Vicarious trauma and compassion fatigue in residential care workers of traumatized children

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Abstract

This research comprised of 13 face-to-face semi-structured interviews with residential care workers (seven males and six females), all based within the same UK residential care organisation, offering care for adolescents aged 11 to 17 years. Interviews focussed on the psychological impact of traumatic events on staff functioning. Findings noted that participants had been exposed to varied distressing and traumatic experiences, occurring within and outside their employment. Experiences included witnessing or being a victim of physical and sexual aggression, witnessing self-injury or suicidal behaviour, and reading about neglect, abuse, self-injury, suicidal behaviour, and physical and sexual aggression from residents' histories. When considering the psychological impact on staff, qualitative analyses identified themes of emotional distress and interpersonal discord. Furthermore, increased exposure to a young person's traumatic experience led to endurance being prioritised over emotional wellbeing, ineffective coping, and poor sleep hygiene. A reduction in the impact of exposure to a young person's traumatic experiences related to emotional and proactive support from others, use of effective coping, and increased knowledge and preparation into distressing events. The findings are discussed in relation to the overall impact of trauma exposure on staff, protective factors, and suggestions for staff intervention to reduce and/or remove potential impact.

Keywords: Children; Trauma; Vicarious Trauma; Secondary Trauma Stress; Compassion Fatigue; PTSD

Introduction

Employees confronted with the abusive experience of others, such as that which occurs in children's residential services, has the potential to evoke trauma responses. Such exposure can be varied, including the reading of distressing material of the child's life experiences of abuse, directly discussing the child's trauma with them, or being witness (direct or otherwise) to the child's continuing distressed response to their negative life experiences. This can further be exacerbated by staff's prolonged exposure to such engagement, particularly where the child has been removed from the care of their caregiver. This may include a child's exposure to negative developmental experiences, such as neglect, emotional, physical and/or sexual abuse. It is noted that individuals who work directly with traumatised populations have an increased risk of secondary traumatic stress (Hatcher *et al*., 2011). This is especially the case where the professional presents with a history of at least one traumatic episode, prior unresolved trauma, low social support, and/or a

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higher number of years' experience, with this group suggested to be at an increased risk of developing a traumatic response as a product of work experiences (Cummings *et al*., 2018).

The literature notes a number of potential reactions from professionals when exposed to the distress of others. Various terms have been used to describe such distress, but these have been argued to be conceptually different. For instance, vicarious trauma is noted where the professional is exposed repeatedly to the traumatic experiences of their clients, and where there is a further need for empathic engagement (Sprang *et al*., 2019). In broad terms, this relates to significant but indirect experiences of the distress of another, where a professional engages empathically with a traumatised client (World Health Organisation, 2013), resulting in a vicarious traumatic response within the professional. This has been argued to be distinctly different to other responses to psychological trauma, as it can lead to a change in a professional's cognitive schema due to regular empathic engagement with traumatised clients (Newell & MacNeil, 2010). Ultimately, this leads to an alteration in how the professional views themselves, others, and the world (Cohen & Collens, 2013). For example, when a professional has worked long-term with victims of burglaries, they may come to be fearful that the world is a place that cannot be trusted, perceiving a heightened risk of criminal activity.

Vicarious trauma is also linked and can overlap with two further constructs: secondary trauma stress and compassion fatigue. Secondary trauma stress has been argued to be distinctly different to vicarious trauma, in that this construct is more focused on outward symptomology (Figley, 1995), and is thought to be linked to post-traumatic stress symptoms, such as avoidance of situations that may trigger a distress reaction, intrusive thoughts related to the distress, sleep disruption, substantial changes in mood, and problematic concentration. This conception would fit with the revised version of Post-Traumatic Stress Disorder (PTSD), where it is now recognised that PTSD can also be noted when an individual has had repeated or extreme indirect exposure to aversive details of the event(s), usually via professional duties (DSM-5; American Psychiatric Association, 2013). By comparison, the term compassion fatigue was conceived in an effort to capture the experiences of broader populations (Figley, 1995), such as those professions where compassion was not necessarily an expected component of the area (Ludick & Figley, 2017). As such, compassion fatigue was noted to be a combination of secondary stress trauma and professional burnout (e.g. Newell & MacNeil, 2010). Yet, this distinction has not always been drawn from the literature. In fact, when discussing the impact of a professional's exposure to the psychological trauma of others in their work, all three constructs have been used interchangeably or linked together within the literature. While some researchers argue against this tradition, noting that these constructs are distinct (e.g., Rauvola *et al*., 2019), what is clear is that regular exposure to the traumatic distress of others in one's line of work can lead to a cumulative effect on the risk of the professional then developing a trauma response (Ramirez *et al*., 2020).

Ultimately, there is an expectation that professionals who are in the role of helping others, should be in a position to set aside their own needs and wants in an effort to provide effective and professional engagement with the client. However, this does not mean that a professional does not experience any adverse reaction to hearing the distress of others, but more that such reactions are directed elsewhere, such as through effective supervision, reflective practice, and general self-care. Self-care for professionals exposed to such work is considered integral to caring professions, and which then enhances the ability for such a professional to be fully present with the client in their requirement to offer effective care (Lewis & King, 2019). Yet, some professions are supported more than others. For example, arguably regulated professionals such as social workers and

psychologists, by their very training, would be expected to have at least some knowledge and skill to recognise and act on any stress manifesting through working with traumatised populations. The same may not be in place for other non-regulated professionals, such as residential workers who engage with these children every day, and who would not have had exposure to the same level of knowledge through their training. Furthermore, the very act of showing compassion and empathy to a traumatised child "extracts a cost under most circumstances" (Figley, 2002, p. 1434). It is this very act of caring for others, that over time and without support, may lead to compassion fatigue, and which can lead to a reduction in the individual's effectiveness within their role (Figley, 2002).

This then raises the question of effective interventions to best support professionals in their role and avoid or reduce psychological reactions. From the existing evidence base, interventions focusing on the management of vicarious trauma have been noted as helpful in managing and alleviating the main psychological issues arising from exposure to such trauma, as well as having a further positive impact on self-efficacy, job satisfaction and mindfulness; supporting professionals to be less self-critical, to possess a heightened sense of belonging, and to feel relaxed and mindful (Kim *et al*., 2021). The scoping review of Kim *et al*. (2021) argue the importance of tailoring such interventions to the vicarious trauma being reported. The researchers argue the positive value of a group setting intervention, as this offers longer-term benefits in addressing the presenting symptoms, whilst also allowing for peer support and an opportunity to address the full complexity of symptomology. Kim *et al.* further argue the importance of tailoring such interventions to the characteristic of the group and bespoke to the service setting, as well as attending to protective and risk factors for a potential vicarious trauma response (Kim *et al*., 2021). For instance, compassion satisfaction has been argued to have an inverse relationship with a trauma response, with compassion satisfaction relating to a sense of gratification from the very act of helping others, which is linked to perceived professional achievement, leading to increased motivation and interest (Cummings *et al*., 2018). As part of this, the professional's background is also considered key with Molnar *et al*. (2020) noting in their systematic review of vicarious trauma in child welfare and child protection professionals, that personal trauma history was the most consistent factor for vicarious trauma, although it is not clear if they considered whether such trauma had been resolved or was still creating distress for the professional. Overall, Kim *et al*. (2021) argue that such interventions should be responsive to the age, race, gender, previous trauma, and work experience of the professional, as well as being developed with clear goals and targets. Further, such approaches should be responsive to the organisational culture, support, and resources in place, as this may also impact on the response to vicarious trauma (Kim *et al*., 2021).

Thus, the aim of this research was to explore the impact on residential care workers who are regularly exposed to the unresolved trauma of children in their care, most notably adolescent children. Such exposure can be varied, such as working closely with the child, discussing their traumatic life events, as well as having access to distressing material in their background via professional documents provided as part of their care.

Method

Participants

A child residential provider supported the proposal for research and agreed for their staff to be accessed. As such, seven male and six female staff within one residential care organisation agreed to be interviewed. This organisation provides care to young people aged 11 to 17 years who have

experienced abuse and neglect, and who present with a variety of emotional and behavioural difficulties. Staff's mean age was 44 (SD = 11.22). The mean number of years that staff had worked in residential care with children was 12 years (SD = 8.86).

Procedure

Ethical approval for the research was obtained from the University of Central Lancashire's ethics committee. The residential care organisation provided approval for their staff to be approached. All staff within the organisation were informed about the study and were asked to contact the researcher if they wished to take part. Further information about the nature and purpose of the study was provided to staff who expressed interest. Those who then wished to take part provided consent and a face-to-face interview was undertaken by the researcher which focused on a number of areas. One area was current and historic exposure to traumatic experiences of children in their care. Another area was exposure to traumatic experiences of their own. Traumatic experiences were defined as witnessing or experiencing the following: life threatening situations, threat of or exposure to physical or sexual abuse, the death of another person, a person intentionally hurting themselves, and reading material about the abuse of a person. The interview also asked staff about current and historic symptoms which may be associated with PTSD, but no diagnosis was made (as defined by the DSM-5; American Psychiatric Association, 2013). This was used to guide the interview. Staff were also asked about their empathy towards both general situations and children in their care, and the methodologies by which they cope both generally and specifically following exposure to the traumatic experiences of others. Each interview was recorded and transcribed. Interviews lasted from between 45 to 60 minutes.

Analysis and Quality Appraisal

Thematic analysis was used to determine, analyse, and report patterns within the transcribed data according to recommended guidelines (Braun & Clarke, 2006). Transcriptions were examined multiple times to identify initial common features. Themes were then developed based on relevance to the research aims. Identified themes were analysed further, including by conducting comparisons between different components of the data set. Steps were taken to ensure analytical rigour was met. This included scrutiny of features and themes by a member of the research team who had not undertaken any of the interviews, and then by an independent researcher who was unaware of the research aims.

Results

A range of themes were identified and are presented below. It was noted that staff reported being exposed to a variety of intra and interpersonal distressing experiences, occurring both within and outside of their residential care employment. These included witnessing or being a victim of physical and sexual aggression, witnessing self-injury or suicidal behaviour, and reading about neglect, abuse, self-injury, suicidal behaviour, and physical and sexual aggression; all of which linked to secondary trauma and compassion fatigue.

The themes identified related to (1) how staff were impacted by exposure to young people's traumatic experiences; (2) factors which increased the impact of exposure to young people's traumatic experiences; and (3) factors which buffered against the exposure to young people's traumatic experiences. These are presented below:

Impact on staff

Two themes emerged with respect to how staff were impacted by exposure to young people's traumatic experiences: *emotional distress* and *interpersonal discord*.

Emotional distress

Exposure to young people's traumatic experiences appeared to cause emotional distress in a number of forms. Staff reported re-experiencing distressing memories, for example *"Just being [in] the same places inside the home can make me feel like I am back reliving it again [hearing about young people's abusive experiences]"* (p4[2]). Staff also stated they felt emotionally tired and experienced difficulties in quality and quantity of sleep, for example *"I might only get three hours sleep a night for a while [after hearing a young person speak about their experiences]"* (p7). Professionals also explained that they often became more vigilant after hearing about young people's experiences. Participant 3 explained, *"There are some bad things in the world and knowing what they have gone through does make me think about that and needing to guard my family against it"* (p1), and *"After hearing about it, it can make me a bit more defensive of my family, knowing what kind of people are out there walking the streets"* (p3).

Interpersonal discord

Exposure to young people's traumatic experiences appeared to cause interpersonal discord in residential care workers. Staff reported that they became more irritable and less emotionally available in interactions with others, for example *"I can get angry reading background information, wondering why they have to go through that. It's sometimes difficult to not let this impact on my mood for my family when I get home"* (p3). Staff reported that this emotional impact was also a factor in increased interpersonal conflict, for example *"Because it [hearing and reading about young people's traumatic experiences] affected my mood, I think I then caused more fallouts with colleagues and family"* (p9).

Staff also reported greater difficulties maintaining appropriate professional boundaries following exposure to young people's traumatic experiences. For example, *"Seeing what they have been through makes me feel sorry for them. With one person, I can't forget his background and I kind of want to spend time with him so that I make him as happy as possible and I probably go past what I should"* (p7). Participant 4 similarly stated *"I can't help sometimes but go a bit beyond how much help I give and how involved I am – knowing what they have been through can make it hard to limit myself"* (p4).

Increased impact of exposure to young people's traumatic experiences

Factors which increased the impact on staff following exposure to young people's traumatic experiences emerged, including when *endurance was prioritised over emotional wellbeing*, *the use of ineffective coping*, and *poor sleep hygiene.*

Endurance prioritised over emotional wellbeing

Staff reported that the impact of working with young people's traumatic experiences increased when endurance was prioritised over wellbeing. For example, participant 8 stated *"There can be pressure to put up with these things as its seen as normal and part of the role. That can make things worse, especially when how we are feeling is not seen as important"* (p8). Staff reported that when they perceived an expectation from the organisation to endure, their trauma responses increased. For example, *"I feel like there is a perception that if this stuff bothers you, then you*

[2] P# refers to participant number.

shouldn't be doing the job, because you get it all the time. This pressure just adds to it all" (p6). Similarly, participant 12 noted *"When I was not supported after hearing about it [a young person's distressing event], I felt alone and helpless. I was just encouraged to get on with the job. This made it more difficult for me"* (p12).

Staff described a similar impact of perceived expectation from their family, *"Even if I am struggling because of this [knowing about young people's traumatic experiences, I can't afford to take time off work. I think about my family who I need to provide for. They expect and need me to provide for them. This is another added burden"* (p4). Similarly, participant 8 indicated that *"every-time I think of it [the difficulty working with young people's traumatic experiences], I also think of my family and what would happen if I didn't have a job. This pressure makes it worse"* (p8).

Use of ineffective coping

Staff reported some use of ineffective coping strategies in managing the impact of exposure to young people's traumatic experiences. This was described as leading to increased trauma responses. Some reported a long-term use of avoidant coping. Participant 7 stated, *"So I said to myself 'man up'; I thought I could brush it off, be fine, and come to work as if nothing happened. But I couldn't, it made it worse"* (p7). Similarly, staff spoke about 'minimising the impact' as an ineffective coping strategy: *"By making myself get on with it and thinking to myself that it wasn't affecting me as much as it actually was, it got worse and worse over time"* (p10). Others reported a tendency to blame themselves. For example, *"I remember at the time I really blamed myself for what happened. Looking back, it clearly wasn't my fault. And … it prolonged the impact of what happened"* (p8).

Participants suggested that the impact of exposure to young people's traumatic experiences had been increased due to emotional over-involvement with children in their care*: "Reflecting back now on what happened and how it affected me, I was too emotionally involved. I think my lack of experience meant that I naturally cared too much rather than just the right amount, and this took its toll on me"* (p10). Similarly, participant 4 verbalised that *"In this job, if you don't act with boundaries and open yourself up too much to the difficult things you see and hear, then it can really get you down"* (p4).

Finally, a limited use of downtime to cope with trauma responses was suggested by staff as leading to an increased impact. For example, *"My natural tendency, even though I was struggling, was to come into work and not ask for any time off. I didn't want it to seem that I couldn't do my job, and I needed the money. But I think this really didn't help me"* (p13). Similarly, participant 10 noted that *"Thinking back to when I was new at the job, I used to think about work when I was at home. This stopped me using my own time to relax, and this made everything worse. It was like a negative spiral"* (p10).

Reduced impact of exposure to young people's traumatic experiences

Additional themes emerged that related to factors which decreased the impact on staff of exposure to young people's traumatic experiences. These included *emotional and proactive support from others, use of effective coping*, and *increased knowledge and preparation into distressing events*.

Emotional and proactive support from others

Within this theme, perceived and actual support from colleagues, supervisors and employers were found to buffer against trauma responses. For example, participant 12 stated that *"The main thing*

which helps me to deal with these challenges is getting a lot of support from other staff, from the top [of the hierarchy] all the way down to the bottom" (p12). Staff also reported that they found support from independent professionals beneficial: *"Having someone independent who I can talk to about my feelings, who won't judge me, and where they sometimes can offer me a new perspective, really helps me cope [with exposure to young people's traumatic experiences]"* (p3). Generally, having an opportunity to express thoughts and feelings in healthy manner appeared to buffer against trauma responses: *"When I feel okay with talking about what happened to people, then that helps me deal with it. For me it's just having the means to offload what I think and feel"* (p4).

Use of effective coping

Staff reported some use of effective coping strategies in managing the impact of exposure to young people's traumatic experiences. This was observed to lead to decreased trauma responses. Leading a fulfilling life outside of work was described as helpful. For example, *"I make sure I have multiple hobbies and that helps me shut off and detach. I love my music…I have got my dogs and cycling… Generally, I study a lot too. I read things other than work"* (p9). Problem-solving was also described as an effective coping strategy by staff: *"Sometimes it is difficult to do especially early on, but I am someone who really tries to work out the problem and take action to fix it. If the situation [related to exposure to young people's traumatic experiences] is fixable, then this helps me deal with the situation"* (p8). Perspective taking was further reported as helpful by staff. For example, *"It can also help me to speak to someone more independent, like the onsite therapists because I can then put things into a different perspective… this can help me feel more at ease with the situation"* (p2). The use of relaxation was another coping strategy described as effective: *"Outside of work, I do things to relax. This helps me cope with what I hear [regarding young people's traumatic experiences]. I walk the dog and play games on my phone"* (p11).

Some staff indicated that they could cope more with exposure to young people's traumatic experiences when they had successfully endured a greater frequency of distressing events. For example, *"early on in my career, I had not seen much, either at home or at work. The things I saw at work I found more difficult because I think they were so new to me"* (p4). Another person said, *"What really helps me deal with things I see and hear is that I have come from a difficult upbringing. I have seen and heard these things before, and overcome them, moved on completely, on a personal level. This gives me a bit of protection"* (p2). Staff also observed that *"When people who have very little life experience come into this line of work, they really struggle to cope with what they see and hear [about what young people have experienced]. I've seen it many times and it's because what actually goes on in the world is new to them. It's the shock"* (p5).

Increased knowledge and preparation into distressing events

Within this theme, staff reported that increased readiness for potential traumatic events was helpful in reducing their impact. Having a pre-existing awareness of young people and their experiences was described as being beneficial. For example, *"Before they arrive, looking at their backgrounds, the referral information, at where they have come from, the background history, it all gives me a good knowledge of what we are expecting. It helps me deal with it [exposure to young people's traumatic experiences] when it happens"* (p1). Another staff member noted, *"When you see or hear things unexpectedly, it hits you harder"* (p7).

Staff also described that having a greater understanding as to why young people can be exposed to traumatic events was helpful. For example, *"The training we get helps. By having an*

understanding of what they have been through and why, you can be empathic, and it helps you deal with the distress from it" (p5). Similarly, participant 10 noted that *"having a bit more understanding about why [young people's traumatic experiences] happen helps it impact me less. This is why training and other things like it are useful"*. The benefits of training were thought to increase when training included suggestions on how best to support young people: *"When I am more prepared, then I feel like I can understand, empathise, and also help them move forward. This makes knowing about what they have been through easier for me to handle. Because I can make a difference"* (p3).

Discussion

This research supported findings from various studies as to the psychological impact of professionals working with traumatised individuals, demonstrating comparable reactions in residential staff members caring for traumatised children. Of note, this study found that staff exposure to trauma in the work environment, and their response to this, can be further exacerbated by unresolved trauma, as well as exposure to psychological difficulties outside of the work environment. Indeed, impacts on residential workers can be varied, including re-experiencing of trauma, sleep disturbances, emotional disturbances, and less helpful coping, such as emotional over-involvement and more limited down-time. Findings further demonstrated the impact on staff member's work, such as concerns relating to managing professional boundaries, and insufficient support within the organisation. Interestingly and despite viewing the job as burdensome, staff noted they continued to work in said role to provide for their own families. When considering the psychological impact on staff, this thematic analysis identified emotional distress and interpersonal discord as important themes, alongside ideas of endurance being prioritised over emotional wellbeing, the use of ineffective coping, and poor sleep hygiene. Conversely, factors that may buffer against such detrimental impact included emotional and proactive support from others, supporting the use of effective coping, and increased knowledge and preparation into distressing events.

These findings support the research of Hatcher *et al*. (2011), who similarly found that there was an increased risk of secondary traumatic stress by exposure to traumatised populations. Indeed, when reviewing the revision by Figley (1995), the notion of compassion fatigue (i.e., secondary traumatic stress and professional burnout) was observed in the current study. It was further found that certain staff would work with these traumatised populations, whilst simultaneously suffering from their own personal experiences of trauma. Yet interestingly, this notion cannot be considered a linear and direct relationship of staff's own trauma then relating negatively to their response to such exposure in the workplace, such as that argued by Cummings *et al*. (2018). Though it was observed that some residential staff have been exposed to earlier traumas, this thematic analysis did not then observe this as critical in their psychological reaction to trauma in the workplace but acted in a manner which heightened the importance of personal trauma as unresolved and/or then being triggered in the work environment. This study therefore argues that it is too simplistic to regard a staff member's personal trauma as automatically impacting on their work role, especially if such trauma is resolved or not triggered within the workplace.

The notion of exposure to trauma in the workplace impacting on the cognitive schema of staff members due to regular empathic engagement with the client, was further observed. This

aligns with Newell and MacNeil (2010) definition of vicarious trauma, and how such contact can alter staff member's view of the world (Cohen & Collens, 2013). For instance, this was reflected by participants who noted that they would often become more vigilant following exposure to the trauma of the young person in their care, and subsequently perceive an amplification of risk of crime in the community.

The observed findings direct towards an awareness as to the cumulative impact of exposure to trauma, with trauma symptomology considered by participants as gradually building over time. This would certainly compare with the arguments of Ramierez *et al*. (2020), who elucidated the cumulative effect of exposure to trauma over time. This all directs toward the importance of self-care, whilst recognising that professionals who care for traumatised young people are at an increased risk of a trauma response, due to a need to demonstrate a clear empathic response to the child as part of their employment. Thus, it is critical to support staff in their role, and even more so where they may not have necessarily been exposed to initial. Whilst the support from the organisation is always considered a critical component to manage the well-being of all staff exposed to the risks of vicarious trauma and compassion fatigue, this may be considered even more critical where certain staff may not present with the level of knowledge that is routinely provided in other regulated professions (i.e., psychology). This would certainly fit the observations of Figley (2002), who argues that the very act of caring, without support, can lead to compassion fatigue.

Despite the noted risks of working with traumatised populations, this research has identified the value of protective factors that may buffer against this risk of compassion fatigue in staff, most notably through the emotional and proactive support from others, the use of effective coping, and an enhanced knowledge and preparation against trauma impact. This would fit closely with the observations of Kim *et al*. (2021), namely developing effective interventions that are tailored towards the staff group, and the provision of further support via group interventions that allow staff to recognise solidarity in their psychological reactions. Specifically, the current research raises the importance of staff interventions as a supportive factor in reducing potential distress in professionals. Supportive measures may include:

- Both perceived and actual non-judgmental support from colleagues in the workplace. This also extends to support offered by professionals seen as more independent from the organisation, such as psychologists and therapists, who engage with the organisation but are not direct employees. This is to allow space to discuss feelings in an open and trusting way, and to offer a different perspective to any difficulties.
- To focus on self-care, thus allowing an effective work-life balance, such as engagement in fulfilling interests and hobbies outside of work, and which are distinctly separate from the work environment, providing space to distract and relax.
- To focus on effective coping that is appropriate to the presenting difficulty, such as problem-solving but only where a solution is possible.
- To be best prepared by developing knowledge regarding psychological trauma, how it can present, and the impact this can have on staff, as well as steps that could be taken in mitigation. This also extends to sufficiently understanding a new person's background to allow for timely preparation.

Limitations

Although this research was thorough in its interviews and thematic analysis, it is still restricted by a small participant pool, and which is localised to one organisation. As such, this may limit the

generalisability of the presented findings. Further, and whilst thematic analysis can allow for richness of data and observations that may not have been predicted, it is still subject to researcher biases in attending to and filtering the detail. Though efforts were made to minimise said biases, such as utilising independent research members, this does not necessarily lend to the validity of findings.

Conclusion

This study has elucidated the negative and cumulative impact of staff exposure to the psychological trauma of others. While the impact of such trauma can be varied, traumatic responses appear to be strengthened in staff who have been exposed to such material through direct contact with young clients who have unresolved trauma, as well as exposure to regular documented material. Such impacts can include symptoms of intrusion, such as sleep disturbance and re-experiencing of trauma, as well as negative alterations in cognition and mood, such as emotional disturbances. Importantly, such negative impacts may be reduced or mitigated through the use of tailored interventions that are bespoke to the staff and/or organisations needs.

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