilst those who are closed prefer that which is familiar to them. Janse van Rensburg (2009) and Grant and Langan-Fox (2006) puts forth that a prevailing aspect of social work is to integrate theory and practice with real people and real problems. Newly qualified social workers that are too open to experience may thus have difficulty grasping the practical application of theory in an ever-changing environment. Similarly, those who are too closed to experienced may become fixated on the practical problem or situation, and thus struggle to incorporate their notion of the problem into an abstract concept that can be appropriately linked to a solution.

The next personality trait is conscientious versus expedient (Fincham & Rhodes, 1999). A newly qualified social worker who scores highly in conscientiousness will impose a

larger sense of obligation on themselves and be more aware of others' expectations of them, whereas low scorers are more individualistic and will have less self-imposed standards (Grant & Langan-Fox, 2006). Both ends of the spectrum are expected to find specific workplaces more stressful. Conscientious types may find work that expects more adaptability and spontaneity more stressful, whereas a low scorer may find work that requires procedure and regulation to be more stifling and restrictive. Another source of stress is that of role conflict (Janse van Rensburg, 2009). Conscientious types may experience stress in such situations, as they are not living up to the expectations of others regarding their performance. Likewise, these individuals may also experience pressure to perform in a way that conforms to their own standard of work and not necessarily those of others.

The third personality trait is that of introversion versus extroversion (Fincham & Rhodes, 1999). The most evident source of stress for social workers in the workplace pertaining to this trait is that of support systems. Grant and Langan-Fox (2006) argue that extroverts are more socially confident, and thus often find it easier to develop strong support systems, not only privately, but also at work. This support system, in turn, acts as a buffer for stressors and also increases their coping efficacy. Introverts, on the contrary, may find it more difficult to develop strong support systems, and may also experience a reduction in self-efficacy and satisfaction as a result of a reduced social confidence.

The second to last personality trait is agreeableness versus hostility (Fincham & Rhodes, 1999) and involves the way in which the newly qualified social worker interacts with others. Those who are agreeable tend to be cooperative, friendly, and trusting, whereas those who are low scorers are more stubborn, irritable, and less trusting. Janse van Rensburg (2009) asserts that both of these poles have positive and negative aspects regarding the experience of stress related to work. The more hostile individual will find situations involving conflict less stressful than those who are agreeable. Moreover, those who are more agreeable may also find challenging environments to be less stressful, as their nature may lead them to be more conducive to adaptation, whereas those who are hostile are less adaptable.

The final personality trait is neuroticism versus emotional stability (Fincham & Rhodes, 1999). Aspects of neuroticism include anxiety, tenseness, low self-esteem, guilt proneness, low emotional control, and irrationality. This trait is perhaps also the most evident regarding its influence on work-related stress (Chamurro-Premuzie, Ahmetoglu & Furnham, 2008). High levels of anxiety are already an indicator of increased stress, but stressors increase tangibly for those who are more prone to anxiety on a regular and prolonged basis. Vearing and Mak (2007) and Furnham (2006) similarly argue that newly qualified social workers with more stable personalities react to potential stressors with stress, whereas those who are more irrational exaggerate each stressor and thus exaggerate their reactions. Furnham (2006) explains that this distorted view contributes to workplace stress, as the judgement of every potential stressor is biased by a skewed perception, whereas those with more stable personality types appraise stressors more accurately and thus react more appropriately.

Neurotic personality types also experience stress as a result of low self-esteem (Grant & Langan-Fox, 2006). This is because decision making related to stressors are hampered by the individual's inclination to undervalue their ability to cope and manage a situation. This lack of confidence may also prompt stress as a result of the individual's uncertainty about coping with the stressor. Furnham (2006) further elaborated that neurotic personality types evaluate failures far more critically than those who are more emotionally stable, and also change their perception of their self-esteem to become more self-critical as a result of guilt. Closely related to this, individuals who have high levels of neuroticism also have a tendency for low emotional control, meaning that their reactions to stress are less controlled than their more emotionally stable counterparts. Fincham and Rhodes (1999) elaborate that neurotic personality types may also find professions requiring emotional labour where roles are taken on and presented to be massively taxing and demanding.

3.5. COMPASSION FATIGUE AND BURNOUT

As previously explained, burnout is a component of compassion fatigue according to Stamm (2010) and is related to feelings of hopelessness and challenges in dealing with work and doing the work effectively. In literature, the terms burnout and compassion

fatigue are often used interchangeably depending on the theoretical framework, but authors have found distinct information pertaining to burnout which will be discussed below.

3.5.1. Defining burnout

The term “burnout” was first used to describe a phenomenon noticed among human service workers dealing with emotionally demanding clients (Maslach and Jackson, 1986; Kim & Stoner 2008). In this context, burnout is defined as “a progressive loss of idealism, energy, and purposed experienced by people in the social work profession as a result of the conditions of their work” (Edelwich & Brodsky, 1980:14). This implies that burnout experienced by social workers is a gradual process that seldomly occurs suddenly or with a single event, but instead increases over time as healthy defences and coping are worn down due to onset of emotional demands, frustrating setbacks, as well as difficult situations or individuals (Wagaman *et al*., 2015).

Burnout is also commonly defined in terms of its characteristic symptoms. Maslach and Jackson (1986) identified three components of burnout including emotional exhaustion, depersonalisation (otherwise referred to as cynicism), and diminished personal accomplishment. According to Kim and Stoner (2008:7), emotional exhaustion entails “feelings of being overextended and depleted of emotional and physical resources,” while depersonalisation entails “negative or excessively detached responses to various aspects of the job”, and diminished personal accomplishment entails “feelings of incompetence and a lack of achievement at work.” Figley (2002b) identified other characteristic psychological symptoms to include sleep disturbances, headaches, irritability, aggression, exhaustion, pessimism, issues with work relationships and a decrease in work performance. It is interesting to note that this correlates with the symptoms of compassion fatigue as outlined by Figley (1993, 2002b). Burnout alone can cause significant levels of stress for social workers, and this is also an eminent contributor to compassion fatigue (Figley, 1995; Stamm, 2010; Smith, 2015).

As discussed previously, burnout is characterised by its symptoms, and is thus also closely associated with the effects on both the social worker and their work performance. Burnout’s effects on the individual social worker include physical- and mental health

problems such as depression, insomnia, and gastrointestinal issues (Lee & Ashforth, 1996). However, it mostly impacts the social worker's work performance, and this is often how it is identified in the first place. Its effects include a decrease in job performance, increased absenteeism, a higher turnover, lower organisational commitment, lower productivity, decreased effectiveness when working with clients, as well as tardiness and isolation from others (Maslach & Leiter, 1997; Newell & MacNeil, 2010).

3.5.2. Causes of burnout

Causes of burnout in social workers range from organisational factors, dispositional factors, and an interaction between the two. According to Maslach and Schaufeli (1993), it is the result of demanding and emotionally charged relationships that the social worker has with clients to the extent that they can no longer fulfil basic personal and professional responsibilities and duties. Social worker burnout is also the result of frustration, powerlessness, and the inability to achieve work-related goals (Figley, 2002b). Newell and MacNeil (2010:59) assert that "the single largest risk factor for developing professional burnout is human service work in general."

3.5.2.1. Organisational factors

Kim and Stoner (2008) identified three main causes of work-related burnout, including role stress, job autonomy, and social support. Role stress pertains to high role conflict, role ambiguity, as well as role overload (Söderfeldt, Söderfeldt, & Warg, 1995). Cordes and Dougherty (1993) explain that this is directly related to emotional exhaustion, and that those who experience high levels of emotional exhaustion are also more likely to experience depersonalised attitudes. Job autonomy pertains to the social worker's degree of control regarding their own scheduling and tasks. This is related to reduced personal accomplishment and depersonalisation, as this is associated with social workers' perception of a lack of job control and a lack of involvement in decision making (Posig & Kickul, 2003). Social support pertains to the supportive interactions and exchanges between people both formally and informally (House, 1981). For this reason, it is a powerful moderator of burnout, as sufficient perceived social support in the workplace decreases the probability of burnout. Smith (2015) asserts that newly qualified social workers are at higher risk of burnout than their more experienced counterparts as a result

of a lack of positive feedback or praise, unrealistic job demands, as well as poor managerial support, as this is linked with mental health and emotional exhaustion.

3.5.2.2. Personal factors

Though less in comparison to organisation factors, personal factors also contribute to the development of social worker burnout. Several authors postulate that social workers with traumatic histories, anxiety or mood disorders, interpersonal relationships with conflict, low tolerance for insignificant annoyances, as well as a lack of commitment to the social work profession are at a higher risk for burnout (Newell & MacNeil, 2010; Kulkarni *et al.,* 2013; Wagaman *et al.*, 2015). Likewise, with compassion fatigue, burnout is strongly associated with the personality and coping abilities of the social worker. Maslach, Schaufeli, and Leiter (2001) put forth that low levels of energy, poor self-esteem, and an avoidant coping style is linked to neuroticism and Type-A behaviour. The latter is characterised by intense competitiveness, an attention to time lifestyle, hostility and paranoia, as well as an exorbitant need to control (Maslach, Schaufelli & Leiter, 2001). According to Kim, Ji, and Kao (2011) and Maslach *et al.* (2001), newly qualified social workers are at the highest risk for emotional and psychological disillusionment as a result of inadequate guidance on the part of their supervisor.

3.6. CONCLUSION

Social workers render services to vulnerable individuals, families, groups and communities who are often at risk of trauma. In so doing, they connect and empathise with their clients and further feel compassion. There is, however, a ‘cost of caring’ referred to as compassion fatigue, which pertains to the negative aspects of caring for others. From research, it is evident that newly qualified social workers are at the highest risk of developing compassion fatigue, as they are younger and newer to the practice. Symptoms of compassion fatigue can be classified in terms of cognitive, emotional, behavioural, spiritual, personal relations, somatic, and work performance. These symptoms not only affect the social workers’ professional lives, but also the quality of their work, the care they offer to clients, and their personal lives. Main variables that, if negative, can contribute to compassion fatigue include empathetic ability, empathic concern, exposure to the client, empathic response, compassion stress, sense of

achievement, disengagement, prolonged exposure, traumatic recollections, as well as life disruption.

Theoretical approaches to compassion fatigue emphasise the key role of compassion stress which can be negative, resulting in compassion fatigue, or positive, resulting in compassion satisfaction. In this context, compassion satisfaction is related to job satisfaction and social workers finding joy in helping others. As with compassion fatigue, compassion satisfaction is also influenced by situational factors such as the organisation and work environment, as well as the social worker's own personal disposition. Finally, burnout is also considered to be an important component of compassion fatigue despite it often being used interchangeably. Several authors note that the component of burnout is more prominently associated with workplace factors similar to that of compassion fatigue, but that personal factors may also play a significant role depending on the perception of the social worker.

The next chapter will analyse the concept and importance of self-care, as well as identify and explore the different dimensions of wellness that correspond with self-care, as well as the self-care intervention strategies to be used by newly qualified social workers.

CHAPTER 4: THE EMPLOYMENT OF SELF-CARE BY NEWLY QUALIFIED SOCIAL WORKERS

4.1. INTRODUCTION

Self-care is widely attributed to predicting professional quality of life, which includes compassion fatigue, compassion satisfaction, and burnout. It is, however, evident that many social workers in practice, especially newly qualified social workers, do not practice self-care, despite its negating effects on compassion fatigue and its importance in the promotion of wellness. In this light, this chapter will analyse the definition and importance of self-care within the context of newly qualified social workers, identify and explore the different dimensions of wellness and each dimension's corresponding self-care activities. It will further analyse self-care strategies to be used as interventions by newly qualified social workers, along with the significance of supportive supervision and the necessity of self-care education in social work.

4.2. DEFINING SELF-CARE

Self-care is widely attributed to predicting professional burnout in life, which includes compassion fatigue, compassion satisfaction, and burnout (Goncher, Sherman, Barnett & Haskins, 2013; Bloomquist, Wood, Friedmeyer-Trainor & Kim, 2015). It is predominantly defined as "the intentional effort to improve health and wellness by addressing personal needs […] related to mental, emotional, physical, spiritual, and social states" (Richards, Campenni & Muse-Burke, 2010; Moore, Bledsoe, Perry & Robinson, 2011; Diebold, Kim & Diane, 2018:657). For this reason, Salloum, Kondrat, Johnco and Olson (2015) assert that self-care has preventative and prescriptive properties for social workers and newly qualified social workers alike by managing emotional and psychological distress as it cultivates health and well-being. Ogaswara, Shiihara and Ando (2013), however, argue that self-care differs from individual to individual, and may involve a variety of activities.

The definition and approach to self-care can, however, be delved into deeper, with the most prominent approach pertaining to personal and professional self-care. According to

Bressi and Vaden (2017), the professional self involves the aspects that are engaged at work in relationships with clients, and that this is guided by professional role expectations. The personal self, on the contrary, exists outside of work and is guided by other role expectations such as family life, economic functions, and communities amongst others. Miehls and Moffatt (2000) argue that the 'self' is rooted in ego psychology, which constructs it as a single entity that functions optimally when all of its components are in balance, coherent and has integrity. In response to this, Bressi and Vaden (2017) put forth that the overarching goal of self-care has been to maintain equilibrium or homeostasis in an effort that the professional self does not impinge on the personal self and vice versa. Using this approach, burnout and compassion fatigue is the result of the self not being in balance. The most prominent infringement is of the professional self on the personal self, and this is colloquially described as "bringing one's work home at night,'' which is assumed to result in the personal self being overwhelmed by the emotional distress of clients (Lee and Miller, 2013; Bressi and Vaden, 2017:34). On the other hand, the professional self may be infringed when the social worker's personal emotional functioning is poor. Taking the aforementioned approach into consideration, Lee and Miller (2013:98) define self-care as the following:

> *"Personal self-care is defined as a process of purposeful engagement in practices that promote holistic health and well-being of the self, whereas professional self-care is understood as the process of purposeful engagement in practices that promote effective and appropriate use of self in the professional role within the context of sustaining holistic health and well-being."*

Bressi and Vaden (2017) elaborate that this definition is aimed at protecting both the professional and the personal self in an effort to do one's best at work and using the 'self' cautiously at work.

This approach to self-care is, however, criticised in that the distinction and separation of the self is said to be a "false dichotomy" (Shulman, 2012:37). Postmodern constructivists advocate that the self is not a single entity, but rather that there are multiple selves that are co-constructed in relationships that the social worker has with each client (Knight, 2012). Miehls and Moffatt (2000) explain that these selves are reflexive and complex, and

are open to the influence of professional relationships. In light of this shift regarding self-care, Bressi and Vaden (2017) maintain that the goal of self-care activities needs reconsideration. Firstly, they elaborate that it must incorporate and respond to changes in the construct of the self, as well as practice modalities in which the social worker works closely with clients in the context of uncertainty and vulnerability. Further, they propose that the aim of self-care be inclusive of self-regulated activities that purposefully bolster the ability to understand the experience of vulnerability and uncertainty in social work relationships, as well as that it should make meaning of the ways in which the social workers' selves are changed from working with clients. Miehls and Moffatt (2000) thus identify the goal of self-care as allowing social workers to tolerate the effective and identity dysregulation as a result of experiencing the client, as opposed to decreasing anxiety from a disequilibrium.

4.3. THE IMPORTANCE OF SELF-CARE

For many care professionals, particularly newly qualified social workers, social work is a demanding helping profession as it involves complex caseloads, challenging clients and situations and heavy workloads, not to mention the trauma and crises that the practice exposes its workers to (Hansung & Stoner, 2008; Griffiths, Royse, Murphy & Starks, 2019). Figley (2002a) furthermore asserts that social workers experience awkward and difficult human interactions and must gain thorough knowledge and understanding of clients and their situations to design and render services appropriately. This not only evokes discomfort, but stress, fatigue and burnout. Self-care decreases strain and negative consequences relating to human service work, and is thus positively related to compassion satisfaction and professional resilience (Fink-Samnick, 2009; Kulkarni *et al.,* 2013). This is why self-care is essential. According to Butler (2016), successful self-care is beneficial in the short- and long-term, and affects all aspects of a social worker's life, including the emotional, psychological, physical, spiritual, professional, and relational.

Another primary concern regarding self-care for social workers is that avoiding it may not allow them to render the best services to their clients (Dalphon, 2019). Griffiths *et al.* (2019) elaborate that care professionals encounter threats to their emotional well-being, and that they cannot simply block out what they see, hear and feel. For this reason, social

workers should process the human tragedies that they engage with and emerge emotionally and mentally well enough to serve other clients effectively. In short, their stress not only affects them, but also reduces the efficacy of their service delivery to other clients (NASW, 2008). Miller, Lianekhammy, Pope, Lee and Grise-Owens (2017) expounds that self-care is more than just professional longevity, stating that it is an ethical responsibility in social work as it is every social worker's duty to provide the best possible service. This is confirmed by the National Association of Social Workers (NASW, 2008), who assert that it is the ethical responsibility of social workers to address any impairment or personal challenge that may interfere in their professional decision-making and services. Social workers cannot provide the best possible care and service to clients if they are not taking care of themselves, and this includes any personal, physical, psychological or other barriers (Miller *et al.,* 2017). Stoewen (2017) and Dalphon (2019) build on this view by arguing that it is a professional and personal responsibility as well as an ethical obligation for social workers to tend to their own health and well-being, as sufficient self-care prevents social workers harming those they serve.

4.4. SELF-CARE AND THE DIMENSIONS OF WELLNESS

An essential component of self-care is that of wellness. Stoewen (2017) explains that, although we often think of wellness in terms of physical health, it is much more than that. Wellness is "a holistic integration of physical, mental and spiritual well-being, fuelling the body, engaging the mind, and nurturing the spirit" (Stoewen, 2017:861). Similarly, the World Health Organization (WHO, 1958:1) defines wellness as "physical, mental, and social well-being, not merely the absence of disease." It is about living fully, and it allows you to be the best person that your potentials, circumstances, and fate will allow (Ardell, 1999). There are various dimensions to wellness with their respective self-care activities, and all of these must be paid attention to as neglect will adversely affect other dimensions (Hettler, 1976). Hettler (1976) explains, however, that they do not necessarily have to be balanced equally, but that one should rather aim for personal harmony according one's own priorities, approaches, aspirations, and views.

4.4.1. Occupational wellness

The occupational wellness dimension is related to personal satisfaction and enrichment through work, and has been identified as a predictor of lower burnout and compassion fatigue, as well as a predictor for a greater compassion satisfaction (O'Neill, Yoder Slater & Batt, 2019). Hettler (1976) explains that the core of this premise is that it is related to one's attitude about one's work. In social work, Newell and Nelson-Gardell (2014) define professional self-care as using skills and strategies to maintain personal, familial, emotional and spiritual needs, whilst also attending to the needs and demands of the clients. Within this dimension, a social worker will contribute unique gifts, skills and talents which are personally meaningful and rewarding, as well as convey values through gratifying activities (Hettler, 1976). Central tenets propose that it is better for a social worker to be in a career that is consistent with their personal values, interests, and beliefs as opposed to a career that is unrewarding. It is also better to develop functional and transferable skills than to remain uninvolved and inactive. Accordingly, Bloomquist *et al.* (2015) identify professional self-care activities to include participating in trainings, setting appropriate boundaries with clients, seeking adequate supervision and support, as well as advocating for one's own needs within the workplace. O'Neill *et al.* (2019) further advocate for vacations and support from co-workers and supervisors, as the latter organisational factors can promote or discourage self-care.

4.4.2. Physical wellness

The dimension of physical wellness involves that which is most commonly associated with wellness, namely physical health. According to Hettler (1976), this encourages learning about diet and nutrition whilst simultaneously discouraging the use of tobacco, drugs, and an excessive consumption of alcohol. Optimal physical wellness requires good exercise and eating habits, as well as medical self-care and the appropriate use of the medical system, which in turn involves caring for minor illnesses and knowing when professional medical attention is needed. Hettler (1976) further puts forth that the benefits of physical wellness not only includes looking and feeling good, but that there are numerous psychological benefits, such as an enhanced self-esteem, self-control, determination, and sense of direction. Common physical self-care activities include

exercise, adequate sleep, and a healthy diet (Bloomquist *et al.*, 2015). Simple ways to improve one's physical activity at work could include taking a brisk walk during lunch or break time or inviting a colleague out for a walk. Slade and Kies (2015) elaborate that regular exercise is essential to physical wellness, as it regulates mood, improves self-esteem, combats fatigue, decreases stress, improves sleep, and improves overall health.

4.4.3. Social wellness

The social wellness dimension involves contributing to one's environment and community and further emphasises an interdependence between others and nature. Hettler (1976) asserts that one would improve the world through better communication and wilful choices to enhance personal relationships and friendships. Central tenets propose that it is better to contribute to the greater welfare of the community than to only think of oneself, and that it is better to live in harmony with others than to have conflict. In this light, O'Neill *et al.* (2019) identified social self-care activities to include spending time with friends, family, and significant others, as well as phone calls and social networks, as the latter provide people with support, encouragement and enjoyment. Intimate personal relationships are a significant source of social support for social workers which Manning-Jones, de Terte, and Stephens (2016) found to be a significant buffer from secondary trauma.

4.4.4. Intellectual wellness

The intellectual wellness dimension encompasses one's creative and mental activities. Hettler (1976) puts forth that, in cultivating these, one would expand one's knowledge and skills and cherish intellectual growth and stimulation. This involves problem solving, creativity and learning, as well as spending time pursuing personal interests and staying informed about current issues and ideas. Central tenets of intellectual wellness propose that it is better to challenge oneself intellectually and creatively than to be self-satisfied and unproductive, and that it is better to identify potential problems and their appropriate courses as opposed to waiting, worrying and contending with major concerns later. Psychological self-care activities related to intellectual wellness include therapy, journaling and reading, as these endorse self-awareness and decision making (Bloomquist *et al.*, 2015).

4.4.5. Spiritual wellness

The spiritual wellness dimension encompasses meaning and purpose in existence, and has been identified as a predictor of lower burnout and compassion fatigue (O'Neill *et al.*, 2019). According to Hettler (1976), this includes a deep appreciation for the depth of life and natural forces, and that one's search for meaning is characterised by peaceful harmony between personal emotions and life challenges. Various emotions ranging from positive (e.g. pleasure, joy, happiness and discovery) to negative (e.g. doubt, despair, fear, disappointment and dislocation) are all important experiences, as they will be displayed in one's value system which brings meaning to one's existence. Hettler (1976) explains that one would be sure of spiritual wellness when one's actions are more consistent with one's beliefs and values. Central tenets of spiritual wellness propose that it is better to ponder the meaning of life and be tolerant of others' beliefs than to be closed minded and intolerant. Further, it is better to live a life that is consistent to one's values and beliefs than to feel untrue to oneself. White, Peters and Schim (2011:48) define spiritual self-care as "the beliefs a person holds [about] their subjective sense of existential connectedness including beliefs that reflect relationships with others, acknowledge a higher power, recognise an individual's place in the world, and lead to spiritual practices." Spiritual self-care activities include attending religious or spiritual events, praying and meditation (Bloomquist *et al.*, 2015; O'Neill *et al.*, 2019), as these nurture connections and finding meaning in life.

4.4.6. Emotional wellness

The emotional wellness dimension entails awareness and acceptance of one's feelings, which has been identified as a predictor of lower burnout and compassion fatigue, as well as an independent predictor of greater compassion satisfaction among social workers (O'Neill *et al.*, 2019). Hettler (1976) puts forth that this includes the extent to which one feels positive and enthusiastic about one's own life, as well as the capacity to manage one's feelings and behaviours. This involves making personal choices and decisions based on a synthesis of feelings, thoughts, philosophies and behaviours, seeking and appreciating support and assistance from others, and forming interdependent relationships that are built on commitment, trust and respect. Central tenets of emotional

wellness propose that it is better to be aware of and accept feelings than to deny them, and that it is better to be optimistic that pessimistic. Emotional self-care activities further encourage emotional well-being, and include spending time with loved ones, laughing and self-praise, as well as creative art expressions and reflection (Bloomquist *et al.*, 2015; O'Neill *et al.*, 2019).

4.5. SELF-CARE STRATEGIES AS INTERVENTIONS

Miehls and Moffatt (2000) identify the goal of self-care to be to allow social workers to tolerate the effective and identity dysregulation as a result of experiencing the client, as opposed to decreasing anxiety from a disequilibrium. Moreover, self-care strategies should be aimed at meaning-making and self-discovery. Using this reconsidered framework for self-care, Bressi and Vaden (2017) put forth that social workers should be informed that emotional disturbances and distress are a normal and important aspect of working with vulnerable clients. With this foundation, self-care activities should be aimed at (a) coping with physical and psychological distress, (b) identifying one's own reactions as communication from clients, (c) creating opportunities for self-reflection and reflection about clients, as well as (d) opposing the avoidance of affects and thoughts related to clients as the primary form of self-care (Bressi & Vaden, 2017). Smith (2015) identified two prominent self-care strategies that social workers, and newly qualified social workers, may find useful for coping with compassion fatigue, namely self-compassion and mindfulness.

4.5.1. Self-compassion

Self-compassion, a Buddhist construct, can be understood as the instance when an individual has compassion for themselves during difficult times, when failing, or when observing things that they dislike about themselves. In the same way, they would thus have compassion for other individuals (Neff, 2003). For this reason, Neff and Vonk (2009) propose that self-compassion consists of three components, namely self-kindness, humanity, and mindfulness. Firstly, self-kindness involves individuals accepting themselves when they are aware of their flaws and experiencing pain, as opposed to critiquing themselves severely or ignoring what they are feeling. Further, when self-

compassionate individuals are faced with stress, inadequacy and failure, they avoid judging themselves harshly, instead viewing and treating themselves kindly (Neff, 2003). Lockard, Hayes, Neff and Locke (2014) summarise that this is a personalised, caring and understanding response to pain and suffering. The second component of self-kindness, common humanity, comprises the notion that people feel alone when they are upset about not getting what they want. By extension, this aspect is about acknowledging that all individuals experience pain and mistakes (Neff, 2003). Neff and Costigan (2014) elaborate that common humanity is about putting perceived failure into perspective and acknowledging that it is human. This may relate to reflections being inaccurate and questions being misunderstood, as well as clients dropping out of treatment, which Bischoff and Barton (2002) identify is unsettling for newly qualified social workers who personalise the experiences. Both Neff (2003) and Levit and Jacques (2005) assert that, without a sense of humanity, social workers in training become self-critical and work harder when encountering criticism or perceived failure and may, as a result, lose their ability to attend to, be present, and help their clients. Coaston (2019) thus puts forth that supervisors should normalise and encourage self-kindness as opposed to self-criticism. Finally, mindfulness is defined as “watching negative thoughts and feelings, but not judging, subduing or rejecting them” (Smith, 2015:30). A more detailed discussion of this process will be commenced below.

Ultimately, social workers in training with higher levels of self-compassion have a greater ability to tolerate ambiguity, as they approach themselves with self-kindness when facing failure (Fulton, 2016). Neff and Vonk (2009) corroborate this, as greater self-compassion reduces ego reactivity, which makes it easier for social workers in training to share mistakes.

4.5.2. Mindfulness

According to Kabat-Zinn (1994), mindfulness is about paying attention to the present moment without judgement, as well as creating a balance of awareness. Neff (2011) further argues that this allows the social workers to notice pain or suffering without avoiding or exaggerating it, thus comforting themselves through an act of self-kindness. Within the scope of self-compassion, mindfulness is intended to create a balanced

awareness of both positive and negative feelings, as well as enhancing clarity and perspective (Neff & Dahm, 2015). Furthermore, Bishop (2004:232) proposes two components to mindfulness, namely self-regulation of attention that stays focused on the present, as well as the view of the present moment and experiences that are "characterized by curiosity, openness, and acceptance." On the other hand, Luberto, McLeish, Robertson, Avallone, Kraemer, & Jeffries (2013) identify the four components of mindfulness to include: observing one's environment, describing one's environment, actively being aware of one's surroundings, as well as taking in information from the environment without making judgements. Dalphon (2019) accordingly asserts that mindfulness skills can be developed over time, and that these become stronger through practice. Mindfulness-based practices have been found to be effective in treating psychological problems such as depression and stress, as well as functioning as self-care for stress and tolerating difficult emotions arising from interactions with clients (Fulton, 2016). For this reason, social workers who practice mindfulness are less inclined to experience compassion fatigue and burnout, and experience higher compassion satisfaction, as it reduces stress, negative effect, rumination and anxiety, while increasing positive affect and self-compassion (Thomas, 2012). Mindfulness can thus be regarded as an effective prevention for compassion fatigue. In this light, Dalphon (2019) encourages mindfulness exercises such as 'mindful seeing,' 'body conscious exercise,' 'safe place guided imagery' and 'guided imagery script' as a means of improving mindfulness and preventing compassion fatigue. She further reassures that some of these may feel more natural than others, which may require more practise and should also be practiced whenever the social worker feels comfortable (Dalphon, 2019).

4.5.2.1. Mindful seeing

Mindful seeing involves the social worker taking a visual stimulus without making judgements about what is seen. Dalphon (2019) explains that this can be done anywhere, but preferably outside, as social workers spend most of their day inside offices doing home visits or engaged in indoor work. This exercise thus involves the social worker slowly taking in what they see without making judgements or labelling things (Ackerman, 2017). For example, this could occur when looking at a stop sign and seeing its red colour and many sides, along with the patterns, colour, and movement of the environment.

Dalphon (2019) reassures that social workers may find it difficult to concentrate, especially if it is during a busy workday, explaining that the mind is occupied with thoughts. It is, however, important that the social workers then bring themselves back to mindful seeing.

4.5.2.2. Body conscious exercise

Social workers can notice tension when they develop an awareness of their body. Lisansky (2016) asserts that the social worker should avoid attaching meaning to tension, and instead simply be aware of it. To do this exercise, the social worker should focus all attention to noticing where the most tension is felt in the body. It may be easier to start with one body part and working to the others. All attention should then be directed to releasing this tension (Lisansky, 2016). According to Dalphon (2019), this exercise is the most convenient for social workers as it can be performed anywhere and at any time.

4.5.2.3. Safe place guided imagery

According to Eshelman and McKay (1995), the goal of this mindfulness exercise is to create a mental retreat that can be taken as a break away from the surrounding stressors. It involves thinking of a place where the social worker feels secure and at peace (e.g. a cosy family room). While performing this exercise, the social worker may be in any space whilst laying down or sitting comfortably. A guided imagery script is followed, which may involve a recording of the social worker reading the cues, or a friend or colleague assisting. An example of such a script can be read in Dalphon (2019:91), who asserts that this exercise is effective when the social worker needs relaxing time as the environment pictured is familiar and calming.

4.6. RESILIENCE AND SELF-CARE

Resilience, positive emotions and optimism have been widely studied as playing a significant role in social workers' well-being (Collins, 2008; Kinman & Grant, 2011; Joseph, 2017). Saleebey (2006) and Masten (2001) define resilience as a response to adversity, which involves growth and an expression of insight, knowledge and capacities as a result of the experienced challenges and manifests in the actions that are performed by individuals. Moreover, Pulla (2019) indicates that resilience is not only related to

hardiness, resourcefulness and mental toughness, but is also a dynamic process where one shows positive behaviour alternation when faced by adversity, trauma and stress. A study conducted by Kinman and Grant (2011) found that both resilience and higher coping strategies strongly correlate with individuals who are more adept at expressing their emotions, can incorporate emotional knowledge into their work, and are able to control and regulate their emotions.

Within this context, psychological resilience refers not only to the positive capacity, but also to its influence on the solution of mental health issues (Luthans, 2002). It is about resisting against environmental risk factors that the professional interacts with, as well as maintaining well-being. According to Akova and Turan (2015), psychological resilience not only helps people to cope with stress, but allows them to latch on their work. Um and Harrison (1998) further put forth that those with high psychological resilience maintain controllability, increasing responsibility and decreasing pressure. This is also said to positively affect job satisfaction and protects against traumatisation and secondary traumatic stress. Buyukbodur and Var (2019) thus conclude that psychological resilience can assist social workers in overcoming secondary traumatic stress. Accordingly, they put forth that supporting social workers within their organisation is necessary to reduce the risk of trauma impacting their work.

4.7. SUPPORTIVE SUPERVISION AND SELF-CARE

According to Tham and Lynch (2014), newly qualified social workers are vulnerable and in need of induction, support, and supervision. One aspect of the social work profession that is different to other professions is the provision of emotional support from the supervisor, as this improves productivity by decreasing stress (Kadushin, 1992; Chibaya, 2018). This is corroborated by Tsui (2005), who argues that supervision provides supervisees with the time and place to receive support to prevent burnout, a form of compassion fatigue. Tsui (2005) elaborates on the nature of supervision, stating that there are four elements of support, namely emotional support (e.g. friendliness, caring and warmth), appraisal (e.g. the supervisor affirming the work done by the supervisee), instrumental support (e.g. guidance and assistance), and informational support (e.g. the supervisor sharing useful information with the supervisee which facilitates work

performance). Supportive supervision is also positively linked with job satisfaction and, as a result, the retention of social workers which has a positive impact on the quality of social work service delivery.

Carpenter, Carpenter, Webb, Bostock and Coomber (2012) assert that supervision sessions are perceived as more positive when reflective practice is encouraged and when it is a key element in the supervision of newly qualified social workers. In this context, reflection is understood as the continual re-evaluation of personal beliefs, assumptions and ideas for the purpose of generating alternative interpretations (Chibaya, 2018). It is also a process towards deeper understanding and awareness, and entails more than simply looking back at the task aspects of a specific case in that it involves an analysis of both personal experiences and interactions with clients. According to Coaston (2019), the supervisory relationship is the ideal way in which self-compassion can be taught to newly qualified social workers. Nelson, Hall, Anderson, Birtles and Hemming (2018) agree with this, and identify that early-career post-graduation is the perfect time to learn strategies of self-care and self-compassion. Experiencing compassion within the supervision relationship creates a parallel which models how supervisees can show compassion to clients. Thus, by cultivating a self-compassionate environment, supervisors aid in the development of a compassionate internal voice, normalise human experience and provide optimal conditions for both personal and professional growth.

4.8. SELF-CARE EDUCATION

As the social work profession aims to promote the welfare of those that are disadvantaged and marginalised, it is essential that social work education actively fosters social work students' capacities to cope with the inevitable stressors, challenges and diminishing resources that accompany their work environments (Ying & Han, 2009; Iacono, 2017). Newell and Nelson-Gardell (2014) state that social work students are at risk of leaving the social work profession should they be emotionally and psychologically unprepared. According to Moore *et al.* (2011) there is insufficient research in students' self-care practice, despite its important role in preventing compassion fatigue and burnout, and maintaining well-being. A study conducted by Bloomquist *et al.* (2015) found that social work practitioners did not engage in self-care consistently. Participants explained

regarding their preparation as graduate students that their programmes valued self-care, but did not effectively teach them how to engage in self-care practices. Moore *et al.* (2011) confirms this and asserts that many social work students reach the end of their formal training unprepared to use self-care practices, since social work education often overlooks the topic of and training pertaining to self-care.

The National Association of Social Workers (NASW, 2008:270) has taken a strong stance sanctioning professional self-care as an approved method of improving and restoring the social worker's well-being. In so doing, it recommends "the training of social work students about self-care in their field experience and the modelling of these [behaviours] by field instructors" (NASW, 2008:270). This assertion is aligned with the observation of Pottage and Huxley (1996) decades ago, namely that neither social work students nor experienced social workers can provide proper care and support to their clients if they themselves are chronically stressed and overwhelmed. Griffiths, Royse, Murphy and Starks (2019) agree with this, and state that social workers often take care of others before themselves. They further advocate that a culture shift must take place. The social work profession must take a proactive stance through the prioritisation of self-care, wherein social workers must take ownership of their health and well-being by making a concerted effort (Lee & Miller, 2013). This is eloquently expressed by Grant, Kinman and Baker (2015:2351), who state that one must "put on [one's] own oxygen mask before assisting others." Although there are challenges in incorporating this into social work curricula, Newell and Nelson-Gardell (2014) assert that it is a necessity to include self-care material in social work education as an ethical consideration.

4.9. CONCLUSION

Self-care is widely attributed as having preventative and prescriptive properties for managing distress and predicting compassion fatigue, compassion satisfaction, and burnout. This encompasses both personal- and professional self-care, as it is aimed at protecting both the professional and the personal self in an effort to do one's best at work and using the 'self' cautiously at work. Social work is a demanding helping profession, as it involves complex caseloads, challenging clients and situations, heavy workloads, and trauma which evokes discomfort, stress, fatigue, and burnout. Self-care decreases the

strain and negative consequences relating to human service work and is positively related to compassion satisfaction and professional resilience, as well as being beneficial in all aspects of a social worker's life. Further, it surpasses the mere purpose of professional longevity to become an ethical responsibility in social work in that it is every social worker's duty to provide the best possible service. As such, avoiding self-care may not only negatively affect the social worker's retention in the profession, but also their ability to render the best services to clients.

An essential component of self-care is that of wellness, which encompasses various different dimensions, of which all must be paid attention to, as neglect of any will adversely affect the others. This includes occupational wellness, which is related to personal satisfaction and enrichment through work, physical wellness and -health, social wellness related to contributing to one's environment and community, intellectual wellness relating to one's creative and mental activities, spiritual wellness related to meaning and purpose in existence, as well as emotional wellness related to the awareness and acceptance of one's feelings. With self-care, another prominent strategy is that of self-compassion. Here, social workers, and newly qualified social workers in particular, should be assured that emotional disturbances and distress are a normal and important aspect of working with vulnerable clients. It is about having compassion for themselves when failing, during a difficult time, or when observing things that they dislike about themselves, in the same way they would have compassion for other individuals under these circumstances. This further involves components of self-kindness, humanity, and mindfulness. This is important, as newly qualified social workers with higher levels of self-compassion have a greater ability to tolerate ambiguity as they approach themselves with self-kindness when facing failure. Mindfulness, another prominent strategy, involves paying attention to the present moment without judgement, creating a balanced awareness of both positive and negative feelings, as well as enhancing clarity and perspective. Newly qualified social workers who practice mindfulness are less inclined to experience compassion fatigue and burnout, and experience higher compassion satisfaction as it reduces stress, negative affect, rumination, and anxiety while increasing positive affect and self-compassion. Mindfulness exercises include 'mindful seeing,' 'body conscious exercise,' 'safe place guided imagery' and 'guided imagery scripts.'

Newly qualified social workers are particularly vulnerable and in need of induction, support and supervision. One aspect of the social work profession that is different to other professions is the provision of emotional support from the supervisor, as it improves productivity by decreasing stress. The supervisory relationship is also the ideal way in which self-compassion can be taught to newly qualified social workers. Research, however, indicates that many newly qualified social workers receive little to no supervision. Moreover, as the social work profession aims to promote the welfare of those that are disadvantaged and marginalised, it is essential that social work education actively foster social work students' capacities to cope with the inevitable stressors, challenges and diminishing resources as they transition into being newly qualified social workers. As social workers often take care of others before themselves, research advocates that a culture shift must take place. As such, the social work profession must take a proactive stance through the prioritisation of self-care, wherein social workers must take ownership of their health and well-being by making a concerted effort.

The next chapter will explore factors contributing to symptoms of compassion fatigue in newly qualified social workers in South Africa and the self-care practices that buffer them. This will be done by interviewing a sample of newly qualified social workers from various organisations and expertise.

CHAPTER 5: EMPIRICAL STUDY ON THE COMPASSION FATIGUE AND SELF-CARE OF NEWLY QUALIFIED SOCIAL WORKERS IN SOUTH AFRICA

5.1. INTRODUCTION

This chapter relates to the fourth objective of the study, which is to explore factors contributing to symptoms of compassion fatigue in newly qualified social workers in South Africa and the self-care practices that buffer them. Chapter one provided a concise background on this research topic by exploring what compassion fatigue is, and consequently establishing a goal for the research study, namely to gain an understanding of the compassion fatigue and self-care practices used by newly qualified social workers in the South African context. Building on this framework, the second chapter painted an introductory picture on the background of the study, serving as a framework regarding the conceptualisation of work contexts and working conditions experienced by newly qualified social workers, which are often experienced as challenges, as well as the client factors and professional attributes that influence the working context of the newly qualified social worker.

Chapter three deepened the research topic by analysing the compassion fatigue experienced by newly qualified social workers, and in particular, articulating its conceptualisation, the various symptoms of compassion fatigue, as well as its relationship to compassion satisfaction, job satisfaction, as well as burnout. Chapter four expanded the research topic by identifying self-care practices by those prone to compassion fatigue, as well as the role of social work supervision and education in the enhancement of self-care. Taking all of these aspects into account, this chapter will present the empirical findings on the experiences of newly qualified social workers in South Africa with regard to compassion fatigue and the self-care practices that buffer them. The findings will be presented in the form of graphs, tables, themes, sub-themes, and categories where applicable.

SECTION A

This section contains a coherent overview and reflection on the research methodology that was utilised for the research. The research methodology was discussed in more detail in chapter one.

5.2. RESEARCH METHODOLOGY

This section will discuss the research approach, research design, sampling methods, data collection and data analysis employed in this research study.

5.2.1. Research approach

A qualitative research approach was utilised to reach the research objectives. Fouché and Schurink (2011) put forth that qualitative research broadly refers to the research that motivates research participants' narrative of meaning, experience, and perceptions. In agreement with this, Bryman (2012) asserts that qualitative research prefers an emphasis on ways in which individuals interpret their social world, and that it embodies a view of social reality as it is continuously changing. This research approach was chosen because the research sought to elicit the narratives and voices of the participants regarding their experience of compassion fatigue and self-care. Consequently, it provided the opportunity to probe for in-depth information and discourses regarding the participants' experiences of compassion fatigue and self-care.

Moreover, a deductive logic of reasoning was utilised, which Babbie (2007) explains as moving from the general to the specific, and practically entails conducting the literature study before the empirical study. This allowed the researcher to gain a broader understanding and knowledge surrounding the compassion fatigue and self-care of newly qualified social workers. Although the research is predominantly deductive, a movement occurred between inductive and deductive reasoning as the researcher revisited literature after the empirical study, since participants identified and elaborated on aspects of compassion fatigue and self-care which the researcher was unaware of prior to the empirical study.

5.2.2. Research design

Descriptive and exploratory research designs were utilised for the purpose of the study. A descriptive design, according to Fouché and Schurink (2011), is utilised when information and knowledge regarding a subject exists and the researcher is interested in gaining an understanding of the opinions and thick descriptions of people regarding a specific issue at a specific time. On the other hand, an exploratory design is utilised when there is limited information and knowledge on a subject or phenomenon, and enables the researcher to gain insight into a particular phenomenon (Fouché & Schurink, 2011; Bless *et al*., 2013). Both descriptive- and exploratory designs were appropriate, as they yielded in-depth information and thick descriptive accounts of compassion fatigue and self-care as expressed by newly qualified social workers who participated in the study.

5.2.3. Sampling methods

Snowball sampling, a form of non-probability sampling, was utilised for the purpose of this research study. Bryman (2012) explains that it is a technique in which the researcher samples a small group of participants who, in turn, propose other participants who have the same experience or characteristics relevant to the research. Alston and Bowles (2003) express that it is customarily utilised when there is a lack of knowledge regarding the sampling frame, and when there is limited access to the appropriate participants. This was appropriate, as compassion fatigue and self-care practices of newly qualified social workers in the South African context is arguably a relatively unknown area of study.

The criteria for inclusion of participants were that they:

- Be a newly qualified social worker (0-24 months of working experience).
- Be registered at the South African Council for Social Service Professions (SACSSP).
- Be employed in South Africa as a social worker at any organisation at the time of the empirical study.

The sample for the study consisted of 18 participants. Bertaux (1981) puts forth that 15 participants in a sample is the smallest acceptable size in qualitative research, and therefore, 18 participants are sufficient. In general, qualitative samples are relatively

smaller because there is a point of diminishing return, implying that more data does not necessarily mean new information as the study progresses. Saturation was reached at 18 participants. Saturation, simply put, is when information is repeated and no new information emerges (Seidman, 1998).

Research participants were contacted in their respective personal professional capacities via telephone. All participants were briefed about the purpose, benefits, and potential risks of the research study prior to the interview. All participants were informed about how the research is an attempt to understand their experiences, their rights to refuse to answer questions if necessary or withdraw from the study at any stage (see annexure 2 for the complete informed consent form). Interviews were conducted telephonically in private places. Therefore, it was not necessary to obtain permission from the participants' respective organisations. Participating in their personal professional capacity also ensured their privacy, as indicating and contacting organisations would hamper both the organisation's and the participant's anonymity. The duration of interviews ranged from 30-60 minutes.

5.2.4. Data collection

As mentioned previously, the research study was qualitative in nature, and an interview schedule was implemented for the semi-structured interviews using open and closed-ended questions. Semi-structured interviews were chosen, as it gave a detailed idea of the perceptions, experiences, opinions and beliefs of the participants and allowed the researcher to understand the complexity of the topic due to its flexible nature in which both the researcher and interviewee could guide one another. This was vital for the purpose of gaining an understanding of the compassion fatigue experienced, and self-care practices employed by newly qualified social workers in the South African context, as participants themselves expressed their narratives and identified and elaborated on aspects that they deemed important. See annexure 1 for a general overview of the interview schedule.

Due to the Covid-19 pandemic, South Africa regulated a strict lockdown procedure and social distancing measures to prevent the widespread disease from worsening (WHO, 2020). This affected the data collection, as participants were given the option to choose

between telephonic calls or face-to-face interviews. Of the 18 participants, 17 participants indicated telephonic interviews to prevent contagion and to ensure their health and wellness. WhatsApp voice calls were used to conduct the telephonic interviews, as calls are end-to-end encrypted, meaning that WhatsApp and third parties cannot listen to them (WhatsApp, 2020). Furthermore, this used data, which is cost-effective considering standard call and message charges. One face-to-face pilot interview was also conducted beforehand, which was effective in helping the researcher identify gaps in the interview schedule and prepare probing questions. Comparing the data collected from the pilot and face-to-face interview with the data collected telephonically, there were no discrepancies, and all participants openly provided their narratives. All participants consented to an unused smartphone being used to record for the purpose of data collection, as this allowed the researcher to easily and safely store the data on electronic devices which are password protected. Interviews were conducted from 3 April 2020 to 23 April 2020.

5.2.5. Data analysis

Data analysis is understood as the process whereby the researcher inspects, transforms, and categorises the collected data with the aim of discovering useful information, as well as suggesting conclusions and recommendations (Schurink, Fouché & De Vos., 2011). Data analysis began after all 18 participants were interviewed. Data collected was analysed using thematic content analysis. Thematic content analysis, according to Braun and Clarke (2006), involves a six-step process: (1) familiarising oneself with the data, (2), generating initial codes to identify important features of data, (3) searching for themes, (4) reviewing themes, (5) defining and naming themes, and (6) producing a report. The data collected was manually transcribed to text format. As discussed by Oliver *et al.* (2005), a denaturalised approach was utilised, as it focused more on what is said as opposed to how it is said. Considering this approach, silences, involuntary actions, pauses, repetitions, and stutters were removed from the transcribed data. Furthermore, grammar was also corrected where deemed necessary in order to provide a clearer comprehension of the information. This was done with much caution to avoid changing the meaning and interpretations of what the participants were communicating about their situations to the researcher. To ensure the trustworthiness of the data, member checking

was conducted during and after data collection, prior to data analysis, as data was returned to each participant for them to check for accuracy.

The findings of the research will now be presented in the sections that follow.

SECTION B

This section serves to present specific characteristics of the participants that were examined during the empirical study.

5.3. PARTICIPANT PARTICULARS

The profiling of the participants who took part in this research study will be done individually, with the age and length of time as a social worker being identified in each case. This illustrates a comprehensive context of each individual participant, whilst also giving an overarching context of all participants. This is relevant, as the goal of the study is to gain an understanding of the phenomena. Furthermore, the individual profiling of each participant may also be helpful to interpret the contexts of the narratives and analyses which will presented in the next section.

5.3.1. Individual profiles of participants

Participants will be profiled individually, indicating their gender, age and marital status, as well as the type of organisation they work for, or the type of services rendered.

Participant 1: Participant one is the only male participant. He is 25 years of age, and his marital status is single. He is a social worker in a private practice employed in the field of Employee Wellness, and renders EWP services primarily on farms. He has 15 months of working experience.

Participant 2: Participant two is a female. She is 24 years of age and her marital status is single. She is employed at a youth development organisation funded by the Department of Community Safety, and has eight months of working experience.

Participant 3: Participant three is a female. She is 24 years of age, and her marital status is single. She is employed at an NGO and renders child protection services. She has six months of working experience.

Participant 4: Participant four is a female. She is 24 years of age, and her marital status is single. She is employed at an NGO and renders child protection services. She has three months of working experience.

Participant 5: Participant five is a female. She is 24 years of age, and her marital status is single. She is employed at an NGO and renders child protection services. She has 11 months of working experience.

Participant 6: Participant six is a female. She is 24 years of age, and her marital status is single. She is employed at an NGO and renders child protection services. She has 16 months of working experience.

Participant 7: Participant seven is a female. She is 24 years of age, and her marital status is single. She is employed at the Department of Social Development working at a shelter and has 12 months of working experience.

Participant 8: Participant eight is a female. She is 24 years of age, and her marital status is single. She is employed at an NGO and works with persons with disabilities. She has eight months of working experience.

Participant 9: Participant nine is a female. She is 25 years of age, and her marital status is single. She is employed at an NGO and renders child protection services. She has 10 months of working experience.

Participant 10: Participant 10 is a female. She is 24 years of age, and her marital status is single. She is employed at an NGO and works with persons with disabilities. She has three months of working experience.

Participant 11: Participant 11 is a female. She is 24 years of age, and her marital status is single. She is employed at an NGO working at a residential facility for older persons and has three months of working experience.

Participant 12: Participant 12 is a female. She is 24 years of age, and her marital status is single. She is employed at an NGO and renders victim/offender mediation services. She has four months of working experience.

Participant 13: Participant 13 is a female. She is 25 years of age, and her marital status is single. She is employed at an NGO and renders mental health services. She has 11 months of working experience.

Participant 14: Participant 14 is a female. She is 29 years of age, and her marital status is single. She is employed at an NGO and renders child protection services. She has 14 months of working experience.

Participant 15: Participant 15 is a female. She is 26 years of age, and her marital status is single. She is employed at an NGO and renders child protection services. She has 18 months of working experience.

Participant 16: Participant 16 is a female. She is 24 years of age, and her marital status is single. She is a social worker in private practice and renders services relating to the support of children, families, and schools with children with Autism Spectrum Disorder. She has 16 months of working experience.

Participant 17: Participant 17 is a female. She is 50 years of age, and her marital status is single. She is a social worker in private practice employed in the field of Employee Wellness and renders EWP services primarily on farms. She has 12 months of working experience.

Participant 18: Participant 18 is a female. She is 24 years of age, and her marital status is single. She is employed at an NGO in the field of victim empowerment and renders services to victims of crime and abuse. She has 13 months of working experience.

5.3.2. Age

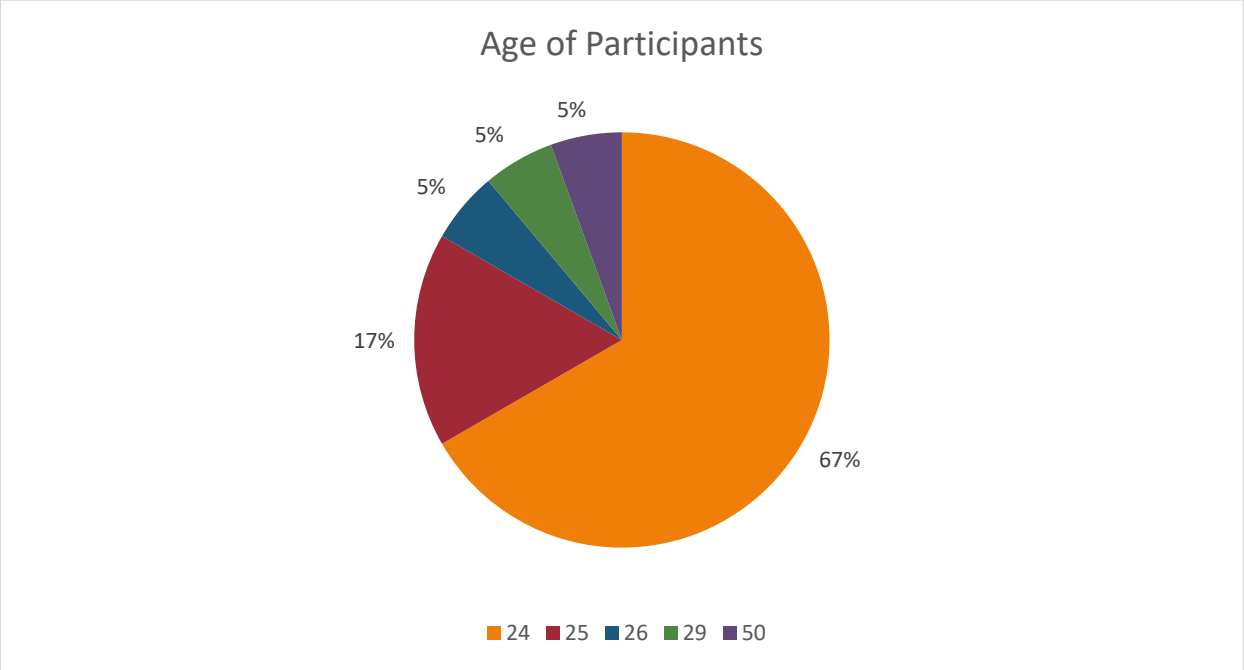

Figure 5.3.1. Age of participants (N=18)

The figure above shows that the majority of the participants who took part in the research were 24 years of age, which was followed by 25 years of age. Most of the participants graduated in 2018/2019. Newly qualified social workers are predominantly young, and as a result are often younger than their client systems. Alpaslan and Schenck (2012) assert that young social workers are often undermined and not taken seriously in that clients feel that these newly qualified care professionals cannot help them. Moreover, social work supervisors in South Africa are predominantly 30 years or older, indicating a definitive generational gap between supervisors and newly qualified social workers who are in an early adulthood phase (Brandt, 2019). Engelbrecht (2014) asserts that generational differences may be detrimental to supervision if not identified and attended to.

5.3.3. Length of time as a social worker

Figure 5.3.2. Length of time of working experience (N=18)

The figure above shows that the majority of the participants taking part in the research study had 12-17 months of working experience, closely followed by 6-11 months. The time of work experience ranges from three months to 18, and this distribution positively contributes to the study as different lengths are represented. All participants taking part in the study are regarded as newly qualified social workers, as they have less than 24 months of experience in practice (Janse van Rensburg, 2009). According to the developmental theory of professional identity, beginner social workers' motivation for supervision is primarily driven by high levels of anxiety owing to the need to gain skills and experience (Engelbrecht, 2014). This indicates that beginner social workers, specifically newly qualified social workers, need guidance.

5.3.4. Work contexts

The majority of the participants work at NGO's (78%), with one participant employed at the DSD (5%) and three working as private practitioners (17%). Analysing the work context of the participants is necessary, as it may assist with the interpretation of the participants' narratives. During this study, it was found that newly qualified social workers

are rarely employed at the Department of Social Development (DSD), despite many of these workers' education being financed by them with the promise that they would be employed upon graduating. In South Africa, social service management occupy both non-profit or private sector and public or governmental sectors. The government sector is structured in terms of the National Department of Social Development, provincial departments and district offices (Rankin & Engelbrecht, 2014). Social workers are employed by local governments, inter-sectoral and parastatal organisations. The most participants are employed within the second typology, the non-government sector, which is further divided into a profitable and non-profitable sector. Formal, registered organisations rely on the state for funding and operate within strict bureaucratic procedures and systems, thereby having limited autonomy and flexibility in programme development due it being based on national norms and standards (Patel, 2015). Three participants are employed as private practitioners, where the private sector is comprised of organisations rendering social work services for profit. Private practising social workers are professionals who offer services to individuals, families, groups and communities/organisations for a fee (South African Association for Social Workers in Private Practice, 2019). Social workers as private practitioners must comply to regulatory frameworks, norms, and standards, and must comply with the conditions of their registration according to the Council of Social Service Professions (Lord & Iudice, 2012).

SECTION C

This section serves to present themes and sub-themes relating to the data collected from participants who took part in this research study. Narratives are presented in italics for the reader's ease.

5.4. THEMES AND SUB-THEMES

A total of four themes, subsequent sub-themes and categories were identified from the participants' narratives. Below is a table summarily showing all the themes, sub-themes and categories.

Table 5.4. Themes, sub-themes and categories

THEMES	SUBTHEMES	CATEGORIES
1. Nature of social work	Working conditions	Workload
		Resources
		Environment
		Remuneration
	Supervision	Structure
		Quality
2. Compassion fatigue	Conception of compassion fatigue	
	Symptoms	
	Reasons	Work
		Personal
	Effects	Work
		Personal
3. Self-care	Conception of self-care	
	Preparation	
	Self-care techniques	Physical
		Social
		Occupational
		Intellectual
		Emotional
		Spiritual
4. Organisational context	Awareness	

The researcher made use of both sub-themes and categories, as it provides structure to the narratives and serves as a framework for analysing the data in correlation to the literature. A table presenting a summary of each respective identified theme and its

related sub-themes and categories will be provided before discussing the respective themes in detail. The pattern of analysis involves explaining what was asked, using narratives as examples and controlling the findings with literature to make deductions. The narratives chosen reflect the examples supporting specific themes and contexts. Core concepts and ideas are underlined in each narrative, after which the context of each underlined concept is explained.

5.4.1. Theme 1: Nature of social work

Table 5.4.1. Theme 1: Nature of social work

THEMES	SUBTHEMES	CATEGORIES
Nature of social work	Working conditions	Workload
		Resources
		Environment
		Remuneration
	Supervision	Structure
		Quality

In this section participants were asked to describe the working conditions of newly qualified social workers and how they perceived it, as well as their opinion regarding the effectiveness of supervision for newly qualified social workers. According to situational theories, satisfaction is derived purely from the working environment, and this determines job satisfaction (Judge & Klinger, 2008; Redmond, 2016).

5.4.1.1. Working conditions

Participants indicated that working conditions vary from sector, type of social work organisation, and area in which the social worker is rendering services. It is evident that participants employed in NGOs experienced much more challenges related to working conditions as these organisations are marked by a high workload, lack of resources, poor remuneration and unsatisfactory working environments. Those employed by the government indicated better working conditions, but also identified challenges relating to

workload, remuneration and working environments. Participants in the private practice most predominantly experience challenges relating to the job and income insecurity along with the spill over of work into personal life.

5.4.1.1.1. Workload

Participants were asked to describe the general workload of newly qualified social workers and how they perceived it. Most participants indicated that they experienced the workload as very high, and that they were unprepared for it. Some of the narratives of the respective participants are presented below:

Participant 6: "I could close a few, but I'm still at 280 [cases] coming down from 367. Mine is exceptionally more."

Participant 11: "I'm the only social worker at the facility and there are on average between 230 and 250 residents."

Participant 14: "I'm still very confused and the workload is very high. Previously it was 70 [cases] but now almost 200."

The narratives above represent the workload of participants involved in the study, and indicates that numerous newly qualified social workers find the significantly high workload challenging. Hunt *et al.* (2016) assert that a high workload can be a significant challenge for newly qualified social workers transitioning from student to qualified social worker. High caseloads are a prevalent issue in South Africa, despite governing bodies such as the National Department of Social Development advising social workers to have no more than 60 cases (Earle, 2008). Several studies conducted in South Africa show significantly high caseloads, with the non-government sector (NGO) reporting social workers having between 110 and 400 cases, and child protection social workers in foster care being responsible for as many as 500 cases (Baldauf, 2007; Narsee, 2013; Joseph, 2017).

Participants also indicated a significant amount of administration forming part of their workload, as can be seen in the following narratives:

Participant 4: "[Administration] is such a big part of our work. Everything has to be written down and your paper trail has to be there otherwise you are lost."

Participant 11: "The administration is a lot; the previous social worker's analysis wasn't in order."

Participant 15: "The admin is hectic and I'm struggling to find a balance between admin and field work."

Taking the abovementioned narratives regarding administration into account, the Department of Social Development (DSD, 2009) explains that there is a decline in productivity and quality of services due to high caseloads. They further state that social workers are increasingly used for non-professional tasks, which further increases their workloads, adds to their stress levels, and deprives them of professional growth.

A lack of balance between work and home life was especially prevalent among the social workers in private practice participating in the research. They indicated working unregulated hours and having work to do after hours due to the nature of the work, as described by the following participants:

Participant 16: "My work hours are unregulated, and my clients have my number and can contact me whenever… I do home visits after hours… In private practice you take your work home with you, even if you don't do the work, you still see the client files in your home."

Participant 17: "The admin is a lot, I try to do the reports before leaving my work area, but I have to do reports after hours a lot of the time."

Calitz *et al.* (2014) argue that social workers experience stress and burnout as a direct result of their high workload and time management, as it leads to social workers feeling emotionally drained and unproductive. Several authors assert that newly qualified social workers may experience this issue, especially as they still need assistance in managing workloads and may not always be able to negotiate them (Bates *et al.*, 2010; Moriarty *et al.*, 2011; Walker, 2014).

5.4.1.1.2. Resources

Participants were asked to describe the resources available to them and how they perceived it. It was evident that resources fluctuate depending on the sector and area in

which social workers render services, with NGOs having comparatively less resources. This is evident from some of the narratives as presented below:

Participant 6: "We are a non-profit so have to do fundraising ourselves. What we get from the government is minimal. We have the basics to do our jobs."

Participant 9: "There is a lack of cars to take you where you need to be."

Participant 14: "We don't have that many resources because the town is small, the court, home affairs and resources like that aren't here, you have to drive far."

Participant 15: "There are definitely more resources at DSD in terms of vehicles. I have a social auxiliary worker and a lot of programmes are available. My previous NGO was under-resourced and had only two vehicles."

The narratives indicate that many newly qualified social workers working at NGOs experience challenges relating to limited resources, such as cars which are necessary for home visits. This correlates with Joseph (2017:42) who asserts that organisations are "overwhelmed, overburdened and financially under resourced." This is further confirmed by Madibogo (2016), who argues that social workers struggle with a lack of resources, including insufficient, unsafe and/or unroadworthy vehicles, a shortage of stationery, inadequate office equipment and space, as well as a lack of basic sanitation on work premises (Madibogo, 2016).

On the contrary, several other participants indicated that they had sufficient resources and felt that the basic resources in the offices were satisfactory, as expressed by the following narratives:

Participant 3: "There are a lot of resources to use, depending on the location of your organisation. For example, the police, SASSA, and DSD that can help in certain situations. I think there are many resources, you as a social worker should know how to use it and make it successful."

Participant 5: "Our office is nice, everyone has their own office, whereas my previous office shared an open plan office. We now have our own phone, laptop, everything of your own. We have enough vehicles; anyone can take a vehicle if you need to do home visits."

Participant 11: "We have more than other NGOs. I have my own office, my own printer, own laptop, which is more than many other social workers."

Participant 13: "I have all the resources I need at the office; we are also provided with cellphones, airtime and a laptop. The organisation is highly resourced."

Comparing the last-mentioned narratives to those prior, it is evident that not all organisations are similarly resourced, with many participants indicating that it depends on the sector of work, the location of the organisation, and the organisation itself. According to the Department of Social Development (2013), resources are a critical aspect of partnership in South Africa due to the limited institutional resource capacity, and NGO's are also subject to funding and subsidisation. They do, however, indicate that it is based on fairness in relation to the costing of services, and NGO's should thus embark on economic development and fundraising initiatives.

5.4.1.1.3. Environment

The participants were asked to describe their working environments and how they perceived it. Many indicated unsafe and unhealthy working environments, both in the office and outside. In general, participants expressed that they are often less than satisfied. To this end, some of the narratives of the respective participants are presented below:

Participant 7: "We had an incident where a perpetrator came to the gate… I felt scared… Perpetrators are aggressive… I'm always afraid that she says my name, or they see me in the shop, and he attacks me. I'm always scared that I'm going to be attacked if they know who and where I am."

Participant 9: "There is no level of safety. You take a risk to go outside every day. There aren't safety measures for when we go out. For example, someone has punched me in the face, there are people that threaten you when you go to their home saying that they will shoot you if you mess with their 'business', there are also a lot of gangsters and they know our car and they usually drive behind us on bicycles with bricks. We are so scared to go outside many times because something might happen to us, but you have to go."

Participant 13: "I take pepper spray with because of the different problems that arise, for example, fighting. Obviously, you take a softer approach as a social worker, but you never know what could happen. I keep the pepper spray just in case. As a social worker you can't choose what you step into."

Participant 15: "I work in an informal settlement which isn't very safe. It's just difficult to get clients in an informal settlement because they don't have phones and you have to go and search for their home address. Sometimes I'm also alone; I'm at risk but I do what I can because I'm still the social worker. You are a target and people make remarks towards you. For example, what if I'm in a home, I won't have a support system, no one will help me because they already think I'm going to take away a child."

Narratives of unhealthy work environments furthermore include:

Participant 4: "You are exposed to a lot of circumstances you are not used to. For example, I had to go into a home where someone was recently diagnosed with TB and you feel that you shouldn't wear a mask or gloves because the client will feel judged."

Participant 15: "I'm at risk…not just physically, but my health because the pipes flow over because they don't have toilets, you don't wear masks, you go into their homes and it's a health risk."

These narratives about working in unsafe and unhealthy work environments correlate with existing literature. The Department of Social Development (2009; 2012) expresses that, in the South African context in particular, there are health and safety challenges such as exposure to violence and other challenges relating to working with difficult and diverse client systems in poor working environments. Working in negative and poor working environments plays a significant role in the job dissatisfaction of social workers.

Narratives from participants in private practice also ranged depending on the specific environment they work at:

Participant 1: "In a private organisation you are judged on your image. [Your clients] want to see the image and status because they are paying for the service and want to see why they are paying for it… I can work from home and mostly be outside of the office doing field work. When I'm on the farms I usually work at a location they make available which

can vary from an empty office to a shed. Usually it is a bit dusty, but it is understandable because it is a working farm."

Participant 16: "Admin I do from the office or from home, I see children at a school's playroom, I have an office at our practice, and there is a small therapy room at another school. One school is sometimes dirty because they don't always clean it, but it is workable, and you don't feel unsafe. I can leave my phone, wallet, and laptop when I go get children."

Participant 17: "At many farms I'm in between the vineyards, and my car is the office. It is quite a setback; the car is hot, there isn't shade, and it affects service delivery. At some of the others there are offices. At others I'm in a storeroom or accommodated here and then there. Other than one place, they don't really make an effort to make me feel comfortable or keep the area clean."

The narratives from the three participants in private practice indicate that the working environment is not necessarily marginally better compared to social workers in other sectors. There is a distinct lack of literature regarding social workers in private practice and the related working conditions. This may be attributed to the controversy and critique for social workers opting to practice privately, as there has been a decades long belief that private practitioners are sell outs who abandoned the profession's mission of social justice (Specht & Courtney, 1994; Lord & Iudice, 2012)

5.4.1.1.4. Remuneration

The participants were asked to describe their opinions regarding their salaries, without indicating the figure, and whether they were satisfied with it. In general, participants indicated that the salary was low compared to the significant amount of work that is done, and expressed that the salaries of social workers depend on the organisation and sector, with those in DSD and private practice earning more. Participants in private practice indicated working on a 'no-work-no-pay' principle. Some of the narratives of the respective participants are presented below:

Participant 5: "If you look at everything we have to put in and the stress we have to deal with daily, it's relatively little."

Participant 6: "Salaries are minimal. I get by. I live on my own, but it's tight. I know DSD pay is determined by how long you have been working, NGO's are not like that."

Participant 9: "For the amount of work you do, no. There is no comparison with what we do. Every day I'm looking for a job. Passion and compassion [are not going to put bread on the table]. I won't be able to build the life I want with a salary below R10 000. The little remuneration impacts your motivation."

Participant 11: "It is less than I wanted. I cannot afford to live on my own, I still live with my parents."

Participant 14: "In NGOs social workers are underpaid for the work that we do."

The narratives indicate that most of the participants feel that their remuneration does not correlate with the work that they do, and are unsatisfied as a result. Though several international scholars indicate low salaries for social workers, Engelbrecht (2006) and Kasiram (2009) point out that South Africa represents the extreme. One participant was quoted saying: "*Passion and compassion 'gaan nie brood op die tafel sit nie.*'" This is an Afrikaans expression that can be translated to correlate with the English expression: "Passion and compassion won't pay the bills." The participant thus expresses that the feeling of passion and compassion from doing social work is not enough to live satisfactorily. This is also indicated by another participant, who stated that they cannot afford to live alone. This correlates with the observation of Smith and Shields (2013), who assert that pay and remuneration remains a substantial predictor of job satisfaction. Many participants expressed a difference in salary between government social workers and those employed by NGOs:

Participant 3: "Salaries depend on where you work. I know DSD gets twice as much as us. I am fine, but if weighed against DSD, there is a big difference."

Participant 8: "We work at an NGO and the expectation is that we get less than government social workers. We wonder how the gap is going to be filled."

Participant 15: "I feel the Department's salaries are reasonable, but compared to NGO, we are much more privileged. Salaries are a touchy subject; you always want more. We have more benefits at the end of the day and also earn more."

The narratives indicate that social workers employed by the Department of Social Development earn more and also receive more benefits. This correlates with existing literature that indicates that social work remuneration is an issue in general but is more dire in the non-government sector (Earle, 2008; Viljoen, 2009). In a study focusing on social workers working in rural areas, Alpaslan and Scheck (2012) found that NGO workers were particularly dismayed about their remuneration, and that the social workers felt that their salaries were not worth it. They also identified that workers were unsatisfied with the pay discrepancy between Department social workers and NGO social workers. Furthermore, Viljoen (2009) confirms this, and states that social workers working for the DSD earn roughly 40% more than their NGO counterparts. This phenomenon is due to DSD regrading salaries to eventually reflect a four year long professional degree, a consideration not widened to include the NGO sector (Earle, 2008). Earle (2008) further elaborates that this regarding is what resulted in the substantial disparity in salaries, which is further exacerbated by benefits such as medical aid, pension, housing subsidies and car allowances, which do not exist for social workers employed in NGOs.

Narratives from participants working in private practice indicate that they work according a 'no-work-no-pay' principle:

Participant 1: "My salary depends on how much I work. The month I work more, the higher my salary, a month where I work less, the less my salary. During lockdown, I was unable to go out and therefore didn't receive any income and had to live off money that I saved from before."

Participant 16: "When I don't work, I don't have an income. The income I get is for the hours I work. My salary differs and varies every month and has now fallen due to the lockdown. With private practice, clients don't always pay; I have a lot of overdue fees and at a point may have to be written off."

Participant 17: "No work no pay, I'm a contract worker paid per hour. I'm just so thankful for the work and I could work before the lockdown and could use that."

Narratives from participants indicate an unstable income that varies monthly. This correlates with Budhoo (2008), who explains that social workers in private practice's income is dependent on the number of interviews they had for the month and that there

may also be delays in payments and non-payments by clients. Budhoo (2008) further elaborates that social workers in private practice experience time pressures and economic uncertainties, as they would not receive income if they were unable to work and experience unstable income.

The narratives and the abovementioned research do not correlate with existing literature that indicate remuneration to be better for private practising social workers. The latter has led to decades of degrading comments, including that private practitioners were sell outs who abandoned the profession's mission of social justice (Specht & Courtney, 1994; Lord & Iudice, 2012). For many years, these workers were critiqued for opting for financial gain and offering services of change to individuals instead of systems (Specht & Courtney, 1994). Despite this, decades ago, Barker (1991) stated that financial gain was not an important motivator for pursuing work in the private sector, which was later corroborated by Brown and Barker (1995), who maintained that many social workers in private practice render services at a reduced rate or for free, and were often more accessible than agency services.

5.4.1.2. Supervision

Participants indicated that they were unprepared for practice after graduating with their degrees and have further expressed challenges related to the transition from student to professional social worker. Despite the significant challenges and uncertainties experienced, most of the participants indicate receiving less than satisfactory supervision that does not correlate with the framework and standards expected from supervision and is not adequate for newly qualified social workers.

5.4.1.2.1. Structure

Participants were asked to describe the structure of their supervision session, specifically regarding its nature, frequency and duration. Most participants indicated that they receive face-to-face supervision, albeit not frequently, while others indicated an informal open-door policy where they could contact their supervisors should the need arise. Several participants also indicated that the reality of supervision does not correlate with what was taught and expected during their studies, and that the planning and execution of

supervision differs. Some of the narratives of the respective participants are presented below:

Participant 1: "No, I do not get any supervision. If I need supervision, I would request it."

Participant 5: "Because she is a supervisor for two offices, she doesn't always have the time to get to everyone."

Participant 6: "Supervision varies. There isn't a set time or duration. She tries to get to us once a month, but that doesn't always happen. In the meantime, you would call or email or wait until you see her again."

Participant 15: "The supervision we learnt about in theory doesn't happen in the organisation. There is an open-door policy, it isn't structured with a date and time. We need structured supervision; I won't say I prefer our current method."

Narratives indicate a lack of structure and no set time, as well as an adoption of an "open door policy." According to participants, an "open door policy" meant that they could walk in and quickly discuss a case or work matter that required the supervisor's immediate guidance or attention. This can be equated to "on the run" supervision, as defined by Noble and Irwin (2009:351). This type of supervision is a reality in many social service organisations because supervisors are consumed with various management tasks (Engelbrecht, 2013; Noble & Irwin, 2009). The duration and approach to supervision is highly dependent on the perceived goal of supervision. Consequently, those who believe the goal should lead to independence and autonomy will terminate the supervision process once satisfied with the supervisee's performance (Engelbrecht, 2019). This is said to fit with managerial and neoliberal tendencies in which cost-effectiveness is a motivator. Engelbrecht (2012) put forth that structural and organisational issues that impede these intentions include scarce resources, unmanageable workloads, and counterproductive working conditions. It is further asserted that, if supervision is not prioritised within an organisation, these structural and organisational issues will always stand in the way of social workers flourishing (Pullen-Sansfaçon *et al.,* 2012).

A number of participants also indicated receiving guidance from colleagues as opposed to a supervisor:

Participant 5: "When you are new you need guidance, and you need your supervisor. At the end of the day your colleagues are not in the position to guide you [they do not know how to, and it is not their responsibility]."

Participant 10: "My manager isn't a social worker, she is the CEO of the company, but there are three social workers in the organisation working in different areas of services. We do supervision together, but it is more debriefing. I see that I'm not the only one struggling. I learn a lot from them. I struggle with guidance because I cannot just ask my colleagues because they are busy, so I just do what I think is right."

Participant 11: "I don't get supervision at all, I'm the only social worker at the facility. If I have serious problems and I need help, I speak with the nurse or occupational therapist in our multidisciplinary team. Other than that, I don't receive supervision, and I would have liked to because it is my first time in the field."

Participant 12: "We don't have a supervisor at the office, and I've learnt everything from the previous social worker. We don't have supervision, it's both necessary and unnecessary. If there is someone familiar in the office… it's like peer supervision."

The narratives indicate that social workers are increasingly managed by professionals who are not social workers, often leading them to receive guidance and support from their colleagues. This correlates with Doel (2012), who asserts that, due to social work services moving into specialisms, social workers are increasingly finding themselves managed by someone who is not a social worker even though they should always seek supervision from a qualified social worker. There are, however, supportive benefits from receiving supervision from peers, as Golia and McGovern (2015) explain that it is often a safer and less intimidating environment. However, they uphold that there are differences in the purposes comparing traditional supervision from a supervisor and that of peer supervision. The purpose of traditional supervision focuses on facilitating professional training and education, fostering the development of clinical judgement and competence, and managing and processing transference and counter-transference issues among others. Purposes of peer supervision, on the other hand, involve creating a supportive and non-judgemental environment to explore and process issues, to provide mutual aid

and support, as well as to normalise trainee anxiety (Golia & McGovern, 2015). Whilst this is valuable, it does not replace the role of expert guidance and knowledge.

5.4.1.2.2. Quality

Participants were asked to motivate whether they found social work supervision to be helpful and effective in terms of the quality of the supervision they received. Their responses varied from expressing gratitude and satisfaction to indicating toxic supervisory relationships and inadequate quality supervision, which were found to be more harmful. Some of the narratives of the respective participants are presented below.

Participant 3: "When I think back to when I started, I didn't know what to do and my supervisor took my hand explained this and that… My supervisor is very hands-on and wants to know what is going on. She wants to know what you are going through and why you are reacting the way that you are."

Participant 5: "My supervisor is amazing, she's the best. She gives you the opportunity to take the lead and say where you need more attention, you say how you feel in terms of dealing with your caseload. She allows you to express those things and then she would guide you. She doesn't decide, you take learning into your own hands… She has a policy where no one may interrupt during supervision, she doesn't have her phone with her, no one may come in, it's only you two."

Participant 7: "The supervision I get is great. I get a lot of insight and I can call and ask her anytime if I don't understand something and need advice. I recently had to do a report and she told me what to do from A to Z."

Participant 8: "It is effective, especially if you are new. Supervision helped me a lot, I didn't know which way and didn't know the expectations of the organisation in terms of in the field and with reports. It was my go-to. Especially in this uncertain time it's been a great guideline of how to stay in touch with clients… My supervisor has an ear that listens and focuses on what I have to say because I am uncertain due to being new."

The narratives indicate that several participants not only find social work supervision helpful, but necessary. This correlates with literature that put forth that supervision is particularly important for newly qualified social workers and it is important to make time

for professional development and caseload management (Bates *et al.,* 2010). According to the definition of social work supervision, functions include education, support and administration in order to promote efficient and professional social work services (DSD, 2012). Ammirati and Kaslow (2017) propose that a supervisory relationship should be characterised by open, two-way communication and useful feedback that is delivered honestly and in a timely manner. This is confirmed by Beddoe (2017), who asserts that there should be a balance of support and affirmation with constructive developmental criticism. Moreover, the quality of supervision received and the social worker's relationship with the supervisor is a crucial ingredient in job satisfaction and a significant motivator in job turnover; receiving limited or no supervision was also an antecedent factor (Manthorpe *et al*., 2013; Smith & Shields, 2013; Hussein *et al*., 2014; Joseph, 2017).

However, some participants expressed dissatisfaction with the supervision they received:

Participant 2: "There are a lot of times where supervisors are overloaded themselves and they don't make the time for you, nor do they prioritise you as a supervisee. You can almost see that they are so disinterested in what you have to say, and you are the last person they want to talk to. Then it is not helpful to me."

Participant 11: "If you are in supervision and want to speak about certain aspects but that supervisor will then say to follow your own mind because you were at university for four years. They'd say that they are not there to spoon-feed you. That is a wrong mindset, especially if it is your first year of work."

Participant 16: "If I was emotional, she was supportive, but I just had to get over it. She also had her own problems, and she would compare our situations. She compared me to her, and I couldn't develop my own identity. She also controlled me. Sometimes I would ask a question and she would respond in a way to make me feel as if I should have known better. At the end of the day she also didn't have boundaries with set times, there wasn't a contract, and she would tell me what to do. At one point we wouldn't have supervision and then she would get mad if something happened, but she cancelled it."

From the narratives, it is evident that not all supervision is effective and helpful, but that it can also be inadequate and harmful to the supervisee, which is reflected in recent South

African research findings by Wynne (2020). Ammirati and Kaslow (2017) argue that inadequate supervision is characterised by the supervisor not fulfilling the triad of functions and responsibilities associated with supervision. In addition, Reiser and Milner (2017) assert that, while both supervisors and supervisees have the responsibility within the supervisory relationship, supervisors should be the experts, commissioned to fulfil the triad of functions through being prepared for supervision, providing consistent feedback and documentation and assisting with problem solving. Brandt (2019) found that several newly qualified social workers had a poor relationship with their supervisor and did not trust their supervisor to discuss personal issues, as it either did not remain confidential or there was a general lack of trust. Similarly, Wynne (2020) found that many social workers indicated that they were not comfortable with their supervisors due to the nature of the supervision sessions and the supervisor's personality. Redpath *et al.* (2015) concede that the supervisor-supervisee relationship is the most important relationship in the social worker's workplace, as it affects the supervisee's emotions, attitudes, motivations, behaviours, health, and work-place retention.

The main deductions from this theme are that working conditions vary from sector, type of social work organisation, and area in which the social worker is rendering services, and that social work supervision for newly qualified social workers is inadequate. Social workers employed at NGOs experience more challenges related to working conditions such as a high workload, lack of resources, poor remuneration and unsatisfactory working environments. Accordingly, the government sector is characterised by better working conditions related to workload, remuneration and working environments. The main challenges pertaining to working conditions for social workers in private practice include job and income insecurity, as well as a lack of boundaries between work and personal life. Newly qualified social workers in general receive less that satisfactory supervision, which does not correlate with the framework and standards expected from supervision and is not adequate for newly qualified social workers taking into account the challenges pertaining to the transition from student to professional social worker.

5.4.2. Theme 2: Compassion fatigue

Table 5.4.2. Theme 2: Compassion fatigue

THEMES	SUBTHEMES	CATEGORIES
Compassion fatigue	Conception of compassion fatigue	
	Symptoms	
	Reasons	Work
		Personal
	Effects	Work
		Personal

In this section, participants were asked to describe their conception of compassion fatigue of newly qualified social workers, its symptoms, as well as both the work-related and personal causes and effects of compassion fatigue.

5.4.2.1. Conception of compassion fatigue

Participants were asked to describe their conception of compassion fatigue. As with their experiences of their respective work situations, they had different opinions regarding what they viewed as compassion fatigue, with the majority admitting that they had not heard of the term before. Those who could conceptualise it defined it as burnout, vicarious trauma, and reaching an emotional threshold. Some of the narratives of the respective participants are presented below.

Participant 14: "Exhaustion. Burnout. When everything gets too much, and you don't know which way."

Participant 15: "Burnout and reaching a point where you do your work just to do your work because you no longer have that compassion, empathy and warmth towards clients."

Narratives indicate that participants think that compassion fatigue is synonymous with burnout. In literature, the terms burnout and compassion fatigue are often used interchangeably depending on the approach, with burnout being related to Maslach (1976) and compassion fatigue being related to Figley (1995). This correlates with the Professional Quality of Life Model theorised by Stamm (2010), which indicates that

compassion fatigue consists of two components including burnout. In this regard, burnout is associated with feelings of hopelessness and challenges in dealing with work or doing the work effectively. Moreover, burnout is defined as "a progressive loss of idealism, energy, and purposed experienced by people in the social work profession as a result of the conditions of their work" (Edelwich & Brodsky, 1980:14). This implies that burnout experienced by social workers is a gradual process that seldom occurs suddenly or with a single event. Instead, it increases over time, as healthy defences and coping mechanisms are worn down due to onset of emotional demands, frustrating setbacks, as well as difficult situations or individuals (Wagaman *et al*., 2015).

Participants also defined compassion fatigue in terms of vicarious trauma:

Participant 13: "If you deal with a lot, traumatic cases, you take that on as a worker. Almost like a desensitisation, you feel less. It's almost as if you are numb to it."

Participant 18: "It is basically vicarious trauma. In our profession we put on other people's cloaks and we carry that with us. We get tired and carry things that aren't ours but affects us personally. Even if you haven't lived through it yourself, it still affects what we do in our daily lives."

Narratives indicate that participants also define compassion fatigue as experiencing trauma due to working with traumatic cases and being impacted by the challenging nature of their work. This corresponds with existing literature, as the term compassion fatigue is often used interchangeably with concepts such as secondary traumatic stress, vicarious traumatisation, and burnout as previously described (McCann & Pearlman, 1990; Figley, 1995; Stamm, 2009). Stamm (2010) explains that compassion fatigue consists of two components, including burnout and secondary traumatic stress. In this context, secondary traumatic stress is the "natural consequent behaviours and emotions resulting from knowing about a traumatizing event experienced by a significant other [i.e.] the stress resulting from helping or wanting to help a traumatized or suffering person" (Figley, 1995:7). Both narratives refer to taking the trauma or experiences of the clients onto themselves, what Figley (date) refers to as "the cost of caring," and this is characterised as the "negative aspects of providing care to those who have experienced extreme or

traumatic stressors… [including] feelings of being overwhelmed by the work that are distinguished from feelings of fear associated with the work" (Stamm, 2010:21).

Participants further defined compassion fatigue as relating to limited empathy:

Participant 2: "You only have so much of an emotional capacity to give out every day and there comes a threshold where you've reached your compassion threshold where you can no longer give it out freely anymore, and any clients you see further are going to suffer because of that."

Participant 11: "Our work demands a lot of empathy and you walk in their shoes and feel it with them to help them work through their emotions. At the end of the day I'm exhausted, I'm done."

Narratives correlate with Figley's Compassion Stress and Fatigue Model, which is based on the assumption that empathy and emotional energy are the driving force for connecting with and helping others (Figley, 2002a). As Coetzee and Laschinger (2018) summarise, this model links empathy with the professional's capability to connect with and help the client and thus highlights the requirement of emotional energy. Figley (2002b) identified several factors pertaining to compassion fatigue, which include empathetic ability, empathetic concern, and empathetic response. Empathetic ability is "the aptitude of the psychotherapist for noticing the pain of others" (Figley, 2002b:1436). Beebe (2016) maintains that it is both essential to be empathetic in order to connect with and help others, and to be vulnerable to the cost of caring. Empathetic concern, on the other hand, is "the motivation to respond to the people in need" (Figley, 2002b:1436). In short, the ability to be empathetic is insufficient if there is no motivation to help others. Direct exposure to suffering, however, also puts the social worker at risk for compassion fatigue (Beebe, 2016). Finally, Empathetic response is the "extent to which the helping professional makes an effort to reduce the suffering through empathic understanding" Figley, 2002b:1436). Figley (2002b) explains that this insight into feelings, thoughts and behaviours involve projecting oneself into the perspective of the client and may result in feelings of hurt, fear, and anger amongst others. Both Figley (2002b) and Beebe (2016) argue that this is where the benefit and the cost of caring lies and is the foundation of the therapeutic alliance. Figley and Figley (2017) confirm this and argue that empathetic

response directly impacts the level of compassion stress as the professional takes in the disturbing information from the client. This supports the experiences and discourses of the participants.

5.4.2.2. Symptoms

Participants were asked to identify the symptoms of compassion fatigue, be it from their own experiences or through observation. Cognitive, emotional-, behavioural-, social-, somatic- and work performance symptoms were identified by the participants without prompts. To this end, some of the narratives of the respective participants are presented below:

Participant 2: "General fatigue, it shows up physically. You are tired, you can become moody, you can become irritable. It makes me almost a cold person; I no longer have the ability to show empathy, show sympathy, show compassion."

Participant 3: "It impacted me physically, having headaches and high blood pressure. I saw others suffering from depression because of it. Your relationship suffers, you don't give time to others. Including your family, your boyfriend; you don't have the energy for them. You are so physically drained you don't feel like doing anything. I think it can lead to a stroke, because of all of the stress. Emotionally, it can make you feel low where you can't look after yourself, because you are so drained. You may also no longer even want to go to work."

Participant 6: "You either withdraw completely and not show emotion, or you will erupt because everything is so much. It depends on the person which way it goes."

Participant 9: "You don't have the motivation and energy to get up in the morning. You are scared and nervous about going to work. You want to get out."

Participant 14: "Sleeplessness, being tired, feeling irritated. I also struggled with headaches."

Participant 16: "I was constantly crying, I ate poorly, and I didn't look after myself at the end of the day… One colleague gets cold sores because her immune system breaks down because of the compassion fatigue. Their attention isn't where it should be. They are very forgetful. They are also listless."

The narratives indicate that participants experience compassion fatigue personally, and that what they face at work impacts them as individuals. This correlates with findings from Figley (1993), who asserts that social workers take on the problems of their clients, and this impacts their mental-, physical- and emotional health (Figley, 1993). Symptoms of compassion fatigue can be classified in terms of cognitive, emotional, behavioural, spiritual, personal relations, somatic and work performance. These symptoms not only affect the social workers' professional lives, but also the quality of their work, the care they offer to clients, as well as their personal lives (Choi, 2011; Coles & Mudaly, 2010). Physical symptoms, also referred to as somatic symptoms, correlate with participants' narratives of feeling tired, suffering from sleeplessness, experiencing headaches, and problems such as high blood pressure, potential of a stroke and cold sores due to a weakened immune system. Social symptoms, or personal relational symptoms, involve withdrawing from others, isolation, not spending quality time with others and becoming cold, as well as not showing compassion, empathy, and sympathy. In turn, behavioural symptoms include eating poorly, not engaging in self-care and irritability, whereas cognitive symptoms include forgetfulness and lowered concentration, and emotional symptoms include feeling emotionally drained and listless, as well as feeling scared and nervous.

Participants also identified symptoms specifically pertaining to their work:

Participant 1: "The biggest symptom is a feeling of not wanting to go, unmotivated. You drag your feet. With me, when I feel unmotivated, I get to a point where I don't really care, it doesn't matter what you tell me. I find it difficult to relate and I get to a point where I feel that I want them to finish their crying and go. It is difficult. You fall into a trap… you try to care so much that you emotionally exhaust yourself with one client and are unable to take that to another client and show the same compassion to the other client."

Participant 9: "You just don't have that compassion and passion to really do everything perfectly and putting 180% into everything. I don't think I've ever worked on all of my files with all of the new files coming in. We just go with the flow. You just try to get through your day. I honestly feel horrible saying that I just try to do the small things."

Participant 13: "Not having empathy for clients anymore, becoming dismissive of clients. It affects your attitude, and you are not motivated; you don't have the same drive or spark. It makes you lazy."

Participant 18: "What stands out is when you start resenting your job and when you can't function optimally anymore. You don't have that heart in you to go to work and that goes above and beyond just being tired."

The narratives indicate that participants experience significantly negative symptoms which impact their work and professionalism. It is with this in mind that the effect of compassion fatigue remains a sensitive topic, as work performance is detrimentally impacted by the compassion fatigue of the social worker. Symptoms from the narratives include low morale, low motivation, avoiding tasks, apathy, detachment, and exhaustion. From the narratives it is also evident that compassion fatigue not only negatively effects the social worker, but also the social service organisation and the client system, which depend on the compassion and performance of the professional. Further, it is clear that participants who have experienced compassion fatigue feel immense guilt because of the impact it had on their work performance, which may further contribute to the worsening of the initial compassion fatigue experienced.

5.4.2.3. Reasons

Participants were asked to identify the reasons for compassion fatigue, be it from their own experiences or from observations. They identified organisational causes such as workload, nature of work and lack of support, and personal causes such as personality. Some representative narratives of the respective participants are presented below:

Participant 2: "Case overload, you just have that many clients to deal with. Also, the type of clients that you are dealing with; such a range of problems that differ in severity. For example, we'd have three clients in the morning who were victims of gang rapes and that would make me feel compassion fatigue and then the next client I have would be having a fight with her boyfriend. Then I have already reached my threshold."

Participant 6: "Our office works from crisis to crisis because we are too little staff and such a large area. There isn't time to debrief and calm down and take a moment to come to your senses. You always deal with what is happening at the moment."

Participant 15: "High caseloads, insufficient emotional support and there isn't health and wellness programmes for employees or debriefing sessions. We aren't always supported by our management because they want results, they don't care or want to know the process or how you feel. They don't really care. You also don't trust your management… I don't feel comfortable talking about personal issues with my supervisor, what if it gets to management."

These narratives indicate the prevalence of organisational factors that play a role in causing compassion fatigue for newly qualified social workers. This correlates with situational theories, which propose that satisfaction is derived from the working environment and that this determines job satisfaction (Judge & Klinger, 2008; Redmond, 2016). Both narratives and existing literature indicate the most prominent organisational factor to be the overwhelming number and nature of caseloads (Beebe, 2016; Gottfried & Bride, 2018; Xu *et al.,* 2019). Other factors include child welfare affiliation, serving clients who have had severely traumatic experiences, a lack of resources, bureaucratic restraints, unsafe environments, low work autonomy, role stress, and a lack of control regarding agency policies and procedures (Figley, 1995; Smith, 2015; Gottfried & Bride, 2018; Xu *et al.*, 2019). The narratives also indicate a lack of support experienced by newly qualified social workers, especially considering the job demand. Unsurprisingly, a lack of support is a significant risk factor for social workers, and especially to newly qualified social workers who develop compassion fatigue. Figley (2002a), Gottfried and Bride (2018) and Xu *et al.* (2019) all indicate that insufficient supervision and a lack of team and co-worker support is detrimental to the social worker, and that newly qualified social workers require mentoring relationships by veteran professionals. This is confirmed by Ray, Wong, White and Heaslip (2013), who assert that social workers with less experience need senior colleagues who can mentor them, and argue that the supportive aspect of the relationship play a role in alleviating stress.

Participants also indicated personal factors causing compassion fatigue:

Participant 3: "Individually, if you are someone that gives your all to your work, putting in everything despite the burnout because you always want to do the right thing. You just want to give your best. Having a personality of wanting to satisfy everyone. You will never put yourself first, always someone else."

Participant 13: "The personality of the worker […] The softer you are as a person, the higher you are prone to it."

Participant 16: "I'm someone that's very hard on myself, I'm a perfectionist and I do things myself. This leads to compassion fatigue because I'm anxious and tired. I put a lot of pressure on myself. I'm also very emotional and feel like I'm failing you if I can't help you."

Participant 17: "People prone to depression […] People with anxiety."

Narratives of participants indicate that there are several personal factors playing a role in the development of compassion fatigue. This correlates with existing literature that asserts that compassion fatigue is the result of a mixture of several factors in both the workplace and the personal environment, including negative life events, personal trauma, lack of social support, and low job mastery (Adams *et al.,*2006). This is also associated with dispositional approaches, which propose that people may be predisposed to either higher or lower job satisfaction, regardless of their working environment or nature of work (Judge & Klinger, 2008; Redmond, 2016). Participants' narratives including descriptions of a "personality of wanting to satisfy everyone" and "perfectionist" may point to personality traits of neuroticism. The seminal work of Adler (1938) regards perfectionism as a neurotic form of overcompensation which is corroborated by Ellis (1958), who asserts that the individual believes in unrealistic, impossible, often perfectionistic goals, especially the goal that they should always be approved by everyone. Ellis (1958) elaborates that individuals with perfectionistic traits do not give up on their illogical beliefs despite contradictory evidence. It is, however, important to note that perfectionism is also linked to other personality traits, such as conscientiousness, and its relationship to personality traits is complex and divergent (Smith *et al.*, 2019). Moreover, several authors postulate that social workers with traumatic histories, anxiety or mood disorders, interpersonal relationships with conflict, and low tolerance for insignificant annoyances are at a higher

risk for burnout and compassion fatigue (Newell & MacNeil, 2010; Kulkarni *et al.,* 2013; Wagaman *et al.*, 2015).

5.4.2.4. Effects

Participants were asked to identify the effects of compassion fatigue, be it from their own experiences or from observations. Participants identified both organisational effects as well as personal effects. Some of the narratives of the respective participants are presented below.

Participant 5: "You don't do your job right. You don't follow up on clients, files aren't up to date. Home visits are rushed. You don't engage with people. You don't have that genuine care; you listen to their problems, but you brush it off."

Participant 7: "Many social workers don't know how to handle it and it leads to them leaving their work."

Participant 16: "Compassion fatigue leads to people not making realistic and ethical decisions. They also don't necessarily get treatment for it… At work you are also more likely to make mistakes because you don't think realistically and do it in a hurry."

The above narratives indicate that compassion fatigue experienced by newly qualified social workers negatively affect work performance and the quality of services rendered. The effects of compassion fatigue are related to its symptoms, which Figley (2002b) identify as low morale, low motivation, avoiding tasks, obsession about details, apathy, negativity, lack of appreciation, detachment, poor work commitments, staff conflicts, absenteeism, exhaustion, irritability and withdrawal from colleagues. From an administrative perspective, signs of compassion fatigue at the workplace include absenteeism, chronic tardiness, chronic fatigue, low completion rates of duties and poor patient care (Maslach & Leiter, 1997; Newell & MacNeil, 2010; Beebe, 2016). This is further worsened by symptoms put forth by the Figley (2002b), which include a decrease in quality and quantity of work, avoidance of tasks, faulty judgement, demoralisation, changes in and poor co-worker relationships, inability to work in a team, aggressive behaviour among staff, negativity towards management, an inability to believe that improvement is possible, as well as a lack of vision for the future. This is closely related

to the effects of burnout, which mostly impacts the social worker's work performance and is often how burnout is identified in the first place. These effects include a decrease in job performance, increased absenteeism, a higher turnover, lower organisational commitment, lower productivity, decreased effectiveness when working with clients, as well as tardiness and isolation from others (Maslach & Leiter, 1997; Newell & MacNeil, 2010).

Participants also identified personal effects of compassion fatigue:

Participant 2: "Individually, it can be quite detrimental to their own mental health as well as their wellbeing."

Participant 8: "It can lead to emotional breakdowns and emotional outbursts."

Participant 13: "Stress, anxiety, burnout. As a social worker you are a mother, wife or girlfriend and you take it home with you. If affects your relationships and your motivation at home to carry out other tasks. Your attitude towards life, you isolate yourself towards others."

The participants' narratives indicate that compassion fatigue can have a detrimental effect on the mental health and wellbeing of newly qualified social workers. There is a lack of literature pertaining to the specific personal effects of compassion fatigue on newly qualified social workers, and social workers in general, as there is an emphasis on the symptoms. Personal effects according to the participants' narratives correlate with emotional symptoms identified by Figley (2002b), which include anxiety, guilt, anger/rage, survivor guilt, shutdown, numbness, fear, helplessness, sadness, depletion and over-sensitivity. Portnoy (2011) and Figley (2002b) further state that individuals with compassion fatigue feel powerless, depressed and experience distressing dreams. In addition, research also indicates frustration, emotional- and physical exhaustion, depersonalisation, lower sense of personal accomplishment, excessive stress, and a diminished capacity for empathy and compassion (Newell & MacNeil, 2010; Stamm, 2010; Whitfield & Kanter, 2014). Coetzee and Klopper (2010) also confirm the emotional effects to include apathy, as well as a desire to quit on the part of the professional.

The main deduction from this theme is that compassion fatigue can be conceptualised as being related to burnout, vicarious trauma, as well as reaching an emotional threshold after which the social worker has no more empathy. Symptoms of compassion fatigue involve cognitive-, emotional-, behavioural-, social-, physical-, and work-related symptoms of which all negatively impact the social worker. Compassion fatigue is predominantly caused by both organisational factors and personal factors and has detrimental impacts on the social worker's work performance and personal life.

5.4.3. Theme 3: Self-care

Table 5.4.3. Theme 3: Self-care

THEMES	SUBTHEMES	CATEGORIES
Self-care	Conception of self-care	
	Preparation	
	Self-care techniques	Physical
		Social
		Occupational
		Intellectual
		Emotional
		Spiritual

In this section participants were asked to describe their conception of the self-care of newly qualified social workers, their opinion on how well newly qualified social workers are prepared in self-care, as well as self-care techniques based on their own or observed behaviour.

5.4.3.1. Conception of self-care

As already mentioned, participants were asked to describe their conception of self-care. Most indicated that it manifests in an intentional effort to address one's needs, be it personal or professional. Some of the narratives are presented below as examples:

Participant 2: "It's very subjective to whoever the individual is.... It is the processes you put in place to ensure your physical-, emotional- and mental wellbeing."

Participant 8: "Making sure that my wellbeing is looked after emotionally, physically, spiritually and professionally. Making sure that I do everything I can not to deteriorate as a person in my personal life as well."

Participant 12: "When a social worker realises that they have a problem, and they tend to it. Being aware of what you are going through and tending to it."

These narratives indicate that self-care, for the participants, involves intentionally addressing needs and problems, be it physical, emotional, mental, spiritual or professional. This correlates with literature that predominantly defines self-care as "the intentional effort to improve health and wellness by addressing personal needs […] related to mental, emotional, physical, spiritual, and social states" (Diebold *et al.,* 2018:657). Narratives also indicate the necessity of addressing both personal and professional needs through self-care.

According to Bressi and Vaden (2017), the professional self involves the aspects that are engaged at work in relationships with clients, and that this is guided by professional role expectations. The personal self, on the contrary, exists outside of work and is guided by other role expectations such as family life, economic functions, and communities among others. Bressi and Vaden (2017) put forth that the overarching goal of self-care has been to maintain equilibrium or homeostasis in an effort that the professional self does not impinge on the personal self and vice versa. Using this approach to burnout and compassion fatigue is the result of the self not being in balance. The most prominent infringement is of the professional self on the personal self, and is colloquially described as "bringing one's work home at night,'' which is assumed to result in the personal self being overwhelmed by the emotional distress of clients (Bressi & Vaden, 2017:34). On the other hand, the professional self may be infringed when the social worker's personal emotional functioning is poor.

5.4.3.2. Preparation

Participants were asked to express their opinion on whether newly qualified social workers are properly prepared in self-care. All of the participants expressed that they were not adequately prepared in self-care, as tertiary education institutions and organisations employing newly qualified social workers do not define and give much attention to self-care, resulting in social workers not understanding self-care and the practical implementation of it. Some of the narratives representing the respective participants are presented below:

Participant 2: "No … There the focus is predominantly on the client and their wellbeing. We only had one lecturer (at university) who focused on the self. You have taken a backseat for the last four or so years of your life and you have no idea how to take care of yourself because you have been taking care of other people."

Participant 6: "No… You keep trying to find your feet and cope, let alone look after yourself. You are too worried about what to do next than to focus on yourself. It wasn't even a priority."

Participant 11: "No, in supervision they said that we should look after ourselves, but they didn't say how we should look after ourselves. It was emphasised that there are people who have less than you and that your sole purpose is to tackle it."

Participant 18: "No. Where in any university course are you taught about self-care? It's lacking. I don't think enough emphasis is put on it, it's an afterthought."

The narratives above indicate that participants are of the opinion that their tertiary education did not thoroughly prepare them in self-care. Participants indicate that the importance of self-care was expressed at some point during their education, but that they did not learn how to implement self-care and are thus not prepared when starting their professional career.

Newell and Nelson-Gardell (2014) state that social work students are at risk of leaving the social work profession should they be emotionally and psychologically unprepared. A study conducted by Bloomquist *et al.* (2015) found that social work practitioners in general are not engaging in self-care consistently. Narratives from this study explained this regarding their preparation as graduate students, particularly that their programmes

valued self-care but did not effectively teach them how to engage in self-care practices. Moore *et al.* (2011) confirms this and asserts that many social work students reach the end of their formal training unprepared to use self-care practices. Social work education, however, has often overlooked the topic of and training pertaining to self-care. The National Association of Social Workers (NASW, 2008:270), within a North American context has taken a strong stance sanctioning professional self-care as an approved method of improving and restoring the social worker's well-being by recommending "the training of social work students about self-care in their field experience and the modelling of these [behaviours] by field instructors." This advocation is aligned with that of Pottage and Huxley (1996) decades ago, this being that neither social work students nor experienced social workers can provide proper care and support to their clients if they themselves are chronically stressed and overwhelmed. Griffiths *et al.* (2019) agree with this, and state that social workers often take care of others before themselves, further advocating that a culture shift must take place. The social work profession must take a proactive stance through the prioritisation of self-care wherein social workers must take ownership of their health and well-being by making a concerted effort (Lee & Miller, 2013).

As the social work profession aims to promote the welfare of those that are disadvantaged and marginalised, it is essential that social work education actively foster social work students' capacities to cope with the inevitable stressors, challenges and diminishing resources (Ying & Han, 2009; Iacono, 2017). This has been stated eloquently by Grant *et al.* (2015:2351) in that they caution one to "put on [one's] own oxygen mark before assisting others." Though there are challenges in incorporating this into social work curricula, Newell and Nelson-Gardell (2014) assert that it is a necessity to include self-care material in social work education as an ethical consideration.

5.4.3.3. Self-care techniques

Participants were asked to identify and describe self-care techniques of newly qualified social workers, be it from their own experience or through observation. Participants identified physical, social, occupational, intellectual, emotional, and spiritual techniques which correlates with Hettler's (1984) six-dimensional model of individual wellness.

5.4.3.3.1. Physical techniques

Participants expressed the necessity of caring for oneself physically and tending to physical needs such as nutrition, sleep, and exercise. Some of the narratives of the respective participants are presented below as examples.

Participant 1: "A little bit of exercise. You need it to get rid of your stress. Limiting your reliance on smoking and finding a healthier option."

Participant 2: "I like to recover from a day of being a social worker by caring for myself by doing the normal things: cook myself a meal, keep up with my hygiene, make sure the house is clean…"

Participant 4: "Look at your eating habits, sleeping habits and exercise. Many times you don't have time for lunch, you grab a chip or cookie in between just to get energy. Get into a sleeping pattern; many times you cannot go to sleep because of a busy mind and thinking about everything I have to do tomorrow. What you eat and when you eat it is also important."

Participant 13: "Managing your time to make sure you look after yourself as well. Once a week or day, I take 10 minutes to look after my physical appearance. More than just getting up and showering and getting ready for work. Focus on yourself. Exercising, it's good for physical health and stress relieving."

The narratives indicate an awareness of physical wellness, as well as its association to physical health and stress relief. The importance of a healthy diet and consistent eating schedule was identified, as well as limiting the reliance on tobacco, which correlates with literature such as Hettler (1976), who encourages learning about diet and nutrition whilst simultaneously discouraging the use of tobacco, drugs and an excessive consumption of alcohol. Narratives also indicate the benefits that exercise has on stress relief, which is corroborated by Slade and Kies (2015), who assert that regular exercise is essential to physical wellness as it regulates mood, improves self-esteem, combats fatigue, decreases stress, improves sleep and improves overall health. According to Hettler (1976), optimal physical wellness requires good exercise and eating habits, as well as medical self-care and the appropriate use of the medical system. Hettler (1976) further

puts forth that the benefits of physical wellness not only includes looking and feeling good, but that there are numerous psychological benefits, such as an enhanced self-esteem, self-control, determination and a sense of direction. Common physical self-care activities include exercise, adequate sleep and a healthy diet (Bloomquist *et al.*, 2015).

5.4.3.3.2. Social techniques

Participants expressed the necessity of socialisation and maintaining relationships outside of work. Some of the narratives of the respective participants are presented below.

Participant 1: "I have a constructive conversation with the people that I love."

Participant 3: "Encircle yourself with a lot of positive people, because the work is very negative and working with problems and crises. Have positive people that will build you up when you feel low and unmotivated. Get good support in your life."

Participant 6: "Don't isolate yourself, speak to friends, family, significant other. Keep and maintain your relationships."

Participant 11: "As a social person, on weekends I do things with friends that I enjoy so that I feel that I'm not wasting my life away. I visit others."

These narratives indicate the necessity of healthy social relationships and interactions with others outside of work. It is important to understand that participants previously expressed feeling isolated and detached from others when experiencing compassion fatigue. It may be that participants understand the necessity of socialisation but may find it challenging to practice when experiencing compassion fatigue. The importance of social self-care, including interacting with others and maintaining relationships, is present in existing literature. Hettler (1976) asserts that one would improve the world through better communication and wilful choices to enhance personal relationships and friendships. O'Neill *et al.* (2019) also identified social self-care activities to include spending time with friends, family and significant others, as well as phone calls and social networks, as the latter provide people with support, encouragement and enjoyment. Intimate personal relationships are a significant source of social support for social workers, which Manning-Jones *et al.* (2016) found to be a significant buffer from secondary trauma.

5.4.3.3.3. Occupational techniques

Participants indicated the importance of occupational self-care, specifically pertaining to maintaining a balance between work and home, as well as the necessity of support from supervisors and colleagues with similar experience. Some of the representing narratives of the respective participants thus include the following examples:

Participant 2: "Lean on your supervisors and colleagues. As a newly qualified social worker you will always be surrounded by people who have experienced the same and more than you. They have gone through the process before and first-hand and if they are still there, it is most likely that they have found a way to overcome it. Lean on those that have the same experiences as you, just knowing that someone is going through it with you can be a huge relief."

Participant 3: "Work stays at work, and your home stays your home. Learn that balance."

Participant 6: "At work me and my colleagues would take a tea break together and talk, talk after a crisis. Take time out."

Participant 8: "When walking out the door at the end of the day leaving your work at work and being at home being your own person, not a social worker."

It comes as no surprise that participants indicate the importance of occupational self-care considering the prevalence of work-related causes and symptoms of compassion fatigue in the previous sections. In social work, Newell and Nelson-Gardell (2014) define professional self-care as using skills and strategies to maintain personal, familial, emotional and spiritual needs, whilst also attending to the needs and demands of the clients. Narratives specifically call for maintaining a balance between work and home, which can be elaborated as setting and maintaining boundaries in terms of the work done at home. Bloomquist *et al.* (2015) further identify professional self-care activities to include participating in trainings, setting appropriate boundaries with clients, seeking adequate supervision and support, as well as advocating for one's own needs within the workplace. O'Neill *et al.* (2019) also advocate for vacations and support from co-workers and supervisors, as the latter organisational factor can promote or discourage self-care.

5.4.3.3.4. Intellectual and emotional techniques

A number of participants indicated practicing intellectual self-care, predominantly pertaining to seeing a therapist or psychologist, journaling and reading, as well as emotional self-care such as reflection and mindfulness. Both techniques will be covered in one category as it is very closely related in nature. Some of these narratives of the participants in question are presented below.

Participant 7: "Reflecting on what the day will hold. Mindfulness. Take time to reflect on your own feelings. Write in a journal on how your day was, reflect on your emotions."

Participant 16: "Every month I see a psychologist to address what I need help with as well as regularly seeing my supervisor."

Participant 18: "I enjoy reading so I prioritise at least two hours a week where I go to a coffee shop and read. Make sure that you are not isolating yourself and that you have external support, for example seeing a personal therapist. Counselling for the counsellor is the most important self-care I have learnt."

Narratives indicate well-balanced intellectual self-care practices of participants including therapy, journaling, or reading. This correlates with the intellectual wellness dimension, which, Hettler (1976) puts forth, involves problem solving, creativity and learning as well as spending time pursuing personal interests and keeping informed of current issues and ideas. Psychological self-care activities related to intellectual wellness include therapy, journaling and reading, as it endorses self-awareness and decision making (Bloomquist *et al.*, 2015). Personal therapy sought by therapists is not only relevant for newly qualified social workers, as Norcross (2005) indicates that seeking personal treatment repeatedly during one's career supports the conclusion that is an essential part of both formative training, as well as ongoing maturation and regenerative development. Macaskill and Macaskill (1992) found that, despite therapists noting negative effects of personal therapy such as relationship strains, emotional withdrawal and increased psychological distress, a vast majority of participants indicate positive effects such as greater self-awareness, self-esteem and reduced symptoms. It is, however, put forth that therapy is often expensive in terms of time and money, and can thus add to the stress of those who already feel overwhelmed (Brenner, 2006).

Apart from therapy, participants also reflected on emotional techniques:

Participant 7: "Reflecting on what the day will hold. Mindfulness. Take time to reflect on your own feelings. Write in a journal how your day was, reflect on your emotions… Encircle yourself with a lot of positive people, because the work is very negative and working with problems and crises. Have positive people that will build you up when you feel low and unmotivated."

Participant 10: "Doing something that you enjoy, for example dancing, art, drawing… Also just sitting still and taking a breath, just realising that you are reacting too quickly."

Narratives indicate an awareness of the necessity of emotional self-care, taking into consideration the emotionally draining and challenging work of social workers and newly qualified social workers in particular. The emotional wellness dimension entails awareness and acceptance of one's feelings and has been identified as a predictor of lower burnout and compassion fatigue, as well as an independent predictor of greater compassion satisfaction among social workers (O'Neill *et al.*, 2019). Emotional self-care activities encourage emotional well-being and include spending time with loved ones, laughing and self-praise, as well as creative art expressions and reflection (Bloomquist *et al.*, 2015; O'Neill *et al.*, 2019).

5.4.3.3.5. Spiritual techniques

A significant number of participants indicated practicing spiritual self-care and the importance of practicing religion. Some of the narratives representing the discourses of participants are presented below.

Participant 3: "When I feel demotivated or that the work is too much, I pray and ask the Lord for guidance and energy."

Participant 9: "When in a crisis, I sit and close my eyes, take a breath, and pray for calmness. I pray to have the skills to be able to handle everything that comes my way that day. It's very important to breathe."

Participant 11: "I got involved with the church and that gave me a lot of energy. Our church group gave me the opportunity to share and it gave me support and purpose."

These narratives indicate the positive impact of spiritual self-care and the extent to which participants implement it through prayer and attending religious events. One participant in particular indicated receiving support and purpose through her spiritual self-care. This correlates with assertions from O'Neill *et al.* (2019), in which the spiritual wellness dimension encompasses meaning and purpose in existence and has been identified as a predictor of lower burnout and compassion fatigue. According to Hettler (1976), this includes a deep appreciation for the depth of life and natural forces, and that one's search for meaning is characterised by peaceful harmony between personal emotions and life challenges. Various emotions ranging from positive (e.g. pleasure, joy, happiness and discovery) to negative (e.g. doubt, despair, fear, disappointment and dislocation) are all important experiences, as they will be displayed in one's value system which brings meaning to one's existence. Hettler (1976) furthermore explains that one would be sure of spiritual wellness when one's actions are more consistent with one's beliefs and values. Central tenets of spiritual wellness propose that it is better to ponder the meaning of life and be tolerant of others' beliefs than to be closed minded and be intolerant; and that it is better to live a life that is consistent to one's values and beliefs than to feel untrue to oneself. White *et al.* (2011:48) define spiritual self-care as "the beliefs a person holds [about] their subjective sense of existential connectedness, including beliefs that reflect relationships with others, acknowledge a higher power, recognise an individual's place in the world, and lead to spiritual practices." Accordingly, spiritual self-care activities include attending religious or spiritual events, praying and meditation (Bloomquist *et al.*, 2015; O'Neill *et al.*, 2019), as these nurture connections and finding meaning in life.

The main deduction from this theme is that self-care involves an intentional effort to address one's needs, both professionally and personally. Newly qualified social workers, however, are not adequately prepared in self-care as tertiary education institutions and organisations do not define or pay sufficient attention to self-care and its practical implementation.

5.4.4. Theme 4: Organisational context

Table 5.4.4. Theme 4: Organisational context

THEMES	SUBTHEMES
Organisational context	Awareness and response

In this section participants were asked to indicate whether their organisation or other organisations employing newly qualified social workers are aware of the compassion fatigue experienced by newly qualified social workers, and, by extension, how they would respond to the compassion fatigue. Most of the participants indicated that their organisations are not aware of these experiences of compassion fatigue and asserted that the organisation would not react to it. Others, however, mentioned an organisational culture in which compassion fatigue is acknowledged and reacted to through leave from work and other wellness-related activities.

5.4.4.1. Awareness and response

Responding on the question on whether their organisation or other organisations employing newly qualified social workers are aware and would respond to the compassion fatigue experienced by these individuals, participants made the following comments:

Participant 7: "I wouldn't say that they are aware of the term compassion fatigue, but they would take it as you are saying that you are tired… That is why many new social workers leave their jobs because managers and supervisors don't understand what you are going through."

Participant 9: "No, not specifically new social workers. They know that social workers burn out, but they are not aware of how much it impacts new social workers. They have this mindset that university prepared us so well that we know everything. 'Ag wat, jy's mos slim' (never mind, you are clever)."

Participant 10: "I don't think they would react to it at all."

Participant 11: "I won't say that my organisation is aware of it… They don't really understand my work and how it affects me emotionally. If I listen to other social workers, we all experience the same thing and there isn't a way that the managers, organisations and supervisors really address it. They say that you studied it, so you have to deal with the entire package."

The vast majority of participants in the study thus indicated that their organisations, and other organisations employing newly qualified social workers, are not aware of the compassion fatigue experienced and are also of the opinion that their organisations would not react to it or respond appropriately. There is a scarcity in research exploring the lack of input from organisations in preventing compassion fatigue, which is a juxtaposition considering the volume of research indicating the significant challenges experienced by newly qualified social workers. As stated previously, according to Bates *et al.* (2010:152), the transition to a newly qualified social worker and the first year of practice can be described as a "baptism of fire." Donnellan and Jack (2015) corroborate this and state that the first year of social work practice is characterised by sudden and unexpected disruptions and turns, as the newly qualified social worker settles into new norms as an employee. Webb (2017) elaborates on this in an international context and explains that this is further demanding and intricate, as the human service sector is becoming increasingly managerialist with insecure employment arrangements and generic job-roles often rendering social work to be less visible in workplaces and multidisciplinary teams. Factors assisting a newly qualified social worker to cope in their new role include effective supervision, mentoring and coaching, support from colleagues, as well as a staggered increase in volume and complexity of caseload (Agllias, 2010; Donellan & Jack, 2015). However, as evidenced by participants' narratives, this is not always implemented effectively due to various stressors within organisations. It is also clear that organisations are not necessarily aware of the compassion fatigue experienced by newly qualified social workers and may thus not be knowledgeable about the necessity of organisational input.

In contrast, a few participants, indicated that their organisations are aware of compassion fatigue and would respond appropriately:

Participant 4: "I think so. Our organisation is definitely aware of it, especially our supervisor… The supervisor spoke to her (a colleague) saying that she couldn't continue like that and that she would get burnt out. They are also going to give us a questionnaire after lockdown about our experience, trauma, workload, how we cope and asking how they can help. They have things in place to help."

Participant 5: "My organisation has a programme, 'Welwees' and 'Timeout'. It is basically self-care and looking after yourself. Spending time listening to people and giving advice. Anyone can go and sign up for it. It's free."

Participant 18: "The culture is that you should be healthy as a person because then you can render a service as a professional. We are big on mental health days, you communicate it. Self-care is a priority for everyone in the organisation, but it isn't like that it all organisations... [Our organisation is] very much aware of the challenges of a newly qualified social worker. Their reaction would depend on the circumstances, the first line of defence would be time off to recover. For example, if I speak to my boss and justify a mental health day, they will say yes [...] They take it as it comes, the person and the situation."

Narratives of participants indicate that there are social service organisations in South Africa that are aware of compassion fatigue. Despite not necessarily knowing and understanding the term, practices are put in place to assist newly qualified social workers and experienced social workers alike to deal with stressors. Harr (2013) asserts that, in order to promote workplace health among human service professionals, agencies, organisations, social work educators and professionals must address the personal costs to social work practitioners for rendering the services and increase the immediate and long-term benefits on a continual basis in order to create and maintain a healthy balance between the risks and benefits of the profession. Moreover, Harr (2013) asserts that organisational factors can contribute to diminishing the impact of burnout and compassion fatigue on social workers by agencies increasing their compassion satisfaction. It is further suggested that organisations and agencies take responsibility for reducing the

likelihood of compassion fatigue by establishing an emotionally supportive, physically safe, and respectful work environment that will reduce both interpersonal and intrapersonal stress (Brady, Guy, Poelstra, & Brokaw, 1999). Regarding the input from both organisations and professionals, Radley and Figley (2007) suggest promoting satisfaction as opposed to avoiding compassion fatigue. Harr (2013) agrees with this and asserts that, when there is a greater ratio of positive experiences to negative experiences, professionals will have a higher morale and will render better services.

The main deduction from this theme is that, whilst there are organisations and supervisors who are aware of compassion fatigue experienced by social workers, they are not particularly cautious to give special attention to newly qualified social workers who are at increased risk of experiencing compassion fatigue. Transitioning from student to professional social worker is an exceptionally challenging time with fears and anxieties surrounding service delivery and professional identity, as well as a need for both support and professional guidance, as they do not have a lot of practical experience. Taking this into account it is evident that organisations and supervisors should increase their awareness and response efforts on newly qualified social workers to prevent and curb compassion fatigue.

5.4. CONCLUSION

This chapter sought to address the fourth objective of this study, which is to conduct an empirical study to explore factors contributing to symptoms of compassion fatigue in newly qualified social workers in South Africa and the self-care practices that buffer them. This chapter began by analysing the research methodology that was implemented in this research study. A detailed account regarding the profiling of the participants who took part in the study followed thereafter. Finally, four themes and subsequent sub-themes and categories were established and thoroughly examined. These themes included the nature of social work, compassion fatigue, self-care, and organisational context.

The next chapter will present various conclusions drawn from the empirical study. In addition, appropriate recommendations following established conclusions will be presented.

CHAPTER 6: CONCLUSIONS AND RECOMMENDATIONS

6.1. INTRODUCTION

The purpose of this study has been to gain an understanding of the compassion fatigue and self-care practices used by newly qualified social workers in the South African context. A literature review indicated little to no studies undertaken in South Africa regarding how newly qualified social workers experience compassion fatigue and practice self-care as a measure of preventing it. Globally, studies pertaining to compassion fatigue have increased, but newly qualified social workers receive less attention and are often not the focus of the study. Decades ago Figley (1995; 2002a), Stamm (2010) and Hettler (1984) studied compassion fatigue and self-care respectively and in depth, but neglected to study the relationship between both concepts and did not focus on the experiences of newly qualified social workers in particular. This is a necessity, as newly qualified social workers are at increased risk of experiencing compassion fatigue, compared to more seasoned social workers, as they face a multitude of challenges related to the transitioning from student to professional social worker.

Against the above background, this study thus attempted to formulate a conceptual framework of working conditions experienced by newly qualified social workers. It furthermore made provision for analysing and discussing compassion fatigue experienced and self-care strategies employed by newly qualified social workers. An empirical study on the compassion fatigue and self-care of newly qualified social workers in South Africa was conducted. Data was collected from 18 participants by means of a semi-structured interview schedule and were predominantly conducted telephonically. The findings of the empirical study were presented and analysed meticulously in the previous chapter.

Building on the empirical study, this chapter serves to answer the fifth objective of this study, which is to conclude and make appropriate recommendations regarding the experience of compassion fatigue and implementation of self-care of newly qualified social workers.

6.2. CONCLUSIONS AND RECOMMENDATIONS

The conclusions drawn will be based on the findings from the empirical study and recommendations subsequently based on the conclusions made. Key findings from the literature and empirical study will be presented in an integrated manner. The conclusions will follow the same structural format as the themes and sub-themes identified in the previous chapter. Specific recommendations will be subsequently provided following the conclusion on each respective theme identified.

6.2.1. Participant particulars

The profiling of the participants is fundamental in creating a context for the interpretation of the conclusions and recommendations with regard to the identified themes in this research study. All participants who took part in this study were newly qualified social workers. Newly qualified social workers can be described as social work practitioners who have been directly delivering social services for two years or less. The majority of participants who took part in the research were 24 years of age, which was followed by 25 years of age. Seventeen of the 18 participants were female, and all were unmarried. Further, the majority of the participants taking part in the research study had 12-17 months of working experience, closely followed by 6-11 months. Time of work experience ranged from three months to 18. Of the 18 participants, 14 were employed at non-governmental organisations (NGOs), three were in private practice, and one was employed at the Department of Social Development (DSD).

The profile of participants correlates with the profile of individuals most at risk of experiencing compassion fatigue, as they are predominantly young adult females with less working experience. Taking this into consideration, more efforts should be made by organisations and supervisors to support newly qualified social workers, as they are more likely to experience compassion fatigue.

6.2.2. Nature of social work

The majority of participants interviewed retorted significantly high caseloads, which they felt they were unprepared for. Participants also indicated having to do a lot of administration, which meant that finding a balance between administration and field work

was significantly challenging. This correlates with existing literature, which indicates that social workers are recommended to have no more than 60 cases, but that the reality in South Africa is that they often have 110 to 400 cases at any particular time. Participants in private practice admitted a lack of work-life-balance due to the flexible nature of the work and the workload as those in private practice are often expected to render services and do administration after hours.

Narratives from participants alluded that resources vary depending on the sector and area in which services are rendered. The majority of participants employed at NGOs indicated having little resources such as vehicles, stationery, office equipment and space, whereas those employed privately or at the DSD indicated adequate resources. Participants who mentioned being satisfied with the available resources indicated close working relations with other organisations such as welfare organisations, the DSD, hospitals, the police, and schools. Comparing the last-mentioned narratives to those prior, it is evident that not all organisations are similarly resourced, with many participants indicating that it depended on the sector of work, the location of the organisation, and the organisation itself.

The majority of the participants alluded being unsatisfied with the working environments. Narratives indicate participants feeling scared to render services due to unsafe work environments and threating client systems. One participant described an incident where she was physically and violently assaulted whilst attempting to render services. Participants also indicated inadequate safety measures and feeling anxious and vulnerable even after their workday has ended. Participants elaborated on unhealthy working environments and referred specifically to rendering service in informal settlements, which are not hygienic. These participants spoke about rendering services to those who are ill without safety precautions such as masks or gloves, as they fear it would indicate judgement or discrimination towards the client.

The majority of the participants suggested little remuneration compared to the work that is performed. Participants expressed that they are unable to live independently and cannot continue working for such little remuneration in the future. The participants indicated being dependent on others, such as their parents, and expressed that it is not

sustainable. The majority of participants stated that social workers employed at the DSD earn more than them, and also receive more benefits. This was confirmed by a participant employed at the DSD. All of the privately employed participants indicated working on a no-work-no-pay principle which can be stressful due to the financial insecurity and uncertainty.

The majority of participants disclosed that supervision is infrequent, and that their supervisors often adopted an open-door policy. In this context, an open-door policy meant that they could walk in and quickly discuss a case or work matter that required the supervisor's immediate guidance or attention. Participants who indicated infrequent supervision also indicated that there is often no agreed upon date or duration. A number of participants also shared not receiving any supervision, and that they relied on colleagues or managers who are not social workers for guidance and debriefing. Nonetheless, some of these participants indicated that they would receive guidance should they ask for it.

Narratives alluded that the perceived quality of supervision varied from participant to participant. Some of the participants stated that they experienced social work supervision to be helpful and effective, describing that their supervisors are involved and attentive, and are thorough in their guidance. The other participants, however, indicated having experienced harmful and inadequate supervision, describing supervisors as uninterested, unavailable, and not cooperative in terms of providing the necessary guidance and support that is required by a newly qualified social worker. Participants with inadequate supervision spoke of supervisors feeling that tertiary education should have thoroughly prepared social workers to function independently and thus not being willing and patient to provide them with guidance.

Conclusions

Newly qualified social workers in South Africa experience a multitude of challenges that implicate their service delivery and development as professionals. Social workers, and newly qualified social workers in particular, are overwhelmed by the high caseload and relentless amount of administration, thus finding it impossible to render services to all those in need of intervention. The environments in which social workers are expected to

render services are not conducive and there is often an inadequate amount of available resources needed to successfully intervene in a case. The challenges and difficulties experienced by newly qualified social workers are not counteracted with compensation, as remuneration is regarded as considerably low taking in the nature of work performed. It is evident that an unequal balance between remuneration and work has negatively affected the self-esteem and motivation of newly qualified social workers and is a significant reason for social workers changing jobs or careers.

The present practice of supervision for newly qualified social workers is not being held as regularly or for the duration as it should, often due to time constraints and a lack of available supervisors. The lack of structure and frequency of the supervision sessions led to the purpose of the session being merely direct guidance/coaching, and thus neglecting the supportive function of supervision rendering newly qualified social workers to rely on themselves or their colleagues for support. It is also prevalent that a number of newly qualified social workers receive supervision that is harmful and inadequate due to the mindset of social work supervisors who expect newly qualified social workers to work independently instead of viewing supervision as ongoing for the purpose of continual growth.

The implication is that the nature of social work for newly qualified social workers, taking into consideration the high caseloads and administration, unsafe working environments, low remuneration and infrequent and inadequate supervision, significantly impacts their job satisfaction and correlates with an increased the risk of developing compassion fatigue. Perceived negative working environments also impact job retainment and may lead to newly qualified social workers seeking employment elsewhere.

Recommendations

- The South African Council for Social Service Professions and National Department of Social Development should address the number of cases and the workload of newly qualified social workers (specifically within the first two years of practice). This is due to high caseloads often being the result of limited social workers employed at an organisation, and this can be addressed through adequate funding and the employment of more social workers. This should be considered a point of

departure in addressing the compassion fatigue experienced by newly qualified social workers.

- The Social Service Professions Act should enforce and monitor that all supervisees receive frequent, structured individual supervision sessions, specifically during the first two years of practice at their respective social service organisations as indicated in the Supervision Framework, since "on the run" supervision does not qualify as a typical supervision session.
- It should be made mandatory by the SACSSP that all social work supervisors receive constant training in respect to the management of supervisees, including the functions of supervision such as support, but with specific attention to the unique needs, fears and anxieties pertaining to transitioning from student to professional.
- The SACSSP should perform regular audits, which involve assessing the effective implementation of supervision of newly qualified social workers, as well as newly qualified supervisees evaluating their supervisors in terms of the use of power and authority and general relational abilities.

6.2.3. Compassion fatigue

Compassion fatigue was defined as being similar to burnout, being associated with vicarious trauma, and that it involves having a limit to empathy. This correlates with literature, where the terms are often used interchangeably. Narratives where it is synonymous with burnout indicate that compassion fatigue is overwhelming to newly qualified social workers. Participants who described compassion fatigue as being related to vicarious trauma further indicated dealing with traumatic cases and expressed that social workers take the trauma upon themselves. Participants who conceptualised compassion fatigue in terms of having a limit to empathy, acknowledged the necessity of having empathy in the profession, and elaborated that at a certain point after portraying a lot of empathy, it reached a threshold and negatively impacted the newly qualified social worker.

All of the participants are familiar with some form of symptom related to compassion fatigue, including cognitive-, emotional-, behavioural-, social-, physical- (somatic), and

work-related symptoms. Examples of symptoms include tiredness, sleeplessness, experiencing headaches, high blood pressure, potential strokes, cold sores due to a weakened immune system, withdrawal, isolation, not showing compassion, lack of empathy or sympathy, eating poorly, not engaging in self-care, irritability, forgetfulness, lowered concentration, feeling emotionally drained, feeling lethargic, as well as feeling scared and nervous. Many participants identified these symptoms from their own experience, and others observed it from a colleague.

All of the participants attested organisational factors or work-related causes of compassion fatigue. Narratives indicate that newly qualified social workers feel overwhelmed with the high workload, which is further worsened by having to deal with a wide range of problems and a diverse client system. From the narratives it is also expressed that the nature of work, such as dealing with crises and adhering to deadlines and time constraints are significant challenges. Participants further indicated a lack of organisational support, as organisations are continuously becoming more focused on reaching targets instead of addressing the needs of employees. A few participants acknowledged not trusting their supervisors or those in their organisations for support, as they did not believe the information would remain confidential. A few participants pointed out personal causes of compassion fatigue, and narratives predominantly centred around personality characteristics such as perfectionism, the need to please others, and being emotional or sensitive.

All of the participants observed that compassion fatigue negatively impacts one's work- and personal life. Narratives indicate that compassion fatigue negatively affects work performance and the quality of the services that are rendered. Participants indicated this being caused by social workers not following up with clients or keeping administration updated, rushed home visits, not engaging with people, not displaying genuine care, as well as making unrealistic or unethical decisions. One participant in particular also revealed compassion fatigue to be the reason that social workers quit their jobs. A few participants indicated the detrimental effect of compassion fatigue on newly qualified social workers' mental health and wellbeing. Narratives show emotional breakdowns and emotional outbursts, stress, anxiety, burnout, as well as negatively affecting one's relationships and one's attitude towards life.

The implication of this is that newly qualified social workers in South Africa experience compassion fatigue with a multitude of symptoms which impact them as individuals, but also impact their work performance and thus their service delivery. The latter should be regarded as an ethical concern and should thus be acted on by organisations and supervisors through lending holistic support and guidance.

Conclusions

Compassion fatigue is a reality for newly qualified social workers in South Africa. Those who have experienced it or have observed it from colleagues conceptualise it as being synonymous with burnout and vicarious trauma, and describe it as involving reaching a threshold on empathy. The symptoms of compassion fatigue are far-reaching and impact the professional's entire wellbeing, including cognitively, emotionally, behaviourally, socially and physically. Symptoms of compassion fatigue can also be observed in their quality of work, which indicates that compassion fatigue is an ethical concern. Compassion fatigue of newly qualified social workers are not caused by organisational factors or personal factors alone, but a culmination of both factors. Organisational factors that significantly impact the development of compassion fatigue include an overwhelming workload, crises and time constraints, as well as the lack of adequate organisational support. The personality of the newly qualified social worker also plays a role in the development of compassion fatigue, with traits such as perfectionism, agreeableness and being emotional or sensitive being most prominent. Compassion fatigue not only impacts on the professional as a person, but also negatively impacts their work. The professional's mental health and wellbeing is thus impacted, and it adversely affects work performance and the quality of services rendered. From the latter one can conclude that compassion fatigue can be regarded as an ethical concern.

Recommendations

- The National Department of Social Development should make provision of a substantial subsidy to organisations for individual supervision of newly qualified social workers in particular, in order to ensure that all newly qualified social workers receive optimum and quality individual supervision in their respective organisations. This consequently should also entail continual professional

development and support of supervisors at all types of organisations that are employing social workers in South Africa, in order to address the unique challenges rendered by supervision of newly qualified social workers.

- The support function during individual supervision should specifically be promoted in the Supervision Framework of the National Department of Social Development and SACSSP in order to guide and develop supervisees into competent professionals in the interest of service users. Support in supervision of newly qualified social workers should be regarded as a priority of supervision in all organisations in order to strengthen the social workforce in the country.
- The National Department of Social Development should furthermore make provision of a substantial subsidy for independent, registered work-life coaches to newly qualified social workers, in order to support supervisors in the rendering of their support function, but also to serve as an investment in the capacitating of South African social workers as essential workforce in their first two years of practice, specifically in times such as the current Covid-19 pandemic and beyond.

6.2.4. Self-care

The majority of the participants pointed out that self-care can be conceptualised as addressing one's needs and attending to problems. Narratives indicate that this is an intentional effort and that the way in which it is done is subjective and thus varies from individual to individual. Narratives also suggest that self-care is holistic and involves not only physical self-care, but also emotional, spiritual and professional care. Participants indicated that self-care furthermore not only prevents deterioration of the newly qualified social worker as a person, but as a professional.

All of the participants asserted that they perceived newly qualified social workers to be inadequately prepared in self-care when entering the profession. Narratives indicate that self-care is rarely addressed in tertiary education. On the contrary, many participants indicated that they were encouraged during the course of their training to rather focus on their clients than on themselves, which they felt created a negative mindset regarding self-care by the professionals. Newly qualified social workers are thus not knowledgeable of the self-care expected to be performed when they enter the profession.

All of the participants alluded some form of self-care technique that they execute. It was evident that participants in general did not mention or practice a range of holistic self-care techniques, and instead only identified a few limited examples each. Physical self-care included nutrition, sleep and exercise; social self-care included socialising and maintaining relationships outside of work; occupational self-care included maintaining a balance between work and personal life, as well as seeking support from supervisors and colleagues; intellectual self-care included seeking personal therapy, journaling and reading; emotional self-care included reflection, reflection, mindfulness, and creative expression; and spiritual self-care included practicing religion through prayer and religious groups. Participants mostly referred to physical-, emotional- and spiritual self-care.

The implication of this is that self-care is relevant to both personal life and professional life, and should thus be regarded as an ethical concern regarding newly qualified social workers. Unfortunately, many newly qualified social workers are inadequately prepared in practically implementing self-care, and are thus at greater risk of developing compassion fatigue, as proper self-care is a promising protective measure.

Conclusions

The current definition of self-care is that it involves addressing one's needs and attending to problems. This self-care not only pertains to the newly qualified social worker in their personal life, but also pertains to the social worker as a professional. Self-care and its implementation may vary from individual to individual, and is subjective. There is thus no clear-cut standardisation for self-care. Newly qualified social workers in South Africa are undeniably unprepared to practice holistic self-care when entering the profession and the present practicing newly qualified social workers have not been adequately educated in self-care during their tertiary education. Because newly qualified social workers are not knowledgeable about the range of self-care techniques to address all areas of wellness, they cannot practice a varied range of self-care techniques themselves. A lack of knowledge and support to practice self-care leads to the neglect of self-care and thus the deterioration of the newly qualified social worker as an individual and as a professional.

Recommendations

- Tertiary education institutions should incorporate self-care education in the curricula of both social work coursework, and in students' practice education. Self-care as a module should be taught to students at various degree levels and should incorporate specific and practical examples of self-care techniques.
- Organisations employing newly qualified social workers should make it compulsory for those practitioners to attend workshops and training regarding the necessary role and implementation of self-care in order to ensure a healthy workforce.
- Organisations employing newly qualified social workers should mandate the supervisors of those social workers to conduct personal development assessments and formulate personal development plans, specifically pertaining to self-care of their supervisees and to implement these plans during supervision sessions for at least two years as social workers are entering practice.

6.2.5. Organisational context

The majority of participants asserted that their organisations of employment were not aware of the compassion fatigue experienced by newly qualified social workers or were not aware of the extent to which it is experienced. On the contrary, a few participants expressed that their organisations or supervisors were well-aware of the general negative effects of the social work practice on newly qualified social workers, but they did not necessarily indicate an awareness of compassion fatigue. The majority of participants felt that their organisations would not respond to the compassion fatigue experienced by newly qualified social workers at all, indicating that they would have to deal with it on their own and in their own time.

The discourses of participants suggest that organisations are not aware of the challenges related to newly qualified social workers and do not perform the necessary support and intervention should a newly qualified social worker require assistance. It is also evident that the lack of awareness and inappropriate response impacts negatively on the relationship between the newly qualified social worker and the organisation, and

negatively impacts on the attitude the newly qualified social worker has about the profession at large.

The implication of this is that newly qualified social workers do not feel supported by their organisations and supervisors, as they do not express an acknowledgement and concern for the wellbeing of newly qualified social workers and the newly qualified social workers do not perceive their responses to compassion fatigue and self-care as adequate. Whilst it is futile in the effort to reduce compassion fatigue and improve self-care, this lack of trust in organisations and supervisors also negatively impact morale and job retention.

Conclusions

The current practices of supervision of newly qualified social workers and social work management does not reveal an awareness of compassion fatigue or its impact on newly qualified social workers. This indicates a lack of knowledge pertaining to the challenges related to entering the social work profession and the transition from student to professional. Currently, supervisors and managers of social service organisations do not adequately address and respond to compassion fatigue. This suggests a lack of involvement, investment, and support to newly qualified social workers. Not addressing compassion fatigue is detrimental to the work performances of newly qualified social workers, as well as the retention of these social workers.

Recommendations

- The SACSSP should include in their policy on continuous professional development (CPD) that social workers must prove what measures are they taking or undertook to acquaint themselves with self-care measures within the first two years of practice.
- All organisations (government, NGO, or private practice) employing newly qualified social workers should register their specific self-care programmes, plans or opportunities for newly qualifies social workers, with the National Department of Social Development on a central register. This may be a radical way to promote the retention of newly qualified social workers in the social work profession on a national level.

6.3. RECOMMENDATIONS FOR FURTHER RESEARCH

This research study was aimed at gaining an understanding of the compassion fatigue and self-care practices used by newly qualified social workers in the South African context. In order to gain this understanding, this study painted an introductory picture on the background of the study by serving as a framework regarding the conceptualisation of work contexts and working conditions experienced by newly qualified social workers. Moreover, the research topic was deepened by exploring the compassion fatigue experienced by newly qualified social workers, identifying self-care practices by those prone to compassion fatigue, as well as analysing the role of social work supervision and education in the enhancement of self-care. Findings from the empirical investigation showed the definite need to address compassion fatigue and employ self-care practices in South Africa. It is fundamental that the following research areas be further explored:

- An in-depth study on social work supervisors' understanding of the support function of supervision;
- A qualitative study about the implications of neoliberalism on social work practice and social work supervision;
- A qualitative study about the possible role and benefits of outsourcing supportive supervision as a means of addressing compassion fatigue among social workers;
- A qualitative study about the experience of compassion fatigue for intermediate and advanced social workers in the South African context;
- A comparative study on the attitudes and practices of self-care for newly qualified and seasoned social workers.

This research study should be replicated in other provinces in South Africa in order to generalise the results, as this study only investigated the experiences of a small sample of newly qualified social workers in the Western Cape. The study should also be expanded to include intermediate and advanced social workers.

6.4. KEY FINDINGS AND MAIN CONCLUSIONS

This research study was aimed at gaining an understanding of the compassion fatigue and self-care practices used by newly qualified social workers in the South African

context. A number of factors were established as reasons that warranted this study to be carried out. Some of these factors included the absence of any studies on the experience of compassion fatigue and implementation of self-care being conducted in South Africa. Research studies on compassion fatigue and self-care have also paid less attention to newly qualified social workers specifically.

The researcher interviewed, transcribed and meticulously analysed 18 participants' discourses to identify the following key findings and main conclusions: newly qualified social workers work under extremely harsh conditions, which are worsened by challenges related to the transitioning from student to professional social worker; this, along with a lack of organisational support, has increasingly led to the development and experience of compassion fatigue among newly qualified social workers, which is detrimental to them as individuals and to them as professionals; the symptoms of compassion fatigue are far-reaching and impede all aspects of the professional's wellbeing; owing to the negative impact of compassion fatigue on the quality of service rendering, it should be regarded and addressed as a vital ethical informed concern in South Africa.

The implications of these findings are that self-care to buffer compassion fatigue is not just the responsibility of newly qualified social workers themselves, but should be holistically promoted by training institutions, the SACSSP, the national Department of Social Development, organisations employing newly qualified social workers, and the managers and supervisors of those social workers concerned. The dissemination of these research findings and recommendations thus contribute to the body of knowledge and practice of social work in South Africa in order to retain newly qualified frontline social workers, essential to the impact of the social work profession on social development of vulnerable people in the country.

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ANNEXURE 1

INTERVIEW SCHEDULE

THEMES FOR INTERVIEW SCHEDULE FOR NEWLY QUALIFIED SOCIAL WORKERS

1. **BIOGRAPHICAL INFORMATION**

a. Clarify your:

i. Gender

ii. Age

iii. Marital status

iv. Nature of employment (type of organisation and type of work)

v. Years of working experience

2. **ORGANISATIONAL CONTEXT**

a. Is your organisation or other social welfare organisations who are employing NQSWs aware of the impact of compassion fatigue on NQSWs – and if so, how do these organisations respond towards NQSWs compassion fatigue? Give specific examples.

b. In your opinion, is social work supervision helpful to curb compassion fatigue of NQSW? Motivate your answer with an example.

3. **COMPASSION FATIGUE**

a. How would you **define** and describe compassion fatigue of a NQSW? Give a specific example.

b. What is the **prevalence** of compassion fatigue among newly qualified social workers in your professional network? Give specific examples.

c. What are the perceived **reasons** (own or observed experience) of compassion fatigue? Elaborate specifically.

d. What are your perceived or experienced **symptoms** of compassion fatigue of NQSWs? Give specific examples.

e. In your opinion, what are the **effects** of NQSWs' compassion fatigue? Give specific examples.

4. SELF-CARE

a. How would you **define** and describe self-care by a newly qualified social worker to curb/buffer compassion fatigue?

b. What self-care techniques can you suggest to curb compassion fatigue of newly qualified social workers (based on your own or observed experience)? Give specific examples.

c. Do you think that newly qualified social workers are properly prepared in self-care? Motivate your answer.

5. SUGGESTIONS

a. What do you specifically suggest should be done to enhance self-care of NQSWs to curb their compassion fatigue by:

i. Training institutions?

ii. The organisations employing NQSWs?

iii. The NQSWs themselves?

ANNEXURE 2

UNIVERSITEIT•STELLENBOSCH•UNIVERSITY
jou kennisvennoot • your knowledge partner

STELLENBOSCH UNIVERSITY

CONSENT TO PARTICIPATE IN RESEARCH

You are invited to take part in a study conducted by Tanya Pretorius, from the Department of Social Work at Stellenbosch University. The result of the research will contribute to the fulfilment of a Masters Research Thesis.

You were selected as a possible participant in this study because you possess the following criteria for inclusion:

- Be a newly qualified social worker (0-24 months of working experience).
- Registered at the South African Council for Social Service Professions (SACSSP).
- Employed in South Africa at the time of the empirical study.

1. PURPOSE OF THE STUDY

The purpose of the study is to understand the compassion fatigue experienced and self-care practices employed by newly qualified social workers in South Africa. This will allow the researcher to draw conclusions and recommendations to newly qualified social workers, supervisors, managers, and tertiary education institutions.

2. WHAT WILL BE ASKED OF ME?

If you agree to take part in this study, you will be asked to describe your perception of the nature of social work for newly qualified social workers, the prevalence and symptoms of compassion fatigue, as well as express your attitude and techniques regarding self-care. This will be done in a once-off individual interview lasting roughly an hour at a preferable location.

3. POSSIBLE RISKS AND DISCOMFORTS

By volunteering to participate in the study, there is no physical threat to you. You will be responding to the interview questions in a personal professional capacity. Information shared during the interview will be gathered with respect for your worth and dignity. All interviews are regarded as confidential therefore no personal details of participants will be included in the research. There is limited risk for emotional discomfort such as embarrassment, anger, grief or hopelessness. Should the need arise, debriefing services will be made available to you at no cost by a qualified social worker. The registered social worker rendering the debriefing services, Mr Gerhard le Roux (reg. no.: 1050468), can be contacted at PROCARE, 021 873 0532.

4. POSSIBLE BENEFITS TO PARTICIPANTS AND/OR TO THE SOCIETY

The information and insight gathered after interviews with newly qualified social workers can contribute to the development of a healthier and happier newly qualified social workers in South Africa. This study may lead to a better understanding of compassion fatigue and self-care interventions that will make the social workers' work experience healthier and more fulfilling.

5. PAYMENT FOR PARTICIPATION

The involvement in this study comes without remuneration as you will not receive any payment.

6. PROTECTION OF YOUR INFORMATION, CONFIDENTIALITY AND IDENTITY

Any information that is obtained in connection with this study and that can be identified with you will remain confidential and will be disclosed only with your permission or as required by law. Confidentiality will be maintained by means of removal of identifying details for disclosure purposes. The data collected during the interview will be electronically safeguarded and password protected and will only be used by the investigator and the research supervisor.

The interview recording and identifying details will not appear anywhere in the research record. You have the right to request to view the recordings. Permission to provide access to anyone besides the investigator and research supervisor will be obtained from you if needed.

7. PARTICIPATION AND WITHDRAWAL

You can choose whether to be in this study or not. If you agree to take part in this study, you may withdraw at any time without any consequence. You may also refuse to answer any questions you don't want to answer and still remain in the study. The researcher may withdraw you from this study if it is warranted.

8. RESEARCHERS' CONTACT INFORMATION

If you have any questions or concerns about this study, please feel free to contact Tanya Pretorius at 19021569@sun.ac.za and/or the supervisor Prof. Lambert Engelbrecht at lke@sun.ac.za; 021 808 2073).

RIGHTS OF RESEARCH PARTICIPANTS

You may withdraw your consent at any time and discontinue participation without penalty. You are not waiving any legal claims, rights or remedies because of your participation in this research study. If you have questions regarding your rights as a research participant, contact Ms Maléne Fouché [mfouche@sun.ac.za; 021 808 4622] at the Division for Research Development.

DECLARATION OF CONSENT BY THE PARTICIPANT

As the participant I confirm that:

- I have read the above information and it is written in a language that I am comfortable with.
- I have had a chance to ask questions and all my questions have been answered.
- All issues related to privacy, and the confidentiality and use of the information I provide, have been explained.

By signing below, I _____ agree to take part in this research study, as conducted by Tanya Pretorius.

_____ _____

Signature of Participant **Date**

DECLARATION BY THE PRINCIPAL INVESTIGATOR

As the **principal investigator,** I hereby declare that the information contained in this document has been thoroughly explained to the participant. I also declare that the participant has been encouraged (and has been given ample time) to ask any questions. In addition, I would like to select the following option:

	The conversation with the participant was conducted in a language in which the participant is fluent.
	The conversation with the participant was conducted with the assistance of a translator (who has signed a non-disclosure agreement), and this “Consent Form” is available to the participant in a language in which the participant is fluent.

_____ _____

Signature of Principal Investigator **Date**

ANNEXURE 3

UNIVERSITEIT STELLENBOSCH UNIVERSITY

NOTICE OF APPROVAL

REC: Social, Behavioural and Education Research (SBER) - Initial Application Form

26 November 2019

Project number: 11737

Project Title: Compassion Fatigue and Self-Care: Voices of Newly Qualified Social Workers in South Africa

Dear Miss Tanya Pretorius

Your response to stipulations submitted on 13 November 2019 was reviewed and approved by the REC: Humanities.

Please note the following for your approved submission:

Ethics approval period:

Protocol approval date (Humanities)	Protocol expiration date (Humanities)
24 October 2019	23 October 2020

GENERAL COMMENTS:

Please take note of the General Investigator Responsibilities attached to this letter. You may commence with your research after complying fully with these guidelines.

If the researcher deviates in any way from the proposal approved by the REC: Humanities, the researcher must notify the REC of these changes.

Please use your SU project number (11737) on any documents or correspondence with the REC concerning your project.

Please note that the REC has the prerogative and authority to ask further questions, seek additional information, require further modifications, or monitor the conduct of your research and the consent process.

FOR CONTINUATION OF PROJECTS AFTER REC APPROVAL PERIOD

Please note that a progress report should be submitted to the Research Ethics Committee: Humanities before the approval period has expired if a continuation of ethics approval is required. The Committee will then consider the continuation of the project for a further year (if necessary)

Included Documents:

Document Type	File Name	Date	Version
Budget	19021569 Budget	01/10/2019	1
Letter of support_counselling	19021569 Debriefing	01/10/2019	1
Data collection tool	19021569 Themes for Interview Schedule	01/10/2019	1
Default	Pretorius T DESC Form	01/10/2019	01/10/2019
Research Protocol/Proposal	19021569 Research Proposal REC 2	13/11/2019	2
Informed Consent Form	19021569 Informed Consent 2	13/11/2019	2
Default	19021569 RESPONSE LETTER PROJECT 11737	13/11/2019	1

If you have any questions or need further help, please contact the REC office at cgraham@sun.ac.za.

Sincerely,

Clarissa Graham

REC Coordinator: Research Ethics Committee: Human Research (Humanities)

UNIVERSITEIT STELLENBOSCH UNIVERSITY

NOTICE OF APPROVAL

REC: SBER - Amendment Form

4 May 2020

Project number: 11737

Project Title: Compassion Fatigue and Self-Care: Voices of Newly Qualified Social Workers in South Africa

Dear Miss Tanya Pretorius

Co-investigators:

Your REC: SBER - Amendment Form submitted on 17 April 2020 was reviewed and approved by the REC: Social, Behavioural and Education Research (REC: SBE).

Please note below expiration date of this approved submission:

Ethics approval period:

Protocol approval date (Humanities)	Protocol expiration date (Humanities)
24 October 2019	23 October 2020

GENERAL COMMENTS:

1) There is currently a **postponement of all research activities at Stellenbosch University,** apart from research that can be conducted remotely/online and requires no human contact, and research in those areas specifically acknowledged as essential services by the South African government under the presidential regulations related to COVID-19 (e.g. clinical studies).

2) Remote (desktop-based/online) research activities, online analyses of existing data, and the writing up of research results are strongly encouraged in all SU research environments.

Please take note of the General Investigator Responsibilities attached to this letter. You may commence with your research after complying fully with these guidelines.

If the researcher deviates in any way from the proposal approved by the REC: SBE, the researcher must notify the REC of these changes.

Please use your SU project number (11737) on any documents or correspondence with the REC concerning your project.

Please note that the REC has the prerogative and authority to ask further questions, seek additional information, require further modifications, or monitor the conduct of your research and the consent process.

FOR CONTINUATION OF PROJECTS AFTER REC APPROVAL PERIOD

You are required to submit a progress report to the REC: SBE before the approval period has expired if a continuation of ethics approval is required. The Committee will then consider the continuation of the project for a further year (if necessary).

Once you have completed your research, you are required to submit a final report to the REC: SBE for review.

Included Documents:

If you have any questions or need further help, please contact the REC office at cgraham@sun.ac.za.

Sincerely,

Clarissa Graham

REC Coordinator: Research Ethics Committee: Social, Behavioral and Education Research

ANNEXURE 4

REFLEXIVITY REPORT

Gilgun (2006) defines reflexivity as the intentional self-awareness regarding the reciprocal influence of the researcher-participant relationship during the research process. Oliphant and Bennett (2020) clarify that this creates a means through which the researcher's background, experiences, emotions, values and biases are not ignored or neutralised. Rather, these factors are regarded as important variables that contribute to the process of co-constructing knowledge. Moreover, it can be described as "[becoming] aware of [one's] own projections, attachments, assumptions, agendas, and biases—like an eye that sees itself while simultaneously seeing the world" (Probst, 2015:38). Consequently, Ruokonen-Engler and Siouti (2016) deem biographical reflexivity in narrative research a useful approach to reflect the meaning of one's own entanglements in a research process. To this end, they offer six questions for the researcher to explore their reflexivity, which will be addressed below .

1. **What personal experience do I have with my research topic?**

At the time of embarking on this master's thesis, I was a newly qualified social worker who had recently graduated with an honours degree. Coinciding with my research, I started working part-time as a private practising social worker. I encountered the same transitional and working challenges as those identified by the research participants, and also experienced compassion fatigue.

2. **How did I come to study the specific topic in the field?**

This topic is a professional and personal interest I developed as I started studying social work. After conducting more research to construct the initial literature review, it became apparent that the compassion fatigue experienced by newly qualified social workers is neglected even though it is evident that there are significant challenges relating to the transition from student to professional. In addition to this disparity between experience and need, the specific topic of self-care became a buzzword during the course of my undergraduate studies. The relationship between the two concepts were thus combined to comprise the focus of this study, rendering it relevant and contemporary.

3. **What is my relationship to the topic being investigated?**

At the time of conducting the study, I was a newly qualified social worker with less than 24 months of working experience. The feeling that social work was taking a toll was intensified once I started working as a private practising social worker. I felt anxious and uncertain about what I was doing and whether I was doing it correctly. The sudden uncertainty decreased my self-confidence and meant that I was nervous and doubtful when working with clients, which became tiring as I also had to feel and show a considerable amount of empathy. The compassion fatigue of a newly qualified social worker was thus something that I experienced first-hand.

4. **How did I gain access to the field?**

I gained access to the participants using my own professional network. I was a newly qualified social worker, and thus knew many other newly qualified social workers who studied with me. Many of my peers who were already employed at the time of data collection were willing to participate in the research study and were also eager to recommend and refer other possible participants who fit the research requirements.

5. **How does my own position (age, gender, class, ethnicity, economic status, etc.) influence interaction in the field and the data collection process?**

As I conducted my master's study directly after graduating while simultaneously being employed as a newly qualified social worker, I was both in the same position as the research participants, as well as the same age. Being in the position where I could identify with the participants allowed me to show empathy during interviews which encouraged data collection, as participants were open to sharing personal and sensitive details.

6. **What is my interpretation perspective?**

During data analysis it became evident that I took on a subjective perspective, as I noticed agreeing with, enjoying, and even judging narratives. This is due to my perspective being embedded within the research process as opposed being to fully detached from it. As a result, I had to consciously analyse narratives and use member checking to ensure that I was unbiased.