cetc: centre for excellence in therapeutic care

:practice

Secondary Traumatic Stress and Staff Well-being:

Understanding compassion fatigue, vicarious trauma and burnout in therapeutic care

cetc.org.au

The Centre for Excellence in Therapeutic Care is a partnership between the Australian Childhood Foundation and Southern Cross University. The Centre integrates up to date research evidence with cultural knowledge, practice wisdom and the voices of young people in care to produce reports, practice resources and training to support the provision of high quality, evidence informed therapeutic care.

Suggested citation: Macnamara, N. (2022). Practice Guide: Secondary Traumatic Stress and Staff Well-being: Understanding compassion fatigue and vicarious trauma in therapeutic care. Centre for Excellence in Therapeutic Care: (2nd Edition) Sydney NSW.

The Centre for Excellence in Therapeutic Care is a division of the Australian Childhood Foundation.

Table of Contents

Purpose of this guide

This guide has been developed to support organisational congruence and in the provision of trauma-informed therapeutic care and the critical need for a well-supported, capable and stable staff group to deliver this vision.

Effective therapeutic care is situated within a relationship-based approach to practice. Thus the health and well-being of staff involved in this work is central to their ability to engage in relationships of care that have a therapeutic intent.

This guide provides staff and managers with information about secondary traumatic stress, vicarious trauma, compassion fatigue and burnout. It describes organisational, client-related and personal risk and protective factors and provides strategies for assessing and addressing staff support and well-being.

Key Messages

The care of children and young people who have experienced trauma is complex and challenging work. The development of secondary traumatic stress, vicarious trauma, compassion fatigue and burnout is recognised as a common occupational hazard for staff and carers looking after traumatised children and young people.

Organisational variables such as lack of role clarity and high client demands combined with insufficient supervision with little feedback and reduced opportunity to participate in decision making can lead to increased risk of burnout among staff and carers.

There are many personal risk and protective factors that play an important role in the susceptibility for burnout, compassion fatigue, secondary traumatic stress and vicarious trauma.

Vicarious trauma, compassion fatigue and secondary traumatic stress can be resolved successfully with self-care practices and/or professional support should staff and carers experience them. There are a range of effective strategies that organisations and individuals that can be used to assess and support staff well-being.

Introduction

> ***Milton Erickson used to say to his patients, "My voice will go with you." His voice did. What he did not say was that our clients' voices can also go with us. Their stories become part of us – part of our daily lives and our nightly dreams. Not all stories are negative - indeed, a good many are inspiring. The point is that they change us.***
>
> (Mahoney, 2003, p. 195).

The development of secondary traumatic stress is recognised as a common occupational hazard for professionals working with traumatised children and young people. Studies show that from 6% to 26% of therapists working with traumatised populations, and up to 50% of child welfare workers, are at high risk of secondary traumatic stress or the related conditions of PTSD and vicarious trauma.

There is little research looking at vicarious trauma or secondary traumatic stress in staff who care for and support children and young people in therapeutic care yet these are environments where staff are routinely exposed to the manifestations of developmental trauma in the children and young people for whom they care. As such, research from areas close to this, such as mental health, must then be extrapolated to enhance an understanding of the impact of working with this traumatised group.

The care of children and young people with trauma is complex and challenging work

Children and young people are usually placed in therapeutic care because of the complex and challenging nature of their needs and behaviours. Their behaviours can be aggressive, destructive, or disturbing (Frensch, Cameron, and Adams, 2003) and may include self-harm, running away, suicide attempts, verbal escalation, and physical assaults (Seti, 2007). This can make the task of caring for this group complex and demanding (Braxton, 1995). The care environment can become volatile and threatening - for both the staff, children and young people (Kindy et al, 2005; Weaks, 1999).

Underlying the behaviours of children and young people are almost always histories of severe developmental trauma, often in the form of physical, sexual, emotional abuse, and/or neglect (Brendtro, 2004; van Beinum, 2008). Anglin, 2002 (p.110) put it this way:

> ***with such chronic psycho emotional being carried within, these young people become veritable time-bombs for those attempting to relate and work with them.***

These children and young people may have experienced years of humiliation, degradation, chaos, threat, and fear; they have been “incubated in terror” (Perry and Szalavitz, 2006). The lifetime of hurt and pain that they carry with them is reflected in their behaviour (Anglin, 2002). As so eloquently stated by Crenshaw and Garbarino (2007, p. 160)

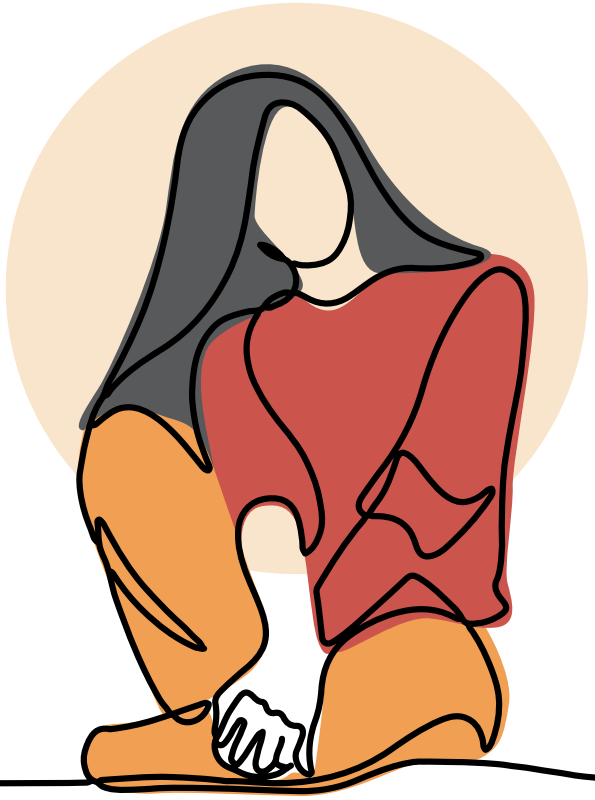
> ***this deep reservoir of unrequited sorrow is the smouldering emotional underbelly to the violence.***

Working with children and young people’s distress and turmoil can take its toll on care and support staff (Kahn, 2005) even in well-functioning teams (Anglin, 2002; Smith, 2009). Being exposed to their pain can leave staff at risk of developing secondary traumatic stress or vicarious trauma (Collins and Long, 2003; Figley, 1995) and compassion fatigue (Seti, 2007). The symptoms of which can include extreme helplessness, victim blaming, emotionally distancing oneself from clients, over-identification with clients (Collins and Long, 2003), anxiety, depersonalisation, and pessimism (Osofsky et al, 2008).

As reflected by Mattingly (1981),

> ***…no matter how skilled and sophisticated the worker, a kick in the shins, broken glasses, an insult, and a child’s lack of progress are all assaults on self-esteem which threaten workers’ perceptions of their helping ability.*** (p. 154).

The expectation that staff and carers should always know what to do or how to respond in the most challenging of situations is referred to by Anderson-Nathe (2010) as "the myth of supercompetence." Subsequently, when staff and carers experience moments of "stuckness," of not knowing what to do, they can become mired in self-doubt, shame, and feelings of inadequacy (Anderson-Nathe, 2010).



Therapeutic care staff are required to develop caring relationships with the children and young people with no expectation that these relationships be reciprocated (Garfat, 1998; Mann-Feder, 1999). Although this is considered to be fundamental to effective practice, it is also purported to be one of the greatest challenges (Smith, 2009). The pervasive frustration and anxiety that can be experienced by the staff and carers, coupled with the entrenched emotional distress of children and young people, often results in power struggles and "counter-aggression" (Brendtro and Ness, 1983) between the two groups.

Children and young people in therapeutic care require responsive caregiving by adults attuned to their needs. When this does not occur the care environment, rather than being therapeutic, can become unhealthy, dysfunctional, and negatively impact on their development and future trajectories. According to Anglin (2004):

> ***Perhaps more than any other dimension of the care work task, the ongoing challenge of dealing with such primary pain without unnecessarily inflicting secondary pain experiences on the residents through punitive or controlling reactions can be seen to be the central problematic for the care work staff.*** (p. 178)

The care of children and young people who have experienced trauma is complex and challenging work. Yet, sometimes, the complexity is unrealised and the care provided is pared down to the most basic elements – managing behaviours, attending to immediate needs with a risk of an increasingly punitive approach emerging in practice. In many programs, conversation and intervention can be superficial and focused almost exclusively on the concrete events of daily living (Anglin, 2002) and the cooperation, or lack thereof, of children and young people (Fox, 1987).

Another common problem that exists in therapeutic residential care is the tendency of some staff to over-identify with children and young people, become over-involved, and experience a loss of perspective (Eisikovits, 1997). This often goes together with difficulties setting limits and maintaining boundaries. Konopka, more than fifty years ago, described the ongoing tension in group care between all-out permissiveness and total control – both of which can be equally damaging – and the difficulties associated with helping front-line staff to maintain an appropriate balance between the two (Konopka, 1954). These problems still exist today.

Practice Reflections

Take a moment

What led you to this work?

What are the rewards of your work?

Trauma Exposure Response: Not “if” but “when”

> ***The expectation that we can be immersed in suffering and loss and not be touched by it is as unrealistic as expecting to walk through water without getting wet.***
>
> (Remen, 1996)

The impact on staff and carers working with traumatised children and young people is variously referred to as secondary traumatic stress, vicarious trauma, compassion fatigue and burnout.

Secondary Traumatic Stress

Secondary traumatic stress is a set of observable reactions to working with traumatised people and mirrors the symptoms of post-traumatic stress disorder. Rather than the source of trauma emanating from an event directly, it comes to us indirectly.

Signs of secondary traumatic stress

- Intrusive thoughts
- Chronic fatigue
- Sadness
- Anger
- Poor concentration
- Second guessing
- Detachment
- Emotional exhaustion
- Fearfulness
- Shame
- Physical illness
- Absenteeism

Vicarious Trauma

Vicarious trauma is defined as the process of change that happens because you care about other people who have been hurt, and feel committed or responsible to help them. Over time this process can lead to changes in your psychological, physical, and spiritual well-being. Vicarious trauma and Secondary Traumatic Stress are frequently used interchangeably.

PHYSICAL SIGNS	BEHAVIOURAL SIGNS	EMOTIONAL – PSYCHOLOGICAL SIGNS
Exhaustion	Increased use of alcohol and drugs	Emotional exhaustion
Insomnia	Anger and Irritability at home and/or at work	Negative self-image
Headaches	Avoidance of clients/patients	Depression
Increased susceptibility to illness	Watching excessive amounts of TV at night	Increased anxiety
Sore back and neck	Consuming high trauma media as entertainment	Difficulty sleeping
Irritable bowel, gastrointestinal distress	Not returning phone calls at work and/or at home	Impaired appetite or binge eating
Rashes, breakouts	Avoiding colleagues and staff gatherings	Feelings of hopelessness
Grinding your teeth at night	Avoiding social events	Guilt
Heart palpitations	Impaired ability to make decisions	Reduced ability to feel sympathy and empathy towards clients or family/friends
Hypochondria	Feeling helpless when hearing a difficult client story	Cynicism at work
	Impostor syndrome – feeling unskilled in your job	Anger at work
	Problems in personal relationships	Resentment of demands being put on you at work and/or at home
	Difficulty with sex and intimacy due to trauma exposure at work	Dread of working with certain client's certain case files
	Thinking about quitting your job	Diminished sense of enjoyment/ career (i.e., low compassion satisfaction)
	Compromised care for clients/ patients	Depersonalisation – spacing out during work or the drive home
	Engaging in frequent negative gossip/venting at work	Disruption of world view/ heightened anxiety or irrational fears
	Impaired appetite or binge eating	Intrusive imagery
		Hypersensitivity to emotionally charged stimuli
		Insensitivity to emotional material/ numbing
		Difficulty separating personal and professional lives
		Failure to nurture and develop non-work related aspects of life
		Suicidal thoughts

Compassion Fatigue

Compassion Fatigue is defined as the overall experience of emotional and physical fatigue that social service professionals experience due to chronic use of empathy when treating people who are suffering in some way (Smullens, 2012; Weaks, 1999). Compassion Fatigue can occur due to exposure on one case or can be due to a "cumulative" level of trauma.

Signs of Compassion Fatigue

- Nervous system arousal (Sleep disturbance)
- Emotional intensity increases
- Cognitive ability decreases
- Behaviour and judgment impaired
- Isolation and loss of morale
- Depression and PTSD
- Loss of self-worth and emotional modulation
- Identity, worldview, and spirituality impacted
- Beliefs and psychological needs-safety, trust, esteem, intimacy, and control
- Loss of hope and meaning=existential despair
- Anger toward perpetrators or causal events

It is important to recognise that vicarious trauma, compassion fatigue and secondary traumatic stress can be resolved successfully with self-care practices and/or professional support should staff experience them. The role of supervision is critical within this area.

Burnout

The term "burnout" was coined in the 1970s by the American psychologist Herbert Freudenberger. He used it to describe the consequences of severe stress and high ideals in "helping" professions.

Psychological burnout is a well-established consequence of work stress - states of emotional, mental, and physical exhaustion caused by excessive and prolonged stress (Smullens, 2012). Burnout is defined by the presence of three primary features—exhaustion, cynicism, and inefficacy—that emerge over time in response to chronic emotional and interpersonal work stressors (Maslach et al, 2001).

Among helping professionals, burnout is often characterised by poor boundaries, feelings of guilt, and low energy or depression (eg. Lonne, 2003). Although burnout affects staff in all professions and occupations, burnout is especially prevalent among human service workers (Lloyd et al, 2002; Lonne, 2003; Maslach et al, 2001; Anderson, 2000). For example, in a randomised sample of social workers (N = 751), 39% of respondents reported current burnout and 75% of the social workers reported having experienced burnout at some point in their careers (Siebert, 2005).

There are three main areas considered to be signs of burnout:

- **Exhaustion:** People affected feel drained and emotionally exhausted, unable to cope, tired and down, and do not have enough energy. Physical symptoms include things like pain and stomach or bowel problems.
- **Alienation from (work-related) activities:** People who have burnout find their jobs increasingly stressful and frustrating. They may start being cynical about their working conditions and their colleagues. At the same time, they may increasingly distance themselves emotionally, and start feeling numb about their work.
- **Reduced performance:** Burnout mainly affects everyday tasks at work, at home or when caring for family members. People with burnout are very negative about their tasks, find it hard to concentrate, are listless and lack creativity.

Research specific to human services has suggested a combination of imbalanced organisational variables—such as lack of role clarity and high client demands combined with insufficient supervision with little feedback and reduced opportunity to participate in decision making—can lead to increased risk of burnout among staff (Lloyd et al, 2002; Lonne, 2003; Maslach et al, 2001).

A qualitative study by Iliffe and Steed (2000) vividly captured experiences of burnout and secondary traumatic stress among counsellors working with domestic violence victims and perpetrators. Respondents described feeling horrified, upset (physically and emotionally), and drained by the stories clients related to them, and many counsellors found it difficult to “shake” certain images. Moreover, repeated exposure to stories of brutality was also shown to lead to cognitive changes among staff, such as feeling less safe and more wary around people; having increased awareness of power and control issues; and becoming more distrustful of others, particularly men (Iliffe and Steed, 2000). In addition, the counsellors reported experiencing increased feelings of fear, isolation from colleagues, family, and friends who lacked an understanding of domestic violence and powerlessness in dealing with the human service and criminal justice systems.

All staff and carers who work with children and young people in therapeutic care are at risk for experiencing vicarious traumatisation, secondary traumatic stress, or compassion fatigue as a result of the cumulative effect of caring for these traumatised individuals (Figley, 1995; Pearlman and Saakvitne, 1995).

Practice Reflections

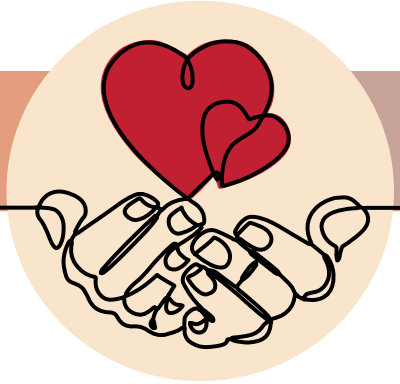
The Self Care Gauge

Write down 3 warning signs that you are getting overloaded with stress (could be physical, emotional or behavioural):

1.

2.

3.



Risk and protective factors for staff and carers well-being

There is an abundance of organisational (Table 1), client-related, and personal factors (Table 2) that have been shown in research to operate as risk or protective factors for staff and carers in relation to the experience of burnout, compassion fatigue, secondary traumatic stress and vicarious trauma. Oftentimes, it is a compilation of one or many of these factors that cause staff distress. The goal should be to increased awareness within therapeutic care services to mitigate the risk factors that these experiences have on children, young people, staff, carers and the broader organisation.

Table 1. Organisational Risk and Protective Factors

RISK	PROTECTIVE
Lack of role clarity for staff	Good staff support and supervision including the opportunity to reflect on the impact of the work with supervisors
High client demands	Staff training, induction and orientation processes for staff
Insufficient supervision	Support from co-workers/team
Little feedback on performance	Support from family and friends
Few opportunities to participate in decision making	Meaningful processes that are consistently applied for staff to feel a sense of ownership of decisions that impact themselves and/or the young people
High/excessive workloads (hours, complexity, number of demands)	Well-balanced and manageable workload with commitment to work-life balance
Lack of autonomy	Support to develop and grow in the role
Insufficient control over resources needed to accomplish role	Clear processes for decision making and strong channels for communication about the rationale for decisions
Lack of staff recognition	Reward and recognition for work contributions i.e. financial, social, intrinsic)
Disconnected staff, lacking in team environment	Strong team culture
Perceived lack of fairness (inequity of workload or salary, lack of openness and respect regarding decision making)	Inclusive workplace with strong communication processes and staff engagement in the culture of the organisation
Poorly aligned values, priorities and ethics between organisation and staff	High levels of organisational congruence and openness to regularly review systems and processes
Lack of access to external supports for staff where required	Provision of external supports such as Employee Assistance Programs, external supervision for staff
Low levels of interagency collaboration re clients	Strong culture of collaboration and joint working

(Lloyd et al., 2002; Lonne, 2003; Maslach et al., 2001; Cordes and Dougherty, 1993; Lee and Ashforth, 1993; Lloyd et al, 2002; Barak et al, 2009; Ray et al, 2013; Brady et al, 1999; Osofsky, 2011; Braley, 2010; Neuman and Gamble, 1995; Choi, 2011; Lonergan et al, 2004; Pistorius, 2006; Van Deusen and Way, 2006; McElvaney and Tatlow-Golden, 2016).

Client-Related Risk Factors

Working with high need children and young people with trauma can be extremely emotionally, physically, and psychologically demanding for workers and carers.

Therapeutic care staff and carers can experience frequent crisis situations and escalations with children and young people which often involve them displaying a range of concerning, challenging and aggressive behaviour. In their study, Vassos and Nankervis (2012) found that the challenging behaviours of clients was a major predictor of all three dimensions of burnout (exhaustion, cynicism, and depersonalisation) and fear in staff.

Personal Risk and Protective Factors

There are many personal risk and protective factors that play an important role in the susceptibility for burnout, compassion fatigue, secondary traumatic stress and vicarious trauma such as personality type, age, culture, personal history, work experience, and self-care strategies (Cieslak et al, 2014; Cheng, et al, 2013; Knight, 2013; Meyer et al, 2014; Ray et al, 2013; Lakin et al, 2008).

A meta-analysis of the relationship of personality variables with burnout found each of the following variables were negatively related to burnout: self-esteem, self-efficacy, internal locus of control, emotional stability, extraversion, conscientiousness, agreeableness, positive affectivity, optimism, proactive personality, and hardiness (Alarcon et al, 2009).

Table 2. Personal risk and protective factors

RISK	PROTECTIVE
Low levels of education/socioeconomic status	Relevant qualifications and ongoing professional development
Inexperience in the workplace	More experienced in the workplace, access to mentoring/buddy systems
History of trauma in own life	Has been able to process own trauma history
Over identification with the clients due to own history	Able to maintain appropriate boundaries
Reluctance to ask for support	Seeks support appropriately
Perfectionism, high need for approval	Sets reasonable expectations for self
Low self esteem	Strong sense of self
Low level of self-reflection	Good reflective capacity
Passive or negative coping styles	Resilient
Few self-care strategies	Range or regularly used self-care strategies
Poor diet	Good nutrition
Poor limit setting on work-life balance, few planned breaks/holidays	Good work- life balance, regular breaks/holidays
Few social/family supports	Supportive network of family and friends
Few interests outside of work	Actively engaged in a range of interests

(Cieslak et al, 2014; Cheng, et al, 2013; Knight, 2013; Meyer et al, 2014; Lakin et al, 2008; Sepulveda, 2003; de Figueiredo, et al, 2014; Ray et al, 2013; Brady et al, 1999; Lonergan et al, 2004; McElvaney and Tatlow-Golden, 2016; Motta, 2012; Osofsky, 2011; Neuman and Gamble, 1995; Weaks, 1999; Sprang et al, 2011; Anderson, 2000; Maslach et al, 2001; Siebert, 2005).

Practice Reflections

Self-Assessment

Review these questions. You may choose to do this with a trusted and supportive colleague/supervisor.

"How am I doing?"

"What do I need?" "What would I like to change?"

"What is hardest about this work?"

"What worries me most about my work?"

"How have I changed since I began this work? Both positively, and perhaps, negatively?"

"Am I experiencing any signs of burnout, secondary traumatic stress, compassion fatigue or vicarious trauma?" (See the list above)

"What am I doing and what have I done to address these?"

"As I think of my work with children and young people what are my specific goals? How successful am I in achieving these goals?"

"What is my sense of personal accomplishment in my work?"

"What work barriers get in the way of my having more satisfaction and how can these barriers be addressed?

"What am I going to do to take care of myself?"

"How can I keep going as a person while working with traumatised children and young people?"

"How can I use social supports more effectively?" Draw a picture (web-diagram of your social supports on the job (colleagues) and in non-job related areas (family, friends etc)

"Is there anything about my work experience or other stressful events in my life that I have not told anyone, that is 'unspeakable', that I have kept to myself (a secret)?" (Try putting it into words, such as, "I haven't' shared it because …" or "I am very hesitant to share it because …" What is the possible ongoing impact, toll, emotional price of not sharing and working through these feelings?)

"Is there anything about my stress experience that I keep from myself?

An area or an event that I have pushed away or kept at arm's length from myself? Or about which I say to myself, 'I can't handle that."? What aspect of my life have I not put into words yet, that is still lurking in that corner of my mind that I have not considered yet?"

Create Positive Habits

- It takes 3 weeks for a change in behaviour to become a habit
- Changes in habit change the way your brain functions
- Replace negative coping mechanisms with sustainable positive habits

(Achor, 2010)

Assess your own level of Compassion Fatigue

If would you like to assess your current level of Compassion Fatigue, Stamm and Figley developed the Proqol (Professional Quality of Life) Self-test. The test is the gold standard measure in the field at this time.

The Professional Quality of Life scale (PROQOL) is free, easy to use and measures two aspects of compassion fatigue: secondary traumatic stress and burnout. The scale can be accessed here: https://proqol.org/proqol-measure.

Completing the tool is a great way to support self-awareness and reflection in - two qualities linked to reduced levels of burnout, compassion fatigue, secondary traumatic stress and vicarious trauma. An added benefit of this tool is that it also measures a positive aspect of work called compassion satisfaction - the satisfaction people get from helping and caring for other people.

Organisational approaches to supporting staff

There are a number of steps that managers can take to help create an inclusive, supported and resilient workplace.

Step 1. Acknowledge and make a commitment to address burnout, compassion fatigue, secondary traumatic stress and vicarious trauma in the workplace

Acknowledge that burnout, compassion fatigue, secondary traumatic stress and vicarious trauma are an occupational hazard. Foster open conversations about it. It can be such a relief for staff to know that there is a name out there for what they are experiencing. It's even more of a relief for staff to know that they aren't the only ones experiencing difficulties.

Make a formal commitment to staff that managers will take steps to manage this hazard in the workplace. Open the channels of communication and ask staff for ideas and suggestions on what conditions or policies they think need to be changed or implemented. A caution here is that it may not be possible to implement all staff suggestions. For example, a suggestion may be to hire more staff which may not be possible with current resources. If this is the case, then managers can acknowledge the suggestion and explain reasons why this is not feasible. An alternative may then be offered.

Step 2. Taking stock: Measure levels of compassion fatigue in the workplace

A necessary part of this first step involves taking stock. What are the current levels of compassion fatigue in the workplace?

If your workplace is experiencing the following, burnout, compassion fatigue, secondary traumatic stress and vicarious trauma may be at high levels.

- High staff turnover
- High levels of absenteeism
- High levels of staff disagreements
- Low morale
- Low productivity
- High rate of WorkCover claims

Managers may wish to have open discussions with staff about their experiences of burnout, compassion fatigue, secondary traumatic stress and vicarious trauma in an informal manner. Staff meetings, workshops or one to one discussions may present further opportunities to open the discussion, however safety of the group setting is important in supporting these conversations.

Ask staff to monitor their own levels of compassion fatigue using the Professional Quality of Life scale (PROQOL) https://proqol.org/ProQol_Test.html.

Step 3. Reduce demands

Understandably, it may not be feasible to decrease the workload for staff; however, it is possible to reduce the demands associated with their work.

- Think about the emotional demands associated with caregiving. Decreasing the frequency and duration of particular tasks that are emotionally draining can stop stress before it starts and halt burnout in its tracks
- Use job task rotations across staff where possible (for example, on the same timeline that shifts are scheduled) to spread the burden of emotionally demanding or time-consuming tasks
- Rotate staff through brief breaks during high-demand work cycles to give them time to relax, recharge, and refocus. Even a short break can help reduce feelings of pressure at work and keep employees from getting in a rut or pattern of compassion fatigue. Ensure staff take annual leave
- Autonomy can go a long way toward reducing stress, so when possible, allow staff some latitude in deciding how often they perform emotionally demanding tasks, listen to and implement suggestions from staff, seeking regular feedback and offering flexible work hours

Step 4. Increase resources

Where demands cannot be reduced, increasing personal and job-related resources should be a top priority. These resources can include job resources like supervisor coaching and autonomy as well as personal resources like self-esteem and optimism.

PERSON-RELATED RESOURCES

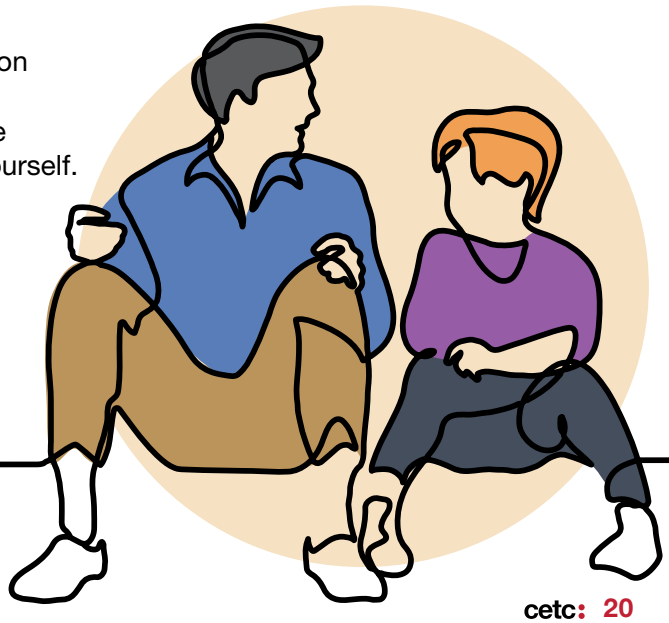
- **Supervision and consultation** has been found to be an important supportive factor for staff to help mitigate and alleviate symptoms. It is a supervisor's responsibility to encourage staff to talk openly about their thoughts, feelings, and actions regarding children and young people, especially the ones that they would most like to keep secret
- **Supportive work environments** have also been found to play a critical role in helping staff to combat and relieve symptoms of burnout, compassion fatigue, secondary traumatic stress and vicarious trauma
- **Employee wellness programs:** Offer staff the opportunity to learn ways to recharge their batteries and relax through programs like yoga and mindfulness meditation
- **Provide coaching:** Positive feedback from management can be a powerful motivator for staff. It shows them that their efforts are recognised and appreciated. Make sure it's personal and genuine
- **Peer support:** Encourage staff to support each other. This can be done informally through briefings over lunch or formally via peer support groups

JOB-RELATED RESOURCES

- **Set clear goals and rewards:** Goals can be set in partnership with staff as a means of fostering a sense of accomplishment
- **Upskilling staff:** Train staff in other areas of the workplace so they can have variety in their role where possible

The management of compassion fatigue, burnout, secondary traumatic stress and vicarious trauma at the organisational level takes time, so patience is required. The key to successful management is good communication with staff. Although it may take some time finding a solution that fits everyone, doing so is well worth the effort.

Most importantly, look after yourself. Managers and Therapeutic Specialists are not immune to compassion fatigue and secondary traumatic stress. Remember, you need to take care of yourself before you can take care of others. So, lead by example and look after yourself.



Useful links and resources

Professional Quality of Life Scale (PROQOL), https://proqol.org/ProQol_Test.html

Skovholt, M. (2014). **Skovholt Practitioner Professional Resiliency and Self-Care Inventory** https://wh1.oet.udel.edu/pbs/wp-content/uploads/2017/07/Skovholt-Practioner-Professional-Resiliency.pdf

Richardson, C. (1999). **Life/work balance self-test: What's Draining You?** http://vuir.vu.edu.au/1461/1/Crozier.pdf

Compassion Fatigue Awareness Project www.compassionfatigue.org/

Intro to Vicarious Trauma https://www.youtube.com/watch?v=A1i7m1By8Nw Dr. Gabor Maté presents an in-depth analysis of vicarious trauma – including definitions, myths, and realities of trauma and vicarious trauma, as well as the sources and triggers for stress, its physiology, and how to release it.

Staff Performance and Retention: Using a Trauma Lens https://www.youtube.com/watch?v=5B7qNg_H2UU This webinar explores what secondary traumatic stress is, why it matters to agency leaders, and how you can address this critical workforce issue.

Teater, M. and Ludgate, J. (2014). **Overcoming Compassion Fatigue: A practical resilience workbook.** PESI

van Dernoot Lipsky, L. and Burk, C. (2009). **Trauma Stewardship: An everyday guide caring for self while caring for others.** Berrett-Koelher.

Saakvitne, K. and Pearlman, L. (1999). **Transforming the Pain: A Workbook on Vicarious Traumatization.** Norton.

References

Alarcon, G. M. (2011). A meta-analysis of burnout with job demands, resources, and attitudes. *Journal of Vocational Behaviour,* 79(2), 549-562.

Alarcon, G., Eschleman, K. J., and Bowling, N. A. (2009). Relationships between personality variables and burnout: A meta-analysis. *Work & Stress: An International Journal of Work, Health & Organisations,* 23, 244-263.

Anderson, D. G. (2000). Coping strategies and burnout among veteran child protection workers. *Child Abuse & Neglect,* 24, 839-848.

Barak, M. E. M., Travis, D. J., Pyun, H., and Xie, B. (2009). The impact of supervision on worker outcomes: a meta-analysis. *Social Service Review,* 83, 3-32.

Bishop, S. and Schmidt, G. (2011), "Vicarious traumatization and transition house workers in remote, northern British Columbia communities", *Rural Society,* Vol. 21 No. 1, 65-73.

Cheng, Y., Chen, I., Chen, C., Burr, H., and Hasselhorn, H. (2013). The influence of age on the distribution of self-rated health, burnout, and their associations with psychosocial work conditions. *Journal of Psychosomatic Research,* 74, 213-220.

Cieslak, R., Shoji, K., Douglas, A., Melville, E., Luszczynska, A., and Benight, C. (2013). A meta-analysis of the relationship between job burnout and secondary traumatic stress among workers with indirect exposure to trauma. *Psychological Services,* 11(1), 75-86.

Cordes, C. L., and Dougherty, T. W. (1993). A review and an integration of research on job burnout. *Academy of Management Review,* 18(4), 621-656.

Creamer, T.L. and Liddle, B.J. (2005). "Secondary traumatic stress among disaster mental health workers responding to the September 11 attacks", *Journal of Traumatic Stress,* Vol. 18 No. 1, 89-96.

de Figueiredo, S., Yetwin, A., Sherer, S., Radzik, M., and Iverson, E. (2014). A cross-disciplinary comparison of perceptions of compassion fatigue and satisfaction among service providers of highly traumatized children and adolescents. *Traumatology: An International Journal.*

Figley, C. R. (1995). *Compassion fatigue: coping with secondary traumatic stress disorder in those who treat the traumatized* (Psychosocial Stress Series) (Kindle Locations 450-455). Taylor and Francis. Kindle Edition.

Figley, C. R. (2002). Compassion fatigue: psychotherapists' chronic lack of self-care. *Psychotherapy in Practice,* 58(11), 1433-1441.

Iliffe, G., and Steed, L. G. (2000). Exploring the counselor's experience of working with perpetrators and survivors of domestic violence. *Journal of Interpersonal Violence,* 15, 393-412.

Knight, C. (2013). Indirect trauma: implications for self-care, supervision, the organization, and the academic institution. *The Clinical Supervisor,* 32(2), 224-243.

Lakin, B., Leon, S., and Miller, S. (2008). Predictors of burnout in children's residential treatment center staff. *Residential Treatment for Children & Youth,* 25(3), 249-270.

Lee, R. T., and Ashforth, B. E. (1993). A meta-analytic examination of the correlates of the three dimensions of job burnout. *Journal of Applied Psychology,* 81, 123-133

Li, A., Early, S., Mahrer, N., Klaristenfeld, J., and Gold, J. (2014) Group cohesion and organizational commitment: protective factors for nurse residents job satisfaction, compassion fatigue, compassion satisfaction, and burnout. *Journal of Professional Nursing,* 30(1), 89-99.

Lloyd, C., King, R., and Chenoweth, L. (2002). Social work, stress, and burnout: A review. *Journal of Mental Health,* 11, 255-265.

Lonne, B. (2003). Occupational stress in human services. In M. Dollard, A. Winefield, & H. Winefield (Eds.), *Occupational stress in the service professions* (281-310). London, UK: Taylor & Francis.

McLindon, E., and Harms, L. (2011). Listening to mental health workers' experiences: factors influencing their work with women who disclose sexual assault. *International Journal of Mental Health Nursing,* 20(1), 2-11

Maslach, C., Schaufeli, W., & Leiter, M. (2001). Job burnout. *Annual Review of Psychology,* 52, 397-422.

Ray, S., Wong, C., White, D., and Heaslip, K. (2013) Compassion satisfaction, compassion fatigue, work life conditions, and burnout among frontline mental health care professionals. *Traumatology,* 19(4), 255-267.

Riches, V., Harman, A., Keen, D., Pennell, D., Harley, J., and Walker, M. (2011). Transforming staff practice through active support. *Journal of Intellectual and Developmental Disability,* 36(3), 156-166.

Rose, J., Mills, S., Silva, D., & Thompson, L. (2013). Client characteristics, organizational variables and burnout in care staff: The mediating role of fear of assault. *Research in Developmental Disabilities,* 34(3), 940-947.

Sepulveda, M. M. (2003). *Compassion fatigue, burnout, and compassion satisfaction among residential child care workers.* Unpublished PhD Thesis.

Siebert, D. C. (2005). Personal and occupational factors in burnout among practicing social workers: Implications for researchers, practitioners, and managers. *Journal of Social Service Research,* 32, 25-44.

Vassos, M. V., and Nankervis, K. L. (2012). Investigating the importance of various individual, interpersonal, organisational and demographic variables when predicting job burnout in disability support workers. *Research in Developmental Disabilities,* 33(6), 1780-1791.

Wagaman, M.A., Geiger, J.M., Shockley, C. and Segal, E.A. (2015), "The role of empathy in burnout, compassion satisfaction, and secondary traumatic stress among social workers", *Social Work,* Vol. 60 No. 3, 201-09.

Weaks, K.A. (1999), *"Effects of treating trauma survivors: vicarious traumatization and style of coping. Texas woman's university"*, Unpublished PhD Thesis, available at: www.researchgate.net/publication/33806681_Effects_of_treating_trauma_survivors_Vicarious_traumatization and style of coping (accessed 19 October 2017).

cetc: centre for excellence in therapeutic care

cetc@childhood.org.au
www.cetc.org.au

Australian Childhood Foundation

The Centre for Excellence in Therapeutic Care
is a division of the Australian Childhood Foundation.