SOCIAL WORK TALK

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MENTAL HEALTH in SOCIAL WORK

IN SOCIAL WORK TALK...

FROM THE EDITORS

Welcome everyone, from everywhere! We usually plan our issues quite a bit in advance, and somehow the stars align and make them very relevant to the time of publishing!

Mental Health is a huge issue in society as we all work out what it means to be in social isolation and how to weather experiences outside of our control.

For Social Workers we are also at a cross roads as we look forward to what it means for us to be in the field of mental health more formally. As the AASW's mental health accreditation becomes a popular route into mental health we asked ourselves, 'Why Social Workers?' and 'What can we achieve that other professions can't?'

We hope that this is an edifying read and you feel challenged and encouraged by the stories of our guests as we tackle our own organisations and our role in mental health.

You may notice that some of our guests this edition are spiritual and that they share how that has impacted their lives and their choice to be social workers. This wasn't intentional and we know that some people may have expected us to edit this out. Spirituality is often forgotten in social work and it is especially excluded in Mental Health. This is the reality of living in an overwhelmingly secular society and a patriarchal society that stems from the enlightenment. As we seek to pry our profession out of the hands of our white, secular, patriarchal society it is so important that spirituality is included in the way that we interact with our colleagues and our clients.

MENTAL HEALTH

Social Work Talk thrives on just that, talk, so please join the conversation with us!

We really enjoy and learn from the conversations we have with our guests, and hope you get as much out of them as we do. We've had a boost of support from everyone who's liked and followed us the past month - thank you! Keep on sharing away!

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COVID-19 continues to challenge the way we support clients and each other. Working with people, face to face, defines a lot of what we do! We reached out to the Australian Association of Social Workers (AASW) for words of support for all social workers. Christine Craik, National President of the AASW, shared openly on the biggest challenges social workers are facing during COVID-19, and how we as a profession can support each other through this time.

We are all living through a moment in history that is unprecedented in our lifetimes. We are feeling the heightened anxieties around the current threats, the grief and the unknowns for future outbreaks and lockdowns. As social workers we are dealing with our own experiences of this for ourselves and our families, while we are also supporting and working with the most vulnerable and disadvantaged individuals and communities. We know that our work now and for a long time into the future with our client groups is going to involve a lot of energy, critical analysis of new government policies as they are rolled out, and a huge amount of advocacy for those we work with because these 'recovery' policies are likely to further discriminate.

In order to face these current challenges and those we can know are ahead for us, social workers need to come together to network, to share resources and learn from each other, and to validate and support each other. As a profession, we know the importance of this and now more than ever is the time to use the AASW as the vehicle for this to happen.

The AASW has been busy in this space, distributing information, bringing social workers together through a dedicated COVID-19 facebook page, through chats, through live webinars, articles, media releases and advocacy work. The AASW has produced and distributed a document for social workers detailing many aspects on working through this time, including: where to get the latest and most accurate information; dealing with heightened anxiety and exacerbated mental health issues in those we work with; assisting parents and families; preparing for quarantine or containment; preparing your practice; an ethics and practice consultation service and of course, the importance of self-care and reflection. The AASW has facilitated a platform for social workers to come together to talk about a variety of COVID-19 related issues including the ethics of various telehealth platforms, issues facing social workers in health settings, and those on the frontline with vulnerable individuals and populations. There are further live chats planned for other fields of practice, including social work education and what happens with field placements for students during this time.

This is all about ensuring that connection, networking and information sharing is available for social workers, along with opportunities for reflection and informal debriefing. Social workers can't do this alone, and need the support of their profession to get through this time.

Social workers can't do this alone, and need the support of their profession to get through this time.

Building on this sense of belonging is going to be vitally important to our mental good health and for us to be able to stay focussed on the work we will have to do.

Stay safe and stay connected.

AASW

You can visit the AASW's website to learn more about professional development, information for the community, membership and more at https://www.aasw.asn.au/

*We think transparency is important! Just so you know, the team at Social Work Talk are not currently members of the AASW.

Marie Vakakis is an Accredited Mental Health Social Worker (AMHSW) who embodies her values and principles through her work as a writer, podcaster, educator, supervisor, counsellor and family therapist. Marie works with family members, parents, couples, teachers and communities to support mental wellbeing. Her work focuses on healthy connections to promote good mental health.

Marie has shared her practice insights in previous issues, and here she shares her knowledge about what is so unique about AMHSWs. Marie also talks about her own path to working in mental health and answers questions that some of our readers, including social workers in the field and students, have about AMHSWs.

Marie, did you always envision that you'd be in mental health? What influenced you in your decision to be an Accredited mental health social worker (AMHSW)?

I wasn't sure to start with, I knew I would be in health care. I enjoyed health, biology and psychology in high school and could have happily chosen other areas of healthcare like being a nurse or paramedic. I knew I wanted to work with people and in a challenging and fast paced environment where I would learn lot and be challenged.

My final year psychology teacher really got me excited about the human brain and working with people, while at the same time my biology teacher was filling my brain with exciting images of wildlife, cells, plants and all this amazing stuff. I ended up applying for and deferring a psychology undergraduate degree

After a gap year teaching English in Ecuador and travelling through the country I was almost tempted back to biology. I loved visiting the Galapagos islands and seeing in person what I studied in year 12 biology. The human brain won me over in the end and I continued my psychology studies.

After my undergraduate degree I decided social work would be a good fit, I enjoyed the systemic and advocacy focus of the degree. From there I continued to study and did a year long research project followed by a graduate diploma in youth mental health and now I'm in my final year of a Family therapy masters. I decided to get my accreditation to reflect the skill set I had in mental health intervention and treatment.

Understanding mental health is such an important part of the work we do. Mental illness doesn't discriminate and so we will be working with clients and staff who have a lived experience. Some of the clients we work with are more vulnerable to developing poor mental health or a mental illness for a range of reasons. Understanding mental health and mental illness is a must.

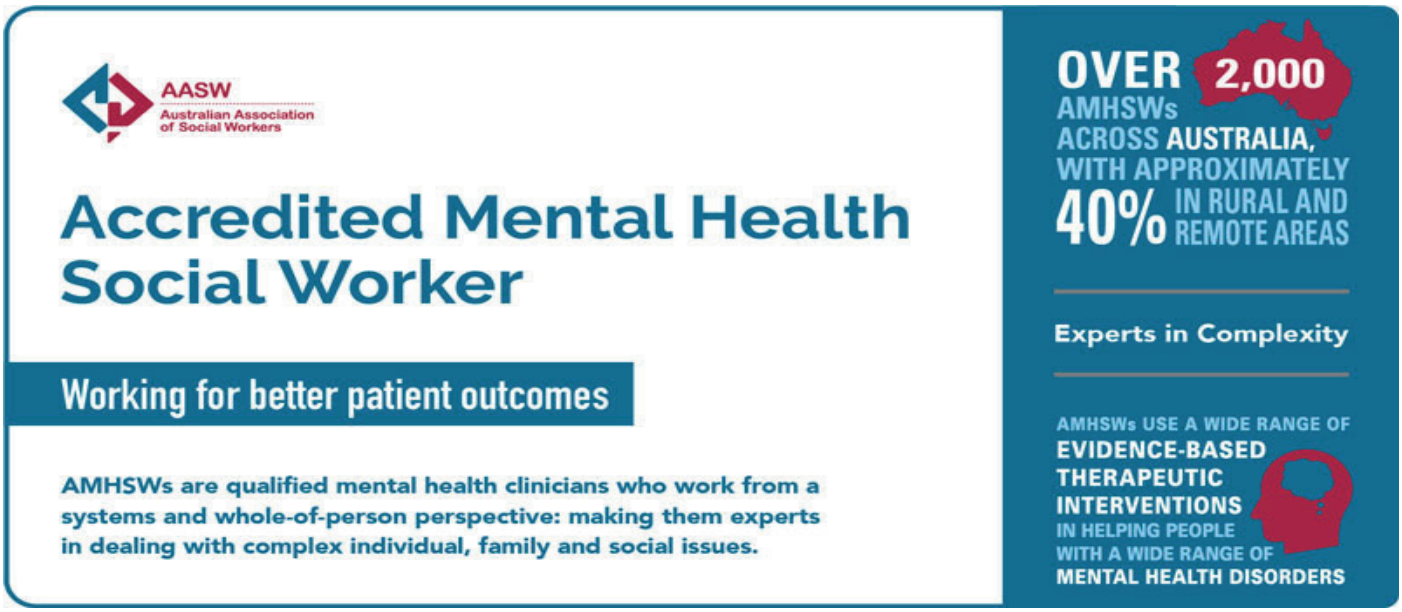
INSIDE SOCIAL WORK PODCAST

Marie hosts the Inside Social Work Podcast, and continues producing thought-provoking discussions with her guests.

Some episodes I found relevant to our Mental Health edition are:

- Episode 9 with Helen Gray, 'Doing the work we love shouldn't make us ill'
- Episode 19 with Louise Hayes, 'You cannot tell ACT to clients, you have to experience it with them'

You can find more episodes by visiting Inside Social Work at https://insidesocialwork.com/, or stream from Spotify or Apple Podcasts.



Some of our readers, including social workers and social work students, were curious about the pathways and role of Accredited Mental Health Social Workers (AMHSWs). You might have had these questions yourself. Here, Marie offers her insights!

Divya recently finished a Master of Social Work (Qualifying) (MSW (Q)) and graduated in April 2020. She's interested in specialising in mental health and wants to know the steps to becoming an AMHSW.

You can find more information about this on the AASW website. You will need at least 2 years full time post qualifying experience in a mental health role. It's important to be looking at professional development that meets the AMHSW guidelines as well as at appropriate supervision.

Erika also graduated with a MSW (Q) in 2019 and currently works as a Mental Health clinician for Queensland Health. She's wanting to know how AMHSWs differ to other mental health practitioners.

AMHSWs like many other mental health practitioners are skilled using evidence-based treatments to help people facing a range of issues including mental illnesses such as depression and other mood disorders, personality disorders, anxiety, stress and eating disorders. They can provide support and services for substance abuse and services for people recovering from domestic violence and sexual assault.

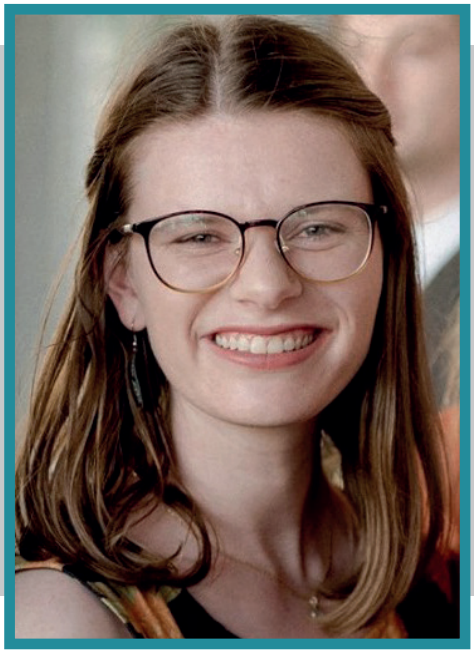
Over the course of their career practitioners develop a range of skills and specialities. This is the same for AMHSW's. Being an accredited mental health social worker also means you have completed a set amount of supervision and training each year.

Tyler graduated with a MSW (Q) in 2019 and now works in Community Mental Health as a Mental Health clinician in Mackay. He's curious about what core skills distinguish an AMHSW in a multidisciplinary team.

Every organisation works differently and has their own culture and way of working. Multi-disciplinary teams offer multiple perspectives and treatment options to get the best outcomes for clients. Some organisations offer a range of training combined with supervision specific to the role you're in. You can combine this with your discipline's theoretical background and frameworks. Over the course of their career practitioners develop a range of skills and specialities. This may compliment other allied health staff or may be similar. Some social workers may choose to apply for accreditation status which means you have completed a set amount of supervision and training each year related specifically to mental health treatment and intervention. AMHSW status indicates that practitioner has a high level of training and skills in the mental health sector.

You can learn more about AMHSWs on the AASW website. A helpful resource includes their March 2019 publication 'Accredited Mental Health Social Workers: Qualifications, skills and experience.'

THE ROLE OF SOCIAL WORKERS IN MENTAL HEALTH



I got to Zoom with Lucinda to discuss why it matters that Social Workers are leading the charge in children's mental health in Out of Home Care (OOHC). Lucinda and I come into contact through our work and I really love her perspective on mental health, trauma and how children can experience healing.

She has recently taken up the role of Team Leader of a clinical team that is made up of social workers. She started in psychology but felt that social workers had something special to offer. She provides immense insight into how social workers can bring their skills, expertise and our values to mental health... and even how we are already doing it!

Lucinda and Alice Cairn

Hello Lucinda! Thank you for Zooming with me this evening - Tell us a little bit about why you chose social work as a profession.

I actually started out in a psychology degree, but in my first year of uni I spent a lot of time thinking about what it meant to be a Christian - thinking about the way Jesus lived his life among the poor, and the broken, and the people that other people didn't want to spend much time with. At the same time, I was realising how deeply embedded psychology is in a social context. I was learning about the brain, but at the same time, starting to understand things like homelessness where mental illness is so profoundly present. But that's not purely because mentally unwell people become homeless. It's because in the context where you don't have a safe place to live then you, you don't have walls around you that protect you from strangers, of course your mental health declines. And so thinking about things like that - how incredibly embedded a person's wellbeing is in the circumstances around them - it felt shallow to imagine meeting with someone and talk about their thoughts without doing anything about the circumstances that might lead them to having that experience. It felt quite invalidating to be trying to change someone's thoughts while they actually have really valid reasons for feeling distressed.

So, in the mix of all that I wanted to move away from a model that focussed just on the brain to thinking more about walking through the mess of life with someone. I felt like social work provided an opportunity to be more on the ground and embedded in a person's actual life. That's why I ended up picking social work, thinking initially that I would pursue working in the homelessness sector, and certainly that I would never work in child protection.

Why homelessness?

I think in that year, that was to me, the most obvious picture of poverty in the Australian context, the most visible sign. In a way that was quite a simplistic approach, but I also started volunteering at the time with an organisation that did food vans for rough sleepers and really loved that, and loved the interactions I had with people and the things I learned from them.

So then, how did you end up going from homelessness and working with adults in distress to then moving into a child protection role, where you currently are now?

Yes, so when I was at uni I felt like so many lecturers were assuming that everyone was going to end up in child protection. I was like 'no, not a chance, not

interested.' **And here you are!** Here I am! In my last role, before I came into the foster care world I was working in homelessness with individuals and families. Those roles brought me in to contact with the child protection systems in ways I wasn't expecting. When I was working with single women, a lot of them had kids that weren't living with them because they had been removed. Some of them were in the process of trying to get kids back in their care. Some of them were in rehab with the hope that one day that could happen, but just trying to juggle having family contact and things like that. And then on the other side, working with families in early intervention where there was risk of FACS (now DCJ) becoming involved if they couldn't be supported to get the things they needed. For example, working with families that where there was domestic violence in the home, but the family couldn't afford to move anywhere else. So there were all these incidental moments.

And quite a threatening presence of child protection. Where you currently work now is much more about being on the healing side of removal, but that's actually a very threatening situation for those families.

Definitely. It was a scenario where making a mandatory report often felt like being a bad guy, because you could see how much it was, for a lot of these families, systemic issues that were causing the children to be at risk. It wasn't that the parent didn't want to protect them, but there were doors closing all around them that meant those opportunities weren't open. As much as they might've wanted to do something, they just couldn't. I also, over time, realised how many of the adults I was working with had their own traumatic histories, and were in the circumstances they were in because of those histories and they hadn't gotten the support they needed. That made me really interested to work with kids because the trajectory of their life is still being set up.

So then that was kind of a realisation you had. What role are you in now?

I work within a foster care agency in a therapeutic specialist role, which involves therapeutic planning for children. When a child presents with emotional or behavioural challenges, we're thinking about - what's actually going on for that child? What does that mean for the therapeutic interventions that are needed? We also play a supportive and psychoeducational role to carers to equip them to respond therapeutically to children's needs. I'm the team leader of that aspect of our program.

So do you have any psychologists in your team?

No, at the moment we have three social workers.

Interesting. What do you think makes that special? What makes having a social work team in that space valuable?

I think a lot of it comes back to my realisation in first year uni about just how embedded emotional and behavioural issues are in the broader context of life. Having a social work team means that everything is thought about in context. You know, if an emotion or behaviour appears it's not just thinking about what's the diagnosis at play, but what are all the factors in a person's world that has led them to present in this way. And yes, part of that might be a diagnosis. Part of it might be hereditary factors, but a big part of it is also what's happened in their own life story, and what's happening in the moment in their social circumstances.

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So it seems to be that wider context around mental health not being something that occurs inside a person. It's something that occurs in conjunction with a whole bunch of factors and experiences.

Which I think, if we're going to talk about social work theory, it comes back to the bio-psycho-social approach to thinking about wellbeing. A psychology model can tend to see things from a very biomedical lens, and that has its benefits, but it's only a small part of a picture. That social work training to think from all those other lenses at the same time and bring them together into one cohesive picture, just really opens up the possibilities of what you can do to respond to the challenges at hand.

Going back to those social work theories, you obviously have those overarching theories that you build on, like systems theories or some of those more holistic theories about human people. What kind of theories are you using in your practice?

There's a few key ones. Definitely we're thinking a lot about attachment theory. **That's pretty key in child protection, isn't it?** Very much so. The reasons kids are coming into the child protection system are primarily to do with attachment disruption. And the challenges common among these kids are because of those attachment disruptions. We're thinking about that all the time; for the child, what are their experiences with attachment that might lead to the current

presentation? As well as, what are the attachment experiences of the adults involved in this picture? Particularly the caregivers - what does that mean for how they respond to the child, or how they interpret the messages a child's behaviour might be giving? It's very much an attachment model and also a family systems model, thinking about how does every member in the family contribute to that system in ways that impact upon everyone else? That meets together with an attachment lens when we're thinking about what's going on in a foster family, because they are a system. It's not just that there's this child that's at the centre of a problem and it all comes back to them. They have their experience and they bring it to the foster family, and the way that everyone experiences that from their own lenses impacts on how the scenario plays out.

What are you using in terms of direct intervention in children? Is there a particular model that you guys hold on to? Or privilege above other models?

In terms of social work models? Or just generally, what are we using?

Yeah, just generally what are you using? Because I think often we talk about how social workers often borrow from psychology models, particularly in child protection, but obviously I think being a social worker, using that model looks really different to being a psychologist using that model.

That's true. The model we're most influenced by is the Neurosequential Model of Therapeutics (NMT). In essence the NMT model is looking at the way that brain development is impacted by experiences of trauma. So, in a sense it's very psychological and very neuroscientific, but at the same time, in its practical application, it's really relying on traditionally occupational therapies when we're thinking about, for example, sensory interventions.

When you say sensory intervention, what might that look like?

When we're thinking about a child being 'dysregulated' - having an unhelpful amount of energy for that particular moment (too much or not enough) - in those moments sensory interventions are often brought in, which might look like touch or vestibular movement, so that might be spinning around on an office chair or swinging on a hammock. Thinking about those different kinds of sensory input and providing a sensory diet for a child is very much an occupational therapy idea. But then the NMT also thinks about things like speech development and how does that reflect a child's brain development. It's really interesting, in that it's psychological and neuroscientific, but in a way it's very multidisciplinary. **How very social work!**

Exactly. It meets perfectly with a social work perspective, where we, I think have that benefit because of the biopsychosocial-spiritual framework where we do have that freedom to draw on the knowledge from multiple disciplines and have that eclectic approach.

It's also got that empirical evidence behind it, doesn't it? It's still quite an evidence-based theory. This isn't just something that's shoved together.

Definitely. It certainly has the neuroscience behind it, but it's still a fairly new approach.

Do they come out of the child protection space? Or is it more your 'typical child' that this model is coming from?

It's come out of a child protection space. But it's

Image by Esi Grünhagen on Pixabay

interesting because it's reflecting what social workers would've said we should've been doing the whole time - looking at a person's context and thinking about how that impacts upon them.

This is quite a new role for you, only having moved into it in the last couple of months, but you were in that team beforehand. So, where do you see this role developing and changing in the child protection space, as you own it as your own? Sorry, that is a loaded question! It's ok if you don't have an answer for that just yet!

That's a really good question. I think I'm just really keen to keep expanding our carers' sense of what healing for a child might look like, beyond the 'they've experienced trauma, so we'll send them off to a counsellor and that will do the trick.' Counselling totally has a place, but I'm keen to keep building this knowledge that trauma is an embodied experience and the healing from trauma will come in an embodied way. There are aspects of this already, but how do we do better at incorporating movement and yoga? How do we think about the place of connecting someone with nature? And helping someone to experience autonomy and learning through gardening?

It seems to be almost a decolonised approach to child protection in some ways, in the sense that, like, talk-therapy is very white-western and Freudian, and you're actually saying, 'wait, hang on a second, the way we experience life isn't talk therapy. It's very much embodied, which is what we see in a lot of non-Western cultures.

That's very true. I think they've been onto something a long time before us because we know that in the trauma world we have this double whammy of kids who ordinarily don't have the same language that adults do for describing their experience, compounded by the fact that their speech development is often impacted by the trauma they've experienced, compounded by the fact that when you're experiencing trauma it makes some of the areas of your brain responsible for speech and language go offline. So, we're really not setting our kids up to succeed if we are just trying to get them into a room with a stranger to talk about what has happened to them. But so many of these embodied ways of thinking and feeling are so intuitive in other cultures and we're only just starting to realise that there's a lot to them.

Yeah, it's the idea that our mind and body aren't two separate entities. They are both present when we experience trauma, and so they're both affected. I guess that's the other thing you're saying is that you want to equip carers. Is that coming back again to that attachment theory?

Yeah, for sure. Another part of the typical approach to sending off a child to a counsellor is thinking that someone else is going to do the healing work, but from the attachment perspective it's the relationship between the carer (the caregiver) and the child that is most fundamental and will offer the most healing when a child has experienced trauma. So, the caregiver needs to be present with the child, and involved in things that will bring bodily healing, if they're going to have the full effect.
It's a big job. It is! It's a good job though. Going back to what led me to this direction, and thinking about the trajectory of a child's life - sometimes it's just getting to see the little moments of connection with a caregiver, or where you see a caregiver responding to a child in a way that makes them feel seen, or valued, you think these are those trajectory moments where you are setting up their life, which is both an incredible responsibility and great privilege.

Another question I have for you is you've obviously started in a mental health space, you started with a psychology degree that could've led you down the path of 7 to 8 years of study. You've then moved into social work, which is a much faster path, but you've kind of ended back up in mental health. My question is, for social workers who are starting to think about that path or who informally do mental health in their current role, what's your advice?

This is something I was thinking about today. I think social work equips us to respond really well to mental health. So much of what's important in mental health work is the relationship you build with someone. We know that from research of various types of counselling that the most consistent factor in positive outcomes is the nature of the relationship between the client and the counsellor. Social work sets us up really well to prioritise that, to do that relationship based work in ways that some other disciplines don't. That can be missed in a model that spends lots of time learning about theory and research, and those things are great, but unless you have the relationship through which you can share that knowledge, it's not going to land with the same impact. So, I think for social workers, whether they're studying or in another field of work, if you're doing that foundational work of walking alongside people in a way that is accepting and empathetic and genuine, then you're halfway

I think social workers do mental health work regardless of where they are, because they are walking with people in really messy times and just the way they are present with people is mental health work.

Image by Tim Mossholder on Unsplash

there. I think social workers do mental health work regardless of where they are, because they are walking with people in really messy times and just the way they are present with people is mental health work.

So, if you're wanting to move in the mental health pathway, then yes there are things to learn that are really important – there's research, practical techniques or strategies that you learn along the way, but the key thing is about being able to build a relationship with somebody that is real.

I think when we're often talking about mental health it's all about, 'do you know how to do CBT?' Or 'do you know how to draw up a safety plan that's going to keep this person from hurting themselves?' But, yeah, I think you're right. As social workers it always comes back down to that foundation we've built with them, and that mutual trust we have.

Yeah, because you can have your survey or diagnostic tool and run through it, but it doesn't mean that it's going to be therapeutic just because you have done the right thing. Often the most therapeutic thing is just the way you make someone feel.

...you can have your survey or diagnostic tool and run through it, but it doesn't mean that it's going to be therapeutic just because you done the right thing. Often the most therapeutic thing is just the way you make someone feel.

Absolutely! I think there is that real value that I always come back down to, is our ethical obligation is advocacy. And I think that's a really important space for social workers. It's not just about addressing that one individual issue that we're funded for.

I think that's such a key part of social work - to come in with that grounding of knowing how important that is. Especially when we're thinking about all the systemic factors that are impacting on that child's wellbeing, or the adult's wellbeing. If you're not advocating for those things, then you are going to be limited in what you can achieve for that person.

If you would like to contact Lucinda as a professional to discuss the work she does, please contact the Social Work Talk Team.

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VICARIOUS TRAUMA RESEARCH IN PRACTICE

Pauline Connelly and
Joanne Young

> “For heads of departments to be able to give themselves permission to ask the question, ‘how are our workers going?’ That actually makes us very vulnerable to ask that question. Because when we ask it, and when we get the answer, then we have a responsibility to do something about it.”

Image from Centacare annual report 2018-19
http://www.centacare.org.au/about/publications/

Centacare
Catholic Family Services

With COVID-19 challenging how we work, I was fortunate to lock in time with Pauline Connelly (Deputy Director Centacare Adelaide) and discuss their 2019 research study, 'Understanding Vicarious Trauma'. Pauline comes with 25 years of management experience, and graduated from the University of South Australia with a Honours degree in Social Work and Social Policy. She's a proud mum of 4 children, and 4 grandchildren, and regularly shares her insights on ABC Adelaide.

Can you give us a brief overview of Centacare and your role there?

Centacare Catholic Family Services has been operating in the Adelaide Archdiocese for over 70 years. It is headed up by Director Dale West and then besides my role of Deputy Director, there are 11 exec managers and about 70 program managers and team leaders. We have over 600 staff. We are the welfare arm of the Catholic Church. We offer over 80 different programs ranging from disability services, residential services, homelessness services, drug and alcohol, relationship education, relationship counselling, family dispute resolution, through to youth – youth homelessness, child protection, foster care program, mental health.

It's quite far reaching. So, in planning for *Social Work Talk's* mental health issue, I wanted to cover vicarious trauma because I haven't covered it in depth and wanted to learn more. A lot of what I read was an individual approach, you know a lot of self-care strategies. We know how persistent systems are and I was eagerly trying to find a systems approach to vicarious trauma, then I came across the Centacare study 'Understanding vicarious trauma.' It is very much from a systems perspective, so I'm really curious what prompted you to initiate this kind of study?

As deputy director one of my real passions, and always has been in management, is staff care. I really believe that the client is at the centre of all we do. So every decision that's made has to be about the client, but in that, the client to get a service that meets their needs as much as possible in every area, in terms of self-determination and dignity and independence and autonomy, staff have to be cared for enough to be able to offer that service. Because we are human beings in a human world. Humans dealing with humans. We all have our needs, levels of resilience and different tolerances. I believe in social work we all come from a place of good intent. If we are gathering people who are trained in the social work field, I mean there's not just social workers, there's youth workers, mental health workers, disability workers, we can't expect them to just go out and do their job and not be impacted upon. And as an organisation I believe we have to take some responsibility for the impact that their work has on them. We all have to have a sense of self responsibility, looking after ourselves. But as an organisation I believe we partner in that with our staff.

With research sometimes it seems very separate from the real world. What I appreciated about the study was the collaboration between Centacare and The Australian Alliance for Social Enterprise (TAASE), part of the University of South Australia's business school. I mean it shows in the research design, like how it's codesigned. How did that relationship between Centacare and TAASE begin?

We were always looking at ways that we can research our programs. We think that in terms of applying for funding, if we can have some type of research base to look at whether our therapeutic technique works, or community development, or whatever it is, then that adds integrity to our programs. We looked into doing some of our own research, forming our own research group here within the organisation, but we didn't have the expertise or really the financial resources to set a team or person aside. So, we approached researchers who were originally at Flinder's university. They were doing work with us anyway, and we decided to form a partnership with them. Jonathon Louth and Ian Goodwin Smith - Ian's the professor that heads up TAASE and Jonathon's the senior researcher. We commissioned them to do 6 research topics over a 3 year period. In that time they moved across to UniSA and formed a separate entity within the uni.

But because I'm passionate about staff care, one of the areas I'm really interested in is vicarious trauma. We used to buy in training for our staff around vicarious trauma, and what to look out for and for our managers about how to care for staff. I used to run some of the internal training. I used to use…these two books became my bible as a younger manager. Babette Rothschild, and then also the *Physiology of trauma and trauma treatment*, so out of these books I developed my own

Image from http://www.centacare.org.au/about/

training packages. With the work in the welfare sector I started to have this thing, that workers are going to be a bit like Vietnam veterans, because the type of issues just increased. The trauma and neglected treatment of vulnerable little children. We had social workers saying that 3 year olds cling to their legs and cry when they were leaving the house because they knew they'd be abused, or neglected, or hurt, once the social worker had gone. I was hearing these stories back in supervision, from managers who would talk to me, and when I run the training I'd hear their stories and think this has got to be having a massive impact on these people. It doesn't matter how committed we are. I became really worried about that.

A part of me being able to do what I can, well that was one of the ideas for a research project. Can we look at vicarious trauma across the organisation and how staff are going? What are we doing that's actually helpful? Because I can be passionate about it and I can try share it with managers, and some are but some aren't. Or some are just so busy surviving. They are traumatised themselves. It was around how they are going in terms of the level of vicarious trauma within our staff; what are we doing that's helping; what are the things they've come up with themselves that help; and what can we do from now on around that?

I would not have been aware of it if I hadn't come across the study. The study uses a broad definition of vicarious trauma. It was defined as 'a response of persons who've witnessed; been subject to explicit knowledge of; had the responsibility to intervene in a seriously distressing or tragic event.' With that definition, I mean we're talking about frontline workers, but that also includes admin workers who might be the first point of contact.

That's right.

And so, it is a workplace health and safety issue.

It absolutely is. And we need to take responsibility for that and not pathologise staff. We had one staff on stress or sick leave, but we supported her. It was sick leave because of trauma. She was saying when she'd arrive at a house for a home visit; she realised she needed help when the smell, initially, and then the sounds were just triggers that kept her awake at night. And it's repetitive. It's not like this work has a quick turnaround. So, it's that sense of working with a family in the worst of circumstances and going back the next week or three days later and there's no change. Then going back the next week and there's no change. So, it's that sense of, it is it's being at the frontline and doing what you can and initially not seeing a lot of results but experiencing the trauma.

The study quotes participants talking about trauma sitting in your body. Smell really embeds heavily in the memory, so it's not surprising. The study's literature review discussed how work stress can be a predictive factor of worker longevity and sustainability, and with social work I think about how we keep it sustainable. So, I wanted to talk about themes that came out of the focus groups, like boundary setting and the space-in-between. Little things, like having an uninterrupted lunch break, making a big difference. Could you expand on those themes, and how it might inform a more sustainable work culture?

I think the important thing is to get to know yourself, and really know your body, and how the trauma's impacting. It is located in certain parts of us. People can feel trauma in their gut; in their chest; in their head. Have a sense when you are being triggered, and you are having experiences in your body, and observing that. There's training around that for staff, in terms of being aware when that's happening and how you can

bring yourself back out of that to your own reality that's not theirs.

One of those ways is boundaries, being able to separate your life from theirs; your story from their story. One of the things that research is showing now is that some of the stuff we were taught…I studied social work in the 70s and early 80s and I did Carkhuff's model of counselling. You lean in, you have eye contact, you go into that bubble of you and the client, you reflect back what you've heard. Now they're saying when you do that with a family where there's significant trauma, or you're witnessing a child high on drugs at the age of 4 or you know, sores all over their body, and you're getting in there; research is saying that triggers in you the same type of trauma response as what can be happening in your client. So be aware if your heart starts racing and you get a knot in your gut. Now they're saying, have a sense of separation. Don't lean in. Don't get into that bubble. Be aware of your breathing. Shift yourself in the chair. Perhaps stand up and walk a bit and so break it along the way so your nervous system isn't caught in the same pattern as your client.

So you're not mirroring them…

Yes, so boundaries even at that stage, but then it's that recognition of how you separate your home and recognising the celebrations you have at home and the realities of home and how safe it is at home. When I was a young social worker - I'm a spiritual person, and the way I would deal with it was I would pray for them and say, 'I'm leaving them with you Lord because I can't actually do anything.' That helped me in a way to separate, but for people to find their own ways of doing that.

People talked about when they'd go back to work not actually everyone debriefing together because that was triggering other people. So being aware of when you're in the staff kitchen and saying, 'oh my god, that was so shocking', and we used to do that when I was a young social worker. We used to get together and describe, almost in colour, because that was their way of debriefing. That was actually triggering other members of the team, or other people in the kitchen. So, we looked at putting boundaries around that as well. We looked at having perhaps one person you can debrief with, whether that's your manager, but not actually all people doing it together. That used to be the thing, everyone thought that was helpful, but research has shown that it's not.

And the spaces-in-between, that's that sense of not fusing with something. Like ACT therapy with Russ Harris, Action and Commitment Therapy. He wrote *The Happiness Trap* and the book called *The Reality Slap*. But he talks about fusing and the concept of some thing becoming so real within you, like making a thought real when a thought is just a thought but then making that reality, so it triggers your flight, fight mechanism. Having the break stops you from fusing with it, from it becoming your world. So, you might be writing case notes, getting up and making a cup of coffee, or walking outside into the sun and remembering there's sun.

Having the break stops you from fusing with it, from it becoming your world. So you might be writing case notes, getting up and making a cup of coffee, or walking outside into the sun and remembering there's sun.

Physically distancing yourself from it. Bit different at the moment, all working from home…

And that's really interesting because staff are finding it very stressful and intense – counselling on the phone. It's so much more intense and you're not comfortable with natural silences on the phone. So, it's that filling in the gaps all the time, instead of creating gaps.

With those themes, are there big shifts in the way Centacare might look at vicarious trauma? I know Centacare already had, like other organisations, internal policies, but curious how that might've changed.

We support our staff through a systemic structure. We have a Quality and Systems department, we have our vicarious trauma policy and all different types of policies around that. But they're only as good as the person that implements them and it's number or letters on pages, and we're talking flesh and blood as well. We have to be continually aware. There's got to be a person who carries it - a champion. There's got to be someone who's committed to it. In this organisation that's a responsibility that I take on board. And out of it we've formed a taskforce looking at implementing the recommendations. We're developing a hub for our portal; a wellbeing hub. Vicarious trauma has to be an agenda item on every team meeting. We're looking at a different model of clinical supervision, and it's a most impressive model of supervision I've ever come across. So, we're looking at getting them into our organisation and doing the initial training with all our clinical supervisors to look at just having a consistent, effective model of clinical supervision. One of the things, and I understand this, is that supervision is often the first thing that goes. You get really, really busy, and you got

issues with staff and reports due and it's easy to say 'can we just change supervision till…' And it's one of the most vital things. But it's also looking at what happens within supervision, and how to look for whether there is some sort of vicarious trauma beginning for a worker. We are looking at changing or upskilling our clinical supervisors around that.

With that sometimes it's the line manager that's giving supervision, and that can be difficult in itself. Having that sort of power dynamic between the, say for example the case worker and manager, versus having an external clinical supervision where you have that separation.

It's an interesting one because administrative supervision and clinical can get mixed in. Often when it's your manager, they have to discern what's a performance issue and what's a supervision issue. I've got a lot of time for the concept of external supervision. My concern is there has to be a loopback of information to the manager, because there can be a whole range of things happening for your staff that you're not aware of. So how then can you best support? If you're just doing admin supervision with your staff and someone else is doing clinical – so there's that. There's also how do you know what your staff are doing as a clinician if you're not getting a loopback of information that that person may need some extra training, extra resources. That's why I think this supervision model I've come across is really excellent, in terms of a manager doing it because it gives you 4 quadrants to work from – personal, professional, educative; I can't think of the fourth. So when a staff member might start saying, 'look I've just been having a really rough time at home that's why I'm not…', you can say, 'actually, can we put that in the personal quadrant, and we'll come back to that? But what I wanted to talk about was this right now…'

Photo by Amy Hirschi on Unsplash

It gives it structure because sometimes, well when I've had supervision with my line manager sometimes it's a matter of, 'oh, uh, what are we talking about?' And if I do start talking about something, is this best time to address it?

Yeah, that's right. And it's really good, and you do get back to it. And it's, 'are you ok to move to this quadrant now? Do you feel like we've covered that?'

What I thought was interesting was the idea of vicarious resilience, and flipping the narrative, and having these small wins. Maybe small wins of the client that then build up vicarious resilience in the workers. That's new to me! Could you talk about vicarious resilience and how that could be incorporated into an organisational approach?

Yeah, it's a bit like those studies years ago when they look at, you know in war time or times of disasters or earthquakes or floods. How do some communities have a resilience, and some don't? How do some families seem more resilient, and some don't? How do some individuals survive the same atrocity than another individual? There are those key factors of resilience that they talk about - I think there's about 12. I think in the work that we do, if you're well supported with supervision, good debriefing and implementing some of those things around the space-in-between, and mindfulness, like meditation – whatever suits a particular individual, you grow resilience muscles.

...if you're well supported with supervision, good debriefing and implementing some of those things around the sapce-in-between, and mindfulness, like meditation - whatever suits a particular individual, you grow resiliance muscles.

It's important to have reflective practice as well and look back and go, 'I've witnessed this, I've done this, but we've worked together and I've seen that my client achieved this.' You learn you're actually surviving it. In terms of the crisis, you turn it from a colour tv into black and white. You know, it's less dominant. The factors of tenacity and intuition and being switched on and coming up with creative ideas, they become more in colour. There's a good feeling around that, that I've got that now to draw on. I've got a resilience out of this that I didn't think I would have. So when they see their client progress, there's such a reward and encouragement for the worker themselves, so there's hope entwined in as well. That what I'm doing is not hopeless, the situation is not hopeless.

So, I think with good support our workers are learning to reflect back and know that they are growing in resilience. And they are seeing their clients grow. And

seeing them as small wins, not as failures because they didn't achieve this, but to have measurable indicators that we are actually moving forward.

Yeah, the reason why I really wanted to talk on that was because, even earlier when you spoke about secondary trauma that's incidental to the work, and so it's good to be able to reframe it and instead of just focussing on the negative, there are those small wins. And that those small wins can then also, as a secondary response in the worker, help to build resilience and make the work feel worth it.

Yes, and they are small moments. And to recognise that when you're with a client, the fact that even that you're together in this house with you – recognising that that's something really quite special. It's so important to look for those moments.

So, from the research there's this evidence-based approach where there's a research body in conjunction with a practicing organisation, so you don't have a distinction. You can see that what the research is doing, and the fact that it's done in collaboration with employees, that there's going to be something practical come out of it. I think it's a lot more approachable for other organisations to say, 'oh actually, this could be applied to the organisation I'm in.' Going forward, how could other agencies engage with the findings in this study?

For starters, I think this report has given other agencies permission to have a look. I think, especially in the Department - I have such admiration for social workers and managers and directors in the Department of Child Protection here in South Australia, and Department of Human Services. Because our communities are hurting so much. There's so much neglect and abuse, and workers are working so hard. I think sometimes, from the top, in the government sector, through to the first-year social worker, there's huge pressure to perform. Because we're also in a political and economic climate where we have to show outcomes, and outputs sometimes, of human interaction. So, there's massive pressure on budgets and funding, which is a traumatic thing in itself.

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For heads of departments to be able to give themselves permission to ask the question, 'how are our workers going? That actually makes us very vulnerable to ask that question. Because when we ask it, and when we get the answer, then we have a responsibility to do something about it.

I get all the pressures that can bring about a culture of not seeming to care for your staff. I think a study like this gives organisations and agencies permission to have a look, because we can have a look, and together have that conversation, staff and managers together, without feeling that we're going to be up for some sort of lawsuit or liability. We have to go to the centre and be the 2 people together, or 200 people, and ask the question. And then our thing as agencies together, we try and support one another.

I shared my thoughts about this with the CEO of the Department of Child Protection here in South Australia, and the deputy CEO of the Department of Human Services, who came to the launch of our report. I said I would love to meet with you both, the three of us, and just look at what can we do. And how can we work across sectors for our wonderful people who are working with our most vulnerable clients. And they were very, very keen, but then it was Christmas and we had all the bushfires…

And floods…

And COVID, but yes, that is on my list to re-connect with them and have those conversations because I absolutely believe we have a responsibility to do that.

You can contact Pauline by visiting Centacare http://centacare.org.au/contact/

Read the full report, 'Understanding Vicarious Trauma' at http://centacare.org.au/new-study-understanding-vicarious-trauma/

THE AUSTRALIAN ALLIANCE FOR SOCIAL ENTERPRISE

Dr Jonathon Louth, research fellow at TAASE, has focussed his research on the intersection between the political economy and the experience of everyday living. His experience spans the community sector, government and academia. I spoke with him about his research collaboration with Centacare on vicarious trauma. Here he summarises key ideas within their 2019 study, 'Understanding various trauma'.

Dr Jonathon Louth

Working with traumatised clients results in very real consequences for professional caregivers. Vicarious trauma, compassion fatigue and burnout are three well noted categories of the psychological consequences of *empathetic labour* (Adams, et al., 2006). With the rapid expansion of the community services sector over the past few decades, frontline workers are experiencing higher levels of trauma that will impact their everyday lives well into the future. Serious consideration needs to be given to this emerging generation of veterans who are returning – not from war – but from working within vulnerable communities and families within our cities, suburbs and regions. This is a 'ticking timebomb' that cannot and should not be ignored by governments, funding bodies and service providers. Current responses to the COVID-19 pandemic only underscores the need to prioritise the wellbeing of frontline community sector workers.

But what is vicarious trauma?

Empathetic or emotional labour defines much of what is performed by social workers and related helper professions. While providing care and working with clients who have experienced trauma can be highly rewarding, the consequences of doing so are also an occupational hazard. Vicarious traumatisation describes the range of cumulative and harmful effects on an individual who has been exposed to and has empathetically engaged with other people's trauma (Baird & Kracen, 2006; McCann & Pearlman, 1990; Pearlman & MacIan, 1995). Moreover, it can manifest emotionally and physically in a manner that an individual's perception of themselves, others and the world is altered (Devilly, et al., 2009; Pearlman & MacIan, 1995; Trippany, et al., 2004).

Compassion fatigue is a reduction in the interest and capacity of caregivers to empathise with the suffering of those they work with. This reflects the exhaustion and emotional impact that can come from empathetic engagement that can have particularly adverse effects upon workers (Adams, et al., 2006). As was also shown with this study, there is a very strong correlation between compassion fatigue and work satisfaction; a takeaway for organisations to consider how appropriate interventions will encourage healthier workplaces that will benefit workers and clients alike.

Like vicarious trauma, compassion fatigue is cumulative, yet it differs in the manner in which it contributes to the *wearing down* of empathy and compassion. It is an empathetic exhaustion that stems from dealing with distressing and emotional circumstances and material that define the daily work of professional caregivers (Newell, et al., 2016).

Hence there is a substantive point of difference where vicarious trauma represents an *empathetic bonding*, while compassion fatigue is more commonly associated with *empathetic erosion*. However, symptomatically, they are similar in the manifestation of 'feelings of emotional depletion, helplessness and isolation' that mimic the 'direct trauma survivor'' (Kadambi & Ennis, 2004, p. 6).

Burnout is a concept that is often interwoven with vicarious trauma, secondary traumatic stress and compassion fatigue. However, burnout can be experienced more broadly and relates to exhaustion or stress from difficult clients or roles rather than exposure to a client's traumatic experience. Burnout results in detachment, depersonalisation and a reduced sense of accomplishment and/or commitment to a job. Like vicarious trauma, burnout can manifest physically, emotionally or behaviourally and impact professional and personal relationships (Devilly, et al., 2009; Maslach, 1982; Tabor 2011).

The important point of difference is that burnout is transient and preventable. Vicarious trauma, on the other hand, is an unavoidable consequence of working with trauma survivors (Kadambi & Ennis, 2004). Mitigating and ameliorating the effects of vicarious trauma needs to be a core concern of frontline community sector organisations. In doing so, burnout – which can be a consequence of or a compounding factor – will and should be addressed through a developed suite of strategies.

While trauma is transformational, its impact is not exclusively negative. Stories of resilience and positive growth that emerge from some traumatic episodes have been shown to positively alter life narratives, inspire communities and have a positive impact on workers. In this sense, client resilience can actually become a source of strength for workers. This vicarious resilience 'effect' illustrates the positive *affect* that clients can have on workers, which, in turn, adds to the value that can be gained from caring work. (see Hernandez-Wolfe, et al. 2007).

What we looked at:

Working closely with Centacare Catholic Family Services (CCFS) in Adelaide, researchers from The Australian Alliance for Social Enterprise at the University of South Australia undertook an 18-month organisational-wide study into the cumulative effects of vicarious trauma. While clear areas of improvement were identified, the overall rate of traumatisation among CCFS staff was low. Further, the study also identified the empathetic abilities of staff. Overall, the findings reflected a unique alignment between Centacare's purpose and mission and the abilities of staff and many workers' very notion of 'self'.

Further to this we identify five key themes. They were:

1. Vicarious trauma (absorption)
2. Workload (exhaustion)
3. Support (care)
4. Job satisfaction (meaningfulness)
5. Structural factors (indifference)

Building on these findings, our study identified a number of key protective and predictive factors for workers in traumatic environments. This included a focus on **work satisfaction** and that it strongly correlates with compassion fatigue. **Informal support networks** were shown to be vital to the overall health of the organisation and that the **'space between' matters** for workers everyday practice. The need for effective **boundary setting** was clear as was the elevation of **small wins**.

While many organisations would feel confident that they do have strategies in place that take these factors into account it is very unlikely that they are considered as a suite of interconnected issues. This means developing polices to ensure that workers empathetic reserves are not depleted, that informal networks are given the space and time to 'breathe' without becoming burdensome. The need for cultural change to resist 'the cult of busy' so that time between clients, time for lunch and time for collegiality is protected. Similarly, the boundary between work and home life needs to be vigilantly attended to. And, finally, the client voice needs to be celebrated as it is their stories that were repeatedly shown to inspire staff and provide meaning for the important work that they undertake each and every day.

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IF SOMETHING IN THIS ISSUE INSPIRED YOU, SPARKED A THOUGHT, CHALLENGED YOU OR YOU'D LIKE TO CHALLENGE US, PLEASE LET US KNOW!

WE'D LOVE TO INCLUDE YOUR FEEDBACK IN OUR NEXT ISSUE.

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