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The Australian Alliance for Social Enterprise

Centacare Catholic Family Services

Understanding vicarious trauma

Exploring cumulative stress, fatigue and trauma in a frontline community services setting

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“It’s a side effect of empathy I think; we’re all going to get it at some level. It’s a spectrum I think, vicarious trauma, we’re all going to get affected by other people’s stuff just based on being empathetic human beings.”

Focus group participant

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Executive Summary

This report identifies risk factors associated with vicarious traumatisation, compassion fatigue and burnout within a community services organisation that provides a diverse suite of programs within vulnerable communities and for families and individual clients across South Australia.

Through capturing the staff voice, the report also identifies points of resilience and strength-based responses that stem from undertaking trauma related work.

While noting the supportive workplace environment provided by Centacare Catholic Family Services, key protective and predictive factors identified within the report include:

- The positive and negative links between work satisfaction and compassion fatigue;
- The importance of and risks associated with informal support networks;
- The need for space, time and boundaries;
- The significance of elevating client voice and sharing ‘small wins’;
- The importance of freedom to express and discuss trauma-based work; and,
- The need for funding arrangements that incorporate protective and predictive factors for workforces.

Action on vicarious trauma is of paramount importance to community service organisations and the organisations that fund them. From workforce retention, through to the health and wellbeing of workers and the translation of workforce wellbeing into optimal client outcomes and social and economic impact, there are compelling reasons to embed vicarious trauma mitigation strategies within organisations and service contracts.

Introduction

"We walk alongside the clients. We listen to those stories. We invest emotionally. We are human, so it has to have an impact."

Trauma cannot be wished away. It needs to be managed, worked through and monitored by workers and clients alike. Moreover, trauma does not simply disappear when workers go home: It leaves a residual presence that can contribute to a cumulative reaction. Empathetic stress, burnout, compassion fatigue, secondary traumatic stress and vicarious trauma speak to a spectrum of dissociative or disjunctive effects (Killian, et al., 2017; Hernandez-Wolfe, et al. 2007).

Vicarious trauma is an unavoidable consequence of working with trauma survivors. For workers in the caring professions, this can mean actual harm over time. Indeed, there are workers who feel that their experiences are less 'vicarious' and represent direct trauma (Pack, 2013). With the rapid expansion of the community services sector over the past few decades, this represents a 'ticking timebomb'. Frontline workers are experiencing high levels of trauma that will impact their everyday lives well into the future. They represent a generation of veterans who are not returning from war, but from working within vulnerable communities and families within our cities, suburbs and regions. This situation cannot and should not be ignored.

However, exposure to trauma can also be transformational and radically impact a person's self-perception and life narrative. Often – and understandably – the viewpoint for practitioners has focused on mitigating the negative effects of traumatic experiences. Dealing with trauma is what they do – everyday. But we can also look to post-traumatic growth and vicarious resilience. Why is it that some clients and workers deal better with traumatic situations than others? Is it possible to identify strength-based approaches to dealing with vicarious trauma?

Through the deployment of an organisational-wide validated survey and a series of in-depth focus groups, this study provides a comprehensive analysis of vicarious trauma within a large community services sector organisation. Our study identifies a number of key protective factors for workers in traumatic environments:

- **Work satisfaction:** There is a very strong correlation between compassion fatigue and work satisfaction. The drivers that inspire work satisfaction can be a protective factor in minimising compassion fatigue when appropriate supports are in place. Unchecked, these very drivers can be a root cause of compassion fatigue as workers' empathetic reserves are at risk of depletion. The takeaway from this is that appropriate interventions and supports will encourage healthier workplaces.
- **Informal support networks:** Peer relationships are vital and are a keystone within this study. However, care must be taken to ensure that traumatic experiences are simply not offloaded onto other staff.
- **The 'space between' matters:** Time between clients, time for lunch, reflection or chatting with colleagues *all* matter. The cult of busy, whether self- or sector-imposed diminishes the effectiveness and likelihood of meaningful support practices. Key considerations around support needs to be around the availability of clinical supervision, an authentic organisational voice around self-care, and a policy approach to managing informal support, without necessarily 'formalising' it in the process
- **Boundary setting:** The boundaries between work and home need to be protected. Workers need to be able to and be supported to better distinguish between their personal and professional lives. Identifying boundaries lessens the burden of carrying traumatic material outside of the workplace

- **Small wins and the client voice:** It is imperative that a culture of celebrating wins and the elevation of clients' voices feature prominently in everyday workday practices. Strength-based narratives can contribute to enhancing and developing resilience in staff and directly contribute to a vicarious resilience informed approach.
- **Organisational relationships:** While organisations require managerial relations, the enabling of a structure that encourages 'power with' as opposed to 'power over' allows for an emancipatory approach to dealing with vicarious trauma. Freedom to discuss and work through solutions lessens the impact of trauma-based work.
- **Recognition by funding bodies:** In order to protect against the economic and health consequences of vicarious traumatisation, funding bodies must factor protective and predictive strategies into funding arrangements.

This study has clearly identified that Centacare Catholic Family Services takes the wellbeing of its staff very seriously. While there are clear areas that can be improved, the overall rate of traumatisation among staff is low. Further, the study has also identified the *empathetic abilities* of staff. Overall, our findings reflect a unique alignment between Centacare's purpose and mission and the abilities of staff and many workers very notion of 'self'. Coupling these strengths with the recommendations herein will place Centacare at the forefront of identifying, responding to and protecting their staff from actual and potential vicarious traumatisation.

Organisational Setting

Centacare Catholic Family Services (hereafter referred to as Centacare) is a community services organisation that operates in South Australia. It has a significant footprint across the state, providing services and programs that reach out from metropolitan Adelaide, Murray Bridge, Whyalla, Mount Gambier and the Berri. This allows the organisation to project its work through the Adelaide Hills, Barossa Valley, Fleurieu Peninsula, Limestone Coast, Murray Mallee, and Riverland regions.

With over 500 employees across six service delivery divisions and another five divisions that come under corporate services, it is an organisation that has a presence in frontline delivery within vulnerable communities and provides much need assistance to people who often are or have experienced deeply traumatic events.

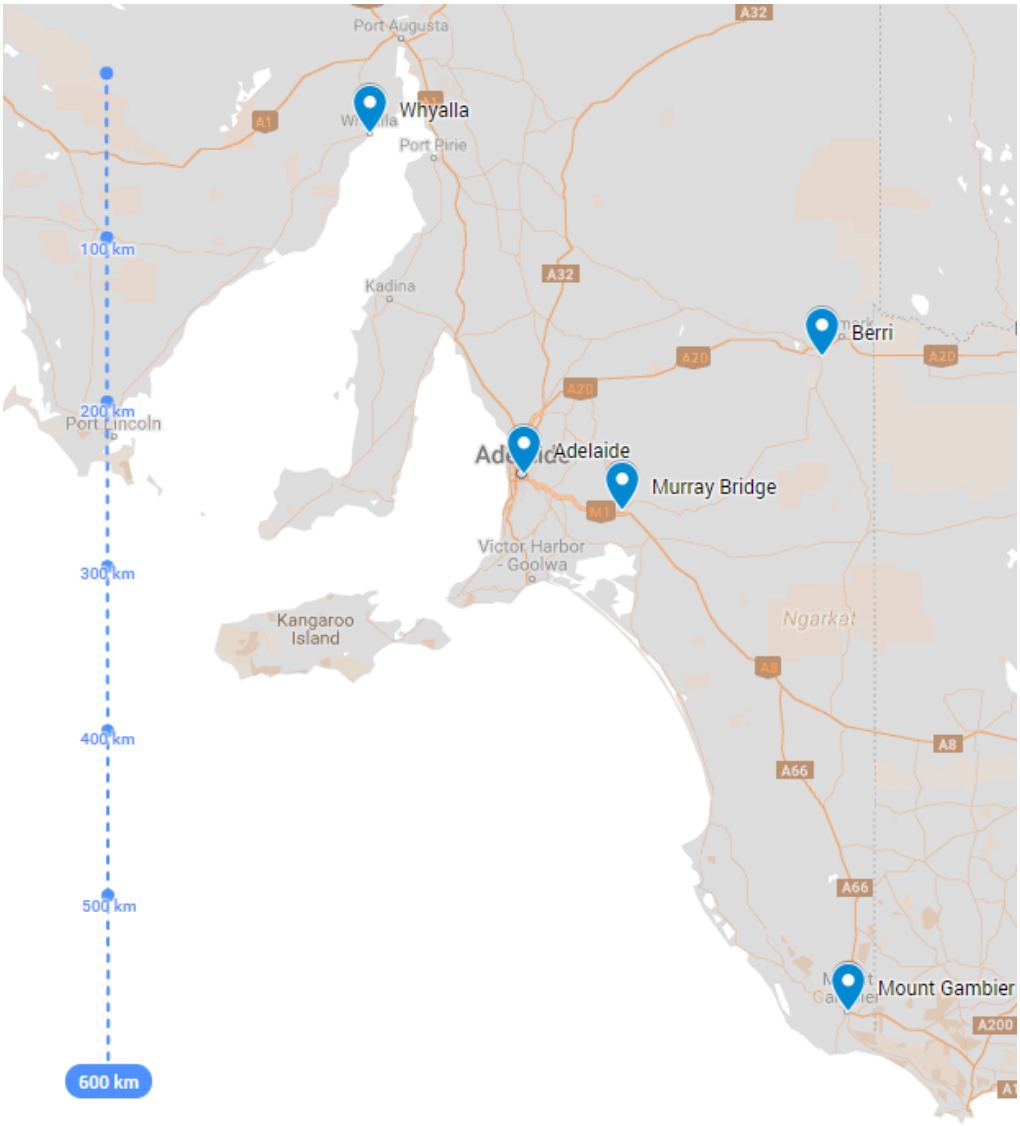

Figure 1: Map of service coverage by main locales

From a service delivery point of view there are six main divisions within the organisation:

- Youth and Community Support Services
- Domestic Violence and Homelessness Services
- Disability Services
- Support Training and Intervention Services
- Relationship Support Services
- Children Services

Across the divisions, through multiple programs, staff work with clients who experience serious mental health issues, episodes of self-harm or suicidal ideation, drug and alcohol addictions, domestic and family violence, child abuse, neglect. In complex cases many of these issues intersect and can be compounded with the need for emergency housing, supported accommodation or respite services. Traumatic experiences can also be encountered through the delivery of family counselling, preservation and reunification.

This snapshot is representative and does not capture the full scope of activities that the Centacare workforce encounters on a *daily* basis.

In order to ensure a safe and supportive working environment, Centacare has developed a suite of policies. This is not just about aligning with legislative requirements, it is core and speaks to the mission of the organisation to ensure a proactive and responsive environment for the ongoing care and wellbeing of employees.

Internal policy framework

Centacare has developed a range of policies that are centred on the organisations commitment and responsibility to provide "a healthy and safe work environment" (Centacare, 2016, p. 1). This includes it most recent work health and safety internal policy document: the Vicarious Trauma Management Guidelines (Centacare, 2016).

As a policy, it acknowledges the risks associated with the core work that is undertaken by the organisation. It defines vicarious trauma as:

> "… a response to repeated exposure and empathic engagement with traumatic material – it happens because you care and work in a way that engages with people through empathy. It is not just a response to one person, one story, or one situation. It is the cumulative effect of contact with people who have experienced violence, abuse and other traumatic events." (Centacare, 2016, p. 1)

The document clearly outlines the risks and responsibilities for both management and individual workers. Specifically, the guidelines underscore the need for appropriate supervision (including clinical), training, peers support, and the latest research (Centacare, 2016).

Importantly, it is a document that does not exist on its own. Centacare have a suite of policy documents that focussing on the health, safety and wellbeing of staff. These include:

- Health and Wellbeing Procedure
- Occupational Violence Procedure
- Potentially Traumatic Events Guidelines
- Remote and Isolated Work Procedure
- Supervision Policy
- Work Health and Safety Handbook
- Worker Safety Guidelines

Understandably, there is a degree of overlap between policy documents. Indeed, this should be encouraged so long as clarity is not lost. However, the Vicarious Trauma Management Guidelines is an outlier in that it is primarily independent of the other policy documents. That said, the Work Health and Safety handbook includes a short section on a need to be aware of the potential rick of "experiencing vicarious traumatisation" and of the "need to practice self-care" (Centacare, 2015, p. 31).

Elsewhere, the Potentially Traumatic Events Guidelines do not directly correlate with the vicarious trauma guidelines. When the definition in the former guidelines is taken into consideration, then there is a clear opportunity to consider how the two policy documents – and the aims and actions that may stem from them – interrelate:

> "Potentially traumatic events are powerful and upsetting incidents that intrude into daily life. They are usually defined as very frightening or distressing events, which may result in a psychological and/or physiological impact on an individual. This may include difficulty coping or functioning normally following a particular event or experience." (Centacare, 2016a, p. 1)

Finally, the Vicarious Trauma Management Guidelines also make the argument of the importance of strength-based approaches. Resilience (with training) is posited as a vital component of dealing with the potentiality of vicarious trauma:

> "Resilience training is recommended for all workers who will be exposed to traumatic situations in the course of their work. The purpose of this training is to increase resilience, optimism, self-care, social support and job satisfaction." (Centacare, 2016, p. 7).

It is within this organisational setting where there is clear concern for the material and emotional wellbeing for staff that this project has taken place. What we do outline in this report, however, is identify gaps and opportunities for further improvement.

Literature Review

Working with traumatised clients presents the potential for very real consequences for the professional caregiver. Vicarious trauma, compassion fatigue and burnout are three categories that identify the psychological consequences of empathetic labour – the effects of which have been noted for some time (Adams, et al., 2006). While there are points of difference between these terms, there are also similarities.

It is the similarities and overlaps identified below inform the approach within this report. Vicarious trauma and related concepts can be framed as 'irrational' responses. However, utilising a constructivist self-development theory (CDST) lens we can reframe these responses as normal adaptations or self-protection mechanisms for helping professionals deal with ongoing exposure to secondary traumatic material (Trippany, et al., 2004).

Vicarious Trauma

Vicarious trauma – as an identified phenomenon – is a relatively recent area of research, with most studies taking place in the last twenty years. McCann and Pearlman's (1990) work coined the term vicarious traumatisation, and this was later built on by Pearlman and MacIan (1995) who undertook a ground-breaking quantitative study of vicarious traumatisation among trauma therapists.

On lived experience:

"...all the training in the world will say vicarious trauma is cumulative. I heard that for years and years and years. Well, it is. And then, I found out; yes, that is right."

Female helper, FG 3

As a concept, 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). Vicarious trauma can manifest both emotionally and physically to the point that an individual's perception on how they view themselves, others and the world is altered (Devilly, et al., 2009; Pearlman & MacIan, 1995; Trippany, et al., 2004). Definitionally, we can state that:

> 'Vicarious trauma describes the process and mechanism by which the inner experience of the therapist is profoundly and permanently changed through an empathic bonding with the client's traumatic experiences (Kadambi & Ennis, 2004, p. 5)'

From a CDST perspective, we can presuppose five components of self and how the self and one's perception of the world develop (McCann & Pearlman, 1990; Newell, et al., 2016; Trippany, et al., 2004). They are:

- frame of reference;
- self-capacities;
- ego resources;
- psychological needs and cognitive schemas; and,
- memory, and perception

When interacting with trauma victims and their stories it is these schema that are disrupted. In particular, it is schemas associated with safety, trust, esteem, intimacy and control needs that have the most significant impact (McCann & Pearlman, 1990; Trippany, et al., 2004).

It is also important to note countertransference as a phenomenon. This is defined as an emotional response to a client and their experiences which can be connected to or result from experiences in the worker's own life (McCann & Pearlman, 1990; Trippany, et al., 2004; Sexton, 1999). Countertransference results in similar emotional experiences to vicarious trauma but is not specifically connected to traumatic materials and is generally time specific around interactions with clients (McCann & Pearlman, 1990; Trippany, et al., 2004; Sexton, 1999).

In essence. vicarious trauma relates to the cumulative effects of dealing with client traumas, while countertransference is specific to individual clients. That said, the two concepts can be mutually reinforcing (Kadambi & Ennis, 2004).

Compassion Fatigue

Empathetic or emotional labour, which defines much of what is performed by social workers and related helper professions, can come at a cost. While providing care and working with traumatised clients can be highly rewarding, the consequences of doing so can present as an occupational hazard. Over time there can be a reduction in the interest and capacity of caregivers to empathise with the suffering of those they work with. In short, the exhaustion and emotional impact that can come from empathetic engagement can have particularly adverse effects upon workers (Adams, et al., 2006).

Compassion fatigue bears significant similarities with vicarious traumatisation. Indeed, it has been defined as:

> '…the natural consequent behaviours and emotions resulting from knowing about a traumatizing event experienced by a significant other, the stress from helping or wanting to help a traumatized or suffering person' (Figley, 1995 p. 7).

It is also cumulative in that it is linked 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). Moreover, these psychosocial symptoms share a similarity with posttraumatic stress disorder (PTSD) symptomology and have interchangeably been labelled as secondary traumatic stress (see Adams, et al., 2006; Baird & Kracen, 2006; Devilly, et al., 2009; Newell, et al., 2016).

Hence there is a substantive point of difference in that 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).

Furthermore, there is a very strong correlation between compassion fatigue and work satisfaction. The takeaway from this is that appropriate interventions will encourage healthier workplaces, something that will benefit workers and clients (Abendroth & Figley, 2013).

Compassion satisfaction or fatigue?

"…because we're in the helping profession every day you go to work and try to be like, a person of hope and that in itself can get very draining and then – what's that saying about you can't pour from an empty cup?"

Female helper, FG 1

Burnout

Burnout is a concept that is also interwoven with vicarious trauma, secondary traumatic stress and compassion fatigue within the literature. 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 (Devilly, et al., 2009; Maslach, 1982; Tabor 2011).

Productivity impact:

"I think if you get in that overwhelmed state, then once you are overwhelmed you are not productive, and then we see it in the clients."

Female helper, FG 3

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; Bell, et al., 2003; 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.

A Combined Approach

Vicarious trauma, burn out, compassion fatigue and countertransference do not exist independently of each other. Therefore they can occur simultaneously and have the potential to trigger or develop into each other (see Trippany, et al. 2004). Further, there is a propensity to shorthand the emotional impact of frontline care and helping work under the rubric of vicarious trauma (see Bell, et al., 2003).

Mutually exclusive concepts?

While it is possible to differentiate between these closely related concepts there is significant debate in the literature about these experiences and their symptomology. Tabor (2011) argues that vicarious trauma must be acknowledged as a unique experience. McCann and Pearlman (1990) propose that trauma therapy work has different impacts then psychotherapy work, and as such vicarious trauma only occurs amongst professions that are specifically trauma focused, such as emergency medical personal and trauma counsellors. Likewise, Dunkley and Whelan (2006) argue that although secondary traumatic stress, compassion fatigue and vicarious traumatisation have been used interchangeably in previous research, vicarious trauma is a specific phenomenon concerned only with people who experience trauma through exposure to client's traumatic material.

There are a number of clear examples within the literature that identify points of difference between these interrelated concepts. Notably:

1. Research undertaken with counsellors who support sexual violence survivors found no correlation between exposure to traumatic related material and burnout or general stress. However, they did find a correlation between trauma exposure and vicarious trauma (Schauben & Frazier, 1995).

2. In another study, which compared two different cohorts of workers, they found that social workers primarily engaged with clients who had experienced sexual abuse reported more cognitive schema disruption than social workers who primarily worked with clients who had cancer. On the surface, this strengthens the argument that particular kinds of trauma work have different impacts on workers, and as such should be categorised and explored as distinct concepts (Cunningham, 2003).
3. Trippany, et al. (2004) argue that vicarious trauma is more sudden and abrupt then burnout and, unlike vicarious trauma, burnout does not impact cognitive schemas around trust, control, intimacy, esteem needs, safety, and intrusive imagery. In this sense it is not the population so much 'but the traumatic history of a population that contributes to vicarious trauma' (p. 32).

While the distinctions above are important, the usage, the similarities and the overlap between the concepts is equally important. Indeed, while compassion fatigue has been utilised interchangeably with secondary traumatic stress and vicarious trauma, the concept of compassion fatigue may better reflect the experiences of and have greater acceptance by practitioners (Kapoulitsas & Corcoran, 2015). Figley (2002), whose work developed the initial concept of compassion fatigue, has described it as a 'more user-friendly term for secondary traumatic stress' (p. 3).

Identified symptoms of vicarious trauma include re-experiencing the event, persistent avoidance, increased arousal and impairment, all of which are reflective of PTSD and consequently secondary traumatic stress, which further blurs the lines between the two concepts (Lerias & Byrne, 2003).

Kassam-Adams (1995) found associations between Secondary traumatic stress and high levels of exposure to traumatised patients. Whilst Devilly, et al., (2009), upon examining the three constructs of Secondary Traumatic Stress, vicarious trauma and burnout together and finding them to be highly convergent constructs, argued that they effectively measure the same phenomena.

Bringing it all together

Irrespective of these debates there is a clear consensus that exposure to traumatic material impacts helping professionals (Howlett, & Collins, 2014). Moreover, the caring and helping professions are at the frontline of a field that is undergoing a rapid expansion, which is underscored by an increasing need for their services. Workers are experiencing higher rates of secondary exposure to violence, abuse, torture, war/terrorism trauma, sexual violence, childhood abuse, and natural disasters due to the nature and expansion of their work. Cumulative empathetic engagement across this spectrum of issues increases the risk for workers; the consequences of which increases the likelihood of fear, anxiety, sadness, anger or disappointment unhealthily manifesting. Further, there is the very real risk that this may impact how they view themselves, others and society (Sexton, 1999).

From this perspective, this project has applied a broad lens to the concept of vicarious trauma. We based our analysis on a definition of vicarious traumatisation as:

> '…the response of those persons who have witnessed, been subject to explicit knowledge of or, had the responsibility to intervene in a seriously distressing or tragic event' (Lerias & Byrne, p.130).

Definitionally, this has allowed for a wide-reaching engagement with Centacare staff experiences and effects that have stemmed from secondary exposure to traumatic material. Taking this approach accommodates for the individualised nature of what people might describe as trauma.

For example, one helping professional could be affected by ongoing exposure to chronic trauma/distress of a client, whilst another may be impacted by exposure to a single but highly traumatic client case. Studies have shown that professionals such as nurses, emergency workers, police officers, trauma workers, social workers and psychologists have identified the experience within their field (see Bell, et al., 2003).

The research herewith is particularly focused on workers who provide socio emotional supports for clients rather than medical support (reflecting the staff profile of Centacare). As such, this targeted literature review primarily explores the experiences of social workers, counsellors, psychologists, care workers, case managers and trauma workers.

Predictive and Preventative Factors

Organisationally, it is also important to appreciate that the effects of vicarious trauma extend beyond the wellbeing of the individual. Studies have shown that motivation, productivity and the very foundation of helping/therapeutic relationships are impacted by vicarious traumatisation (broadly conceived).

In one study with experienced substance abuse counsellors, high levels of secondary traumatic stress were evident (75% of respondents) with a significant proportion (19% of respondents compared to 8% in the general population) presenting potential PTSD diagnoses. The authors of this study concluded that the results highlighted a significant and potential contributing factor that explained staff turnover and issues with service effectiveness and quality (Bride, et al., 2009). This can be further linked to how vicarious trauma can negatively impact empathic engagement and the overall quality of service (Trippany, et al., 2004).

Work stress is an important predictive factor. Across multiple studies (see Adams, et al., 2001; Bober & Regehr, 2006; Finklestein, et al. 2015) this includes, but is not limited to:

- High caseloads
- Lack of or limited:
    - Training/education around traumatic materials
    - Supportive supervision,
    - Time for self-care

However, despite these significant work environment impacts, a qualitative study by Domb, & Whiting Blome (2016) found that although all participants identified vicarious trauma as factor in staff retention and burnout, they did not believe it was a high priority for organisational focus. This is concerning given the potential emotional, social and economic costs of vicarious trauma, it cannot be categorised as only be an individual issue, but instead must be seen as an occupational hazard for helping professionals and thus an organisational concern (Baird & Kracen, 2006; McCann & Pearlman, 1990).

Individualised responsibility

Across the vicarious trauma literature, the individual level is the predominant point of focus (see Bober & Regehr, 2006; Cox & Steiner, 2013; Dombo et al., 2016; Dunkley & Whelan,

2006; Kapoulitsas & Corcoran, 2015; Schauben, & Frazier, 1995). Consequently, there is a focus on personal self-care strategies that places the responsibility to mitigate risk upon the worker. Well established examples of active coping strategies include:

- Leisure activities
- Exercise
- Healthy eating
- Mindfulness
- Conversational activities
- Spirituality based activities
- Humour

Curiously, while organisations advocate for a diet of self-care strategies, the evidence of their effectiveness are not conclusive. Indeed, one study noted that 'there is no evidence that using recommended coping strategies is protective against symptoms of acute distress' (Dunkley & Whelan, 2006, p. 7). That said, good social support networks have been shown to be a protective factor. These networks create the space for workers to better distinguish between their personal and professional lives. Identifying boundaries lessens the burden of carrying traumatic material outside of the workplace (Michalopoulos & Aparicio, 2012; Bober & Regehr, 2006).

Yet the significant point is that these self-care strategies place much of the responsibility on the worker. This individualisation can result in the implication that the worker is not effectively managing their work life balance or utilising coping strategies effectively (Bober & Regehr, 2006). To meaningfully deal with vicarious trauma, organisational culture needs to be responsive to how predictors of vicarious trauma are aligned with structural factors (Bell, et al., 2003; Dombo & Whiting Blome, 2016).

For instance, the number of hours spent working with trauma victims should be viewed through the lens of organisational and sector responsibility and not just placed on the shoulders of individuals to improve their 'self-care' strategies. A nuanced organisational self-care focus does not mean abandoning existing strategies but recognising the frame of reference within which they must occur. Examples of this this would include (Dombo & Whiting Blome, 2016; Sexton, 1999):

- Appropriate workloads and hours
- Safety supports
- Opportunities and flexibility for self-care
- Adequate resourcing

Further to the points above, organisational cultures need to be non-judgemental and adopt the position that vicarious trauma is a likely consequence of trauma exposure. Acknowledging the reality – and the potential consequences – of the challenging that helping professionals face, is a necessity for organisations that wish to better manage vicarious trauma (Bober & Regehr, 2006; Cox & Steiner, 2013; Choi, 2011; Howlett, & Collins, 2014; Kapoulitsas & Corcoran, 2015).

The potential emotional, social and economic costs of vicarious trauma cannot be categorised as only an individual issue. It must be seen as an occupational hazard for helping professionals and thus an organisational concern (Baird & Kracen, 2006; McCann & Pearlman, 1990).

Supervision

Workers that feel supported, have appropriate supervision and opportunities for education may demonstrate increase self-efficacy, which may also in turn act as a protective factor (Finklestein et. al., 2015).

Previous studies exploring vicarious trauma from both qualitative and quantitative perspectives suggest one of the most effective protective factors or management strategies from an organisational approach is supervision (Adams, Matto, & Harrington, 2001; Baird & Kracen, 2006; Cunningham, 2003; Pearlman & MacIan, 1995). It has been noted that this supervision should be positive, allow for debriefing, non-judgemental and safe space that is supportive of self-care (Cox & Steiner, 2013; Dombo, & Whiting Blome, 2016; Everly, Boyle & Lating, 1999; Howlett, & Collins, 2014; Kapoulitsas & Corcoran, 2015).

Moreover, supervision can facilitate education, with education identified as a mitigating factor for vicarious trauma (Cunningham, 2003; Dombo, & Whiting Blome, 2016; Pearlman & MacIan, 1995). Organisations that engage with embedded education and ongoing training – that includes information, coping strategies, and organisational support – have been shown to increase preventative capacity to deal with vicarious trauma (Choi, 2011; Cunningham, 2003; Finklestein, et. al., 2015).

Finally, another protective factor is the feeling of accomplishment in one's work – that is, making a difference in a client lives can upend how we conceptualise vicarious trauma (Bride, et al., 2009; Finklestein et. al., 2015). In this sense, post-traumatic growth in clients can actually build resilience in workers.

Vicarious Resilience

While trauma is transformational, its impact is not always exclusively negative. Stories of resilience and positive growth emanating from traumatic episodes have been shown to positively alter life narratives, inspire communities and even have a vicarious and positive impact on workers. Resilience, in this sense, can become a source of strength for workers.

The concept of vicarious resilience is rooted in a study that examined the experiences of psychotherapists who worked with survivors and the families of survivors of political violence. Stories of adaptation and survival, of reciprocity in the face of adversity emerged as a source of inspiration (Hernandez-Wolfe, et al. 2007). These experiences link with the concept of posttraumatic growth and compassion satisfaction, where meaning and purpose is enhanced through exposure to trauma (Hyatt-Burkhart, 2013; Frey, et al. 2017).

Recent work on vicarious resilience has highlighted that "being positively affected by the resilience of clients" can alter the perspective of a helper professional life, which, in turn, adds value to caring work that is performed. (Hernandez-Wolfe, et al. 2007). Within this context, it is not difficult to recognise that compassion satisfaction and interpersonal growth are intrinsically linked (Frey, et al. 2017).

Passion and confidence:

"...it gives you passion, it helps you work out what's working well for the family, what direction maybe you could go, makes you feel a bit more confident in your role."

Female Helper, FG 2

As a maturing area of study, distinct dimensions of vicarious resilience have been identified (Killian, et al., 2017):

- Changes in life goals and perspectives
- Client inspired hope
- Increased recognition of the clients' spirituality as a therapeutic resource
- Increased self-awareness and self-care practices
- Increased consciousness about power relative to social location
- Increased capacity for resourcefulness
- An increased capacity for attentiveness to the patients' narratives of trauma

From an organisational point of view vicarious resilience is of increasing relevance. However, it is not simply about identifying preventative measures and avoidance strategies, but the explicit encouragement and development of vicarious resilience strategies. This means building resilience through appropriate supervision that allows for consultation and being able to talk openly, particularly in relation to challenges. This may require the flattening of hierarchical structures to enable 'power with' as opposed to 'power over' relationships (Frey, et al. 2017, p. 50)

While there are a numerous elements that inform an individual's resilience (vicarious or otherwise), post trauma support – whether through a community or a workplace – is a significant contributing factor (Tedeschi & Calhoun, 2004). Indeed, peer relationships are vital (Frey, et al. 2017) and are a keystone within this study.

The recent South Australian *Royal Commission into Institutional Responses to Child Sexual Abuse* (2017) noted vicarious resilience deep within one of its appendices. Our work aims to elevate the focus from an addendum and to consider vicarious resilience as a pillar of a strength-based approach to working with trauma and its impacts.

Method Section

The project was developed through a codesign process with Centacare. This not only reflects TAASE's commitment to research that is developed through partnerships, but also ensured that the project best met the needs of the staff at Centacare. This was achieved through the project steering group consisting of researcher, Centacare management and frontline staff. In addition, feedback sessions were offered to all focus group participants and the draft findings and recommendations were discussed with Centacare staff and management prior to the report being finalised.

The primary aims of this study were to:

- Assess the overall effectiveness of Centacare's current vicarious trauma practices through a qualitative investigation of the organisation's workers.
- Investigate and identify any gaps in Centacare's vicarious trauma policy design and related policy documents.
- Develop a series of evidenced-based recommendations to inform a holistic and networked model of vicarious resilience
- Explore the development of a vicarious resilience model for Centacare and contribute to the knowledge base of the sector as a whole around this concept.

Methods

The study employed a mixed methods approach, utilising both qualitative focus groups and a validated survey instrument. The survey instrument provided a baseline to determine the level vicarious traumatisation at organisational level, while the focus groups allowed for an in-depth engagement with staff in relation to how they cope (or do not cope) with the trauma that they encounter as part of the day-to-day activities of simply doing their job.

Focus Groups

Focus groups were chosen for data collection as they allowed a deep qualitative engagement with a broad cross-section of frontline Centacare staff. The focus groups not only provided an opportunity to directly engage with staff, but also encouraged and facilitated the supportive sharing of stories and experiences amongst participants. It has been demonstrated that focus groups provide an opportunity to build a safe and research rich environment from which both the participants and the research can benefit. Provided that appropriate safeguards are put in place and all members of the group adhere to the prescribed conditions of confidentiality, research participants can find safety in numbers and a shared sense of belonging through the process of revealing sensitive information (Oliveira, 2011; Linhorst, 2002; Vogt, 2000).

The focus groups were conducted in a semi-structured manner (see appendix one); however, conversation was allowed to develop organically. Prompting questions to the groups aimed to explore knowledge of Centacare's Vicarious Trauma Policy and experiences of it in practice, experiences of vicarious trauma and suggestions for how this could be better managed. Additionally, the groups were encouraged to discuss the positives of their role and explore points of resilience and strength-based approaches – with a mindfulness as whether or not this was useful for managing risk or experiences of vicarious secondary trauma.

ProQOL survey

An organisational wide survey was used to provide a baseline and a point of comparison with the qualitative depth that emerged from the focus groups. The survey was sent to all staff across Centacare and advertised on an internal online notice board. The tool was comprised of two parts; section one collected demographic data and work-related variables. Section two administered the professional quality of life (ProQOL) validated survey (see appendix two). The ProQOL utilises three distinct scales, that of: compassion satisfaction, burnout and compassions fatigue/secondary trauma. The latter is closely related to vicarious trauma (Hadnall Stamm, 2005; Cooke, et al., 2013).

Sampling & Recruitment

Given the specific organisational focus of this study non-probability sampling methods were used. Purposive sampling was considered appropriate for this research, as participants were to be drawn from an identified group (Neuman, 2013). Snowball sampling, where participants were encouraged to pass on information about the study to their co-workers. was also employed; this was particularly relevant to the focus groups (Neuman, 2013). Notably, the participants cannot be representative of all people that have experienced, have exposure to, or have a risk of exposure to vicarious trauma/traumatic stress/burnout. Instead, the data that was collected from this study can be described as situational and context-based (Neuman, 2013).

Focus groups – sampling method

A general administration employee of Centacare forwarded the focus group recruitment email on behalf of the research team to all Centacare frontline and frontline focussed staff members who work in the following organisational units: Youth & Community Support Services, Domestic Violence & Homelessness Services and Children's Services. Information sheets and consent forms, which invited Centacare staff to contact the researcher if they were interested in participating in a focus group or if they would like further information were attached to this email.

Three focus groups were conducted, with a total of 17 Centacare staff (15 women, 2 men) participating in the focus groups. These all took place at a private room at Flinders University Victoria Square campus. This is a short walk from the main Centacare office in Wakefield Street, Adelaide. While Centacare offered the use of their professional workplaces, the researchers were of the opinion that that site for the focus group should be external to the organisation. All focus groups were audio recorded and professionally transcribed. Field notes were also taken by the primary researcher and a research assistant during the focus groups to provide context and depth to the recordings.

The three focus groups drew from frontline workers across all six organisational divisions. In addition, administrative staff were also invited to take part as they are often the very first point of contact for clients.

	Female (F)	**Male (M)**
Focus Group 1 (FG 1)	4	2
Focus Group 2 (FG 2)	6	0
Focus Group 3 (FG 3)	5	0

Table 1: Focus group composition

Survey – sampling method

An email invitation was forwarded to and distributed by a Centacare general admin employee to all frontline staff members to participate in the survey (505 staff). The email included an Information Sheet and a link to an online survey which was created using SurveyMonkey. It was clearly explained that the survey was voluntary, and it was communicated to potential participants that the decision whether or not to participate would not impact employment. Consent was obtained via completion of the survey.

Online sampling is a legitimate research method for testing hypotheses about associations between variables. Further online questionnaires are regarded less 'stressful' research tools that arguably produce more 'accurate' responses, because participants respond at their best available time (Passer, 2013).

Moreover, our survey results are **valid** and **reliable** because our sampling method was both *random* and *representative,* after the questionnaire was sent to **all** the employees of Centacare.

Ethical Considerations

This study mitigated potential coercion to participate by reinforcing the voluntary nature of participation and reminding participants that they can refrain from answering specific questions and that they were free to withdraw from the study at any time. To further ensure Centacare staff did not feel obliged to participate all recruitment emails directed them to contact the research team to discuss or volunteer for the project. Furthermore, as focus group participants were identifiable to each other the researcher could not guarantee anonymity or confidentiality. This was communicated via the information sheets, consent form and verbally at the beginning of the focus groups. In addition, consent to participate was sought at the time of the focus groups, not prior from Centacare staff. Participants were also assured that all transcripts would be de-identified and stored securely. Participants were able to receive feedback from the researchers on request.

Additionally, as research focuses on participants' experience of secondary/vicarious trauma there was a risk of re-traumatisation. While the focus groups were focused on identifying strength-based narratives and supportive working environments, the researchers and Centacare note that there still remained a risk. This was also identified as potential risk for these survey participants. Potential participants were warned of risk of emotional discomfort prior to consenting to participate. Details were also provided for several supports services in case emotional discomfort was experienced.

Findings and Discussion

Establishing an organisational baseline

Integral to this study has been the development on an organisational baseline for vicarious traumatisation. Utilising the ProQOL survey instrument, Centacare staff were measured for their levels of burnout out, secondary traumatisation stress and compassion satisfaction.

The baseline will allow for both cross sectoral and internal longitudinal comparisons. Importantly, this will allow Centacare to measure and plot vicarious trauma over time, allowing for the testing of specific policy approaches.

Internal reliability of the questionnaire

The data analysis adopted the proposed analysis steps in the ProQOL manual (Stamm, 2010), including the *reversal* of some items and the *sum* of other items. The *cut scores* indicated the three levels in the participants' responses (>22, 23-41, <42). Data analysis was conducted through IBM SPSS v25.

The number of our sample participants (n=108) was very good as a percentage of the overall number of Centacare employees at the time (n= 505).

Utilising what is known as *Chronbach's Alpha* to measure the internal reliability of the survey (in order to establish how consistent are a set of questions or items are to each other), we can report a value of .715. Any number above .700 demonstrates internal reliability of the research tool (Howitt & Cramer, 2011), meaning that the questionnaire measured what it was supposed to measure (i.e. vicarious traumatisation).

Demographic Breakdown

The survey was broken down into two separate sections. Section one identified demographic and organisational data, while section two was the ProQOL instrument. The demographic breakdown allows for a snapshot of the organisation and to ascertain points of correlation with the absence or presentation of vicarious trauma, or across any of the three subscales.

Whole-of-Organisation:

"It is a whole organisation mindset, and it comes right from the very top all the way to everybody. Cleaners, administration, everybody needs to feel that sense of this is all a part of what we do."

Female Helper, FG 3

The survey was deployed organisationally-wide, across all organisational units and levels of employment. It was identified by the project team that traumatic material can be encountered by all employees, not just frontline helpers. For instance, administrative staff are often a first point of contact and information technology staff are responsible for the upkeep of sensitive (and potentially traumatic) data. Likewise, senior or executive managers may not have their own client lists, but they often deal with the most severe files that contain traumatic material.

Tables 2 through to 8 identify the core demographic and organisational data that the ProQOL instrument was correlated against.

Table 2: Organisational Unit	Responses	Percentage (%)
Children Services	25	24
Support, Training and Intervention Services	22	21.2
Youth & Community Support Services	19	18.3
Relationship Support Services	17	16.3
Domestic Violence & Homelessness Services	11	10.6
Disability Services	8	7.7
Corporate Services	2	1.9

Table 3: Position at Centacare	Responses	Percentage (%)
Direct client contact	85	81.7
Management	17	16.3
Administration	2	1.9

Table 4: Highest level of educational attainment	Responses	Percentage (%)
Postgraduate	32	30.8
Bachelor	40	38.5
Diploma	21	20.2
Certificate	10	9.6
Year 12	1	1

Table 5: Year attained highest level of education	Responses	Percentage (%)
Less than 2 years	23	22.1
More than 2 years, less than 5 years	18	17.3
More than 5 years, less than 10 years	30	28.8
More than 10 years	33	31.7

Table 6: Gender	Responses	Percentage (%)
Male	10	9.6
Female	92	88.5
Non-binary	2	1.9

Table 7: Age	Responses	Percentage (%)
18 - 24	1	1
25 - 34	27	26
35 - 44	22	21.2
45 - 54	26	25
55 - 64	21	20.2
65+	7	6.7

Table 8: Aboriginal or Torres Strait Islander?	Responses	Percentage (%)
Yes	1	1
No	103	99

Correlations.

Utilising the *Pearson correlation coefficient* we were able to determine linear relations between variables, but no causality (Howitt & Cramer, 2011). Pearson correlations measure the strength of the linear relationship between two variables (questions/items of the survey) and indicates either strong or very strong correlations between two items (i.e. *age* and *years of experience*).

Results:

No correlations: were found between either demographics or the 3 subscales of the VT tool. Demographics were also run in *t-tests*, similarly, indicating no significant correlations in demographic variables. T-tests determine if there is a significant difference between the means of two groups of questions/ items with a distinctive feature (i.e. demographics and vicarious traumatisation). The outcome aligns with the literature indicating that no statistical differences in the demographics of the respondents to the ProQOL tool.

Strong correlations: All male respondents have been working in the organization for more than 5 years. All new (2-5 years) employee participants were women.

The results from correlating the demographic data reveal – at an organisational level – that the Centacare results do not deviate statistically from outcomes elsewhere.(Mooney et al., 2017). This is important as provides validity to the test and indicates that the results are robust. Beyond male respondents and time employed there are no other strong correlations across the demographic data.

ProQOL findings

Vicarious trauma is an unavoidable consequence of working with trauma survivors (Kadambi & Ennis, 2004). The ProQOL survey acknowledges this and asks participants to reflect on their previous 30 days in relation to their helping role. Specifically, the preamble states:

> When you help people you have direct contact with their lives. As you may have found, your compassion for those you [help] can affect you in positive and negative ways. Below are some questions about your experiences, both positive and negative, as a helper. Consider each of the following questions about you and your current work situation. Select the number that honestly reflects how frequently you experienced these things in the *last 30 days*. (ProQOL, 2009)

Results

There was a strong correlation on the ProQOL across the subscales:

Strong correlations were found **between the three subscales** of the survey tool (compassion satisfaction, burn out, secondary traumatisation stress), meaning that the three subscales are interrelated in their measurement of vicarious trauma.

Table 9: Compassion Satisfaction	Responses	Percentage (%)
High (<42)	33	32.7
Average (23-41)	67	66.3
Low (>22)	1	1

Table 10: Burnout	Responses	Percentage (%)
High	-	-
Average	55	54.5
Low	46	45.5

Table 11: Secondary Traumatisation Stress	Responses	Percentage (%)
High	-	-
Average	51	50.5
Low	50	49.5

Findings

This is a most positive result. There was no indication of vicarious trauma in the respondents. Except for one, all respondents scored the following:

Compassion Satisfaction: **Average / High**

Burnout: **Average / Low**

Secondary Traumatisation Stress: **Average / Low**

The one person who scored low in compassion satisfaction, scored average in both burnout and secondary traumatisation stress. Table 12 shows the overall vicarious traumatisation at nil.

Table 12: Overall Vicarious Traumatisation	Findings	Percentage (%)
Yes	-	-
No	104	100

What we can ascertain from these results is that the respondents do not suffer any noteworthy fears resulting from their work. They may benefit from engagement, opportunities for continuing education, and other opportunities to grow in their position. They are likely good influences on their colleagues and their organisation. They are probably liked by their clients, who seek out their assistance (Stamm, 2010).

However, this needs to be understood within the limitations of the instrument. The participants were self-selecting, they were only asked to reflect on their previous thirty days and there was little or no opportunity to reflect or talk among their peers. While the instrument provides an excellent baseline that can be used to compare both across the sector and longitudinally (should it be deployed internally and consistently over time), it does not provide a deep qualitive inquiry into workers affective experiences. Emotional toil is not always easily captured in a survey.

Focus group findings

By introducing focus groups into the study, we were in a position to explore the internal experiences of vicarious trauma through a qualitative lens that builds and improves upon the results that emerge from a straightforward quantitative study. Moreover, the current study

contributes to the noted need to address gaps in the literature where there needs to be a blending of quantitative and qualitative data (see Adams, et al., 2001).

Initially the researchers developed a series of themes and sub-themes from their fieldnotes immediately following the focus groups. The overarching themes that emerged where around **structures**, **systems** and **policies**. While there was variation among the focus groups, these macro level elements were present in all discussions.

When discussing descriptions of vicarious trauma, the researchers noted the following distinct subthemes that emerged across the three focus groups:

- Exhaustion and busyness
- Informal support networks
- Physical manifestation of vicarious trauma
- Positive experiences/wins/client growth
- Resilience
- Self-care
- Working in isolation or silos
- Workplace culture

Following professional transcription, the focused groups were analysed utilising NVivo software. Here the themes were expanded upon with five key areas identified with numerous sub-themes cascading from the analysis. The table below details the findings:

Themes	Subthemes
1. Vicarious trauma	Burnout Client stories Compassion fatigue • Home life Lateral trauma Sensory triggers • Disturbed sleep
2. Workload	Breaks Client contact outside of work Data and administration Exhaustion Isolation Knowledge and expertise Risk Stress • Not coping
3. Support	Clinical supervision / reflective practice Informal support Self-care Training Well-being
4. Job satisfaction	Positive feedback Self-worth Small wins • Vicarious resilience
5. Structural Issues	Community sector Government • Funding Organisation • Management ○ Admin support ○ Vicarious trauma policy

Cluster analysis

While it is vital to identify key themes, it is equally important to identify the *relationships* between the themes (and sub-themes). Cluster analysis reveals a structure and similarities in the coded qualitative data (Bazeley & Jackson, 2013). Indeed, it is useful to help 'parse' – that is, to break up – what is complex qualitative data through a hierarchical visualisation (see Guest et al., 2012). Illustrating the clusters through a two-dimensional dendrogram (see figure 2) reveals the statistical associations between terms and how some themes are spoken about quite differently, setting them apart from other themes (Bazeley & Jackson, 2013).

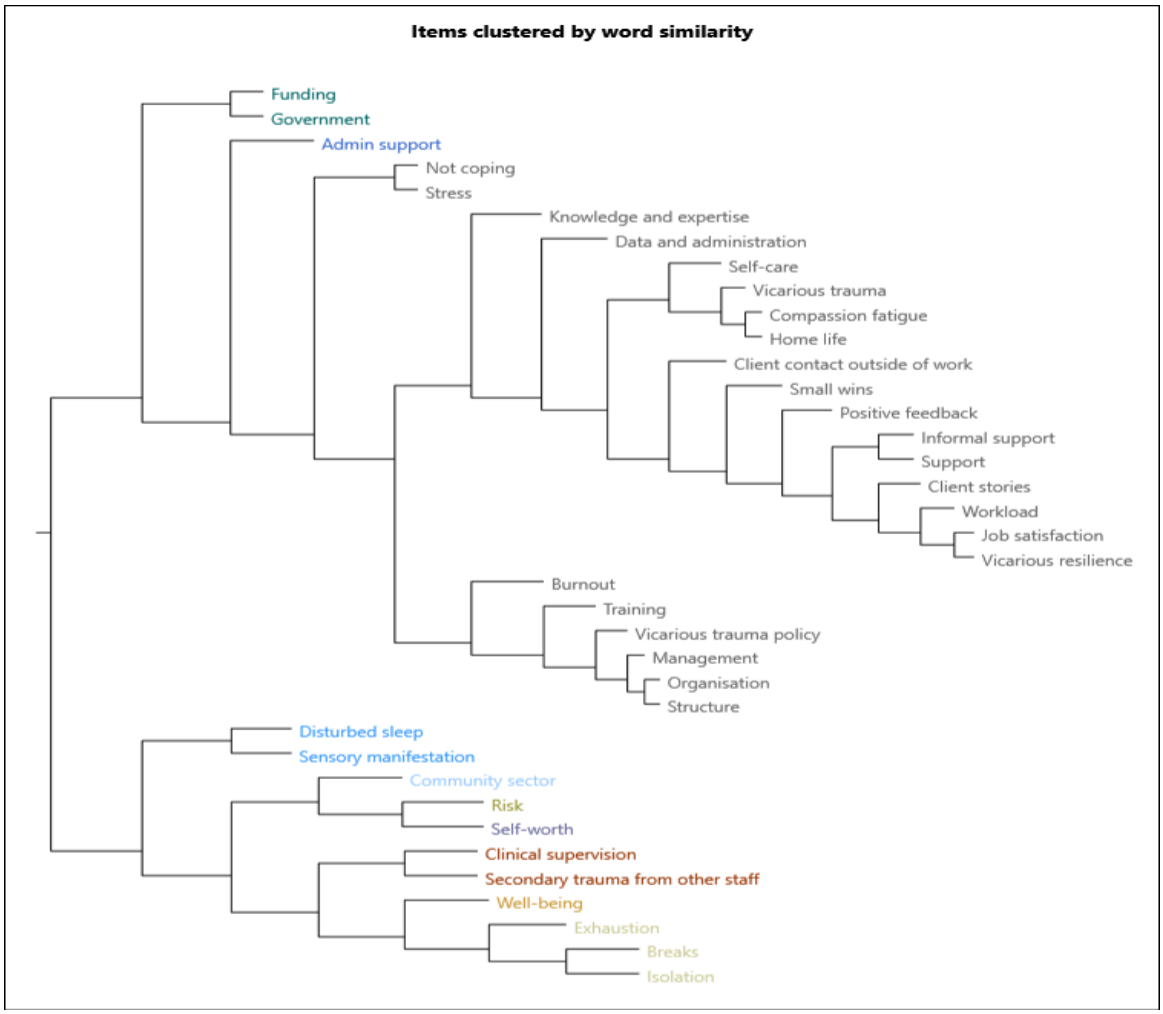

Figure 2: Cluster analysis of key themes and sub-themes

Findings

Given that cluster analysis is predicated on themes identified by the researchers, the data is exploratory and does not offer a definitive set of "explanatory evidence of association" (Bazeley & Jackson, 2013, p. 237). However, that aside, it is an excellent graphic representation of where key ideas and themes have been discussed by participants and the proximity of the ideas and themes to one other.

Key findings from the data include:

- **Burnout:** the finding here correlates overwhelmingly with the existing literature where burnout sits apart from vicarious trauma and secondary traumatic stress. It relates more broadly to exhaustion or stress from difficult clients or roles rather than exposure to a client's traumatic experience (Devilly, et al., 2009; Maslach, 1982; Tabor 2011).

Moreover, participants identified the role and importance of training, policy and managerial responsibility.

- **Physical and sensory manifestation (and the need for clinical supervision):** The manifestation of vicarious trauma bifurcates from the other main themes with disturbed sleep, exhaustion, through to the balance between self-worth and risk coalescing. What is clear is the association with the need for clinical support and that informal supports are a potential risk.
- **Self-care and compassion fatigue:** While self-care was much discussed (both in positive and negative terms), it accompanied conversations around levels of vicarious traumatisation and compassion fatigue. Staff across all three focus groups identified compassion fatigue as an issue that can impact their home life. This is clearly identified in the cluster analysis.
- **Job satisfaction:** Client stories, job satisfaction and vicarious resilience are also closely related. This also speaks to the power of small wins. The importance of support, both formal and informal, present strongly and can be potentially be viewed as contributing factors for what staff identified as vicarious resilience. Interestingly, when a three-dimensional cluster analysis is employed (see Bazeley & Jackson, 2013), stress is also in close proximity. This can be interpreted as that which contributes to job satisfaction, can likewise be a major source of stress if not managed appropriately.
- **Funding and structural factors:** This is quite clearly a high-level concern that framed much of the discussion around the impact of empathetic labour.

The Staff Voice

There is much that can be gained from a cluster analysis, but it must be approached with caution. Many more links or relationships can be identified within the chart above, but this needs to be done in relation to the literature, the identified themes and reflecting on the staff voice.

Theme 1: Vicarious Trauma

A recent Canadian study that utilised the ProQOL instrument to explore PTSD, burnout and vicarious traumatisation among homelessness sector workers, concluded that sector support workers are at greater risk than first responders (Waegemakers Schiff & Lane, 2019). That emergency service workers, police and emergency department nurses are less likely to present the emotional effects of their professional helping when compared to frontline social workers and case workers, must become a priority issue for community sector organisations and funding bodies.

While the results of the survey established a baseline that indicated that Centacare does not have a vicarious trauma issue across its organisation, the focus groups clearly indicated the cumulative effects of working in the sector. Staff regularly made comments of absorbing trauma "through osmosis" (M, FG 1), through to regular issues with sleeping, or how a television advertisement "will set you off" leaving the worker in tears (F, FG 3). Participants, while largely unaware of Centacare's vicarious trauma policy, had a developed understanding of the risk factors, particularly in relation to its cumulative effects:

> *"It's a side effect of empathy I think; we're all going to get it at some level. It's a spectrum I think, vicarious trauma, we're all going to get affected by other people's stuff just based on being empathetic human beings."* (F, FG 2)

These empathetic responses range from wanting to take a small child home to "give him a bath" and to "feed him" (F, FG 2), through to the sensory manifestation of other peoples' trauma. Workers spoke about how the trauma transfers and "sits in our bodies" (F, FG 3) and how the sensory experiences associated with works seeps in:

> *"I am not sure what you do with it, because even if you tell the facts to somebody, they are not sitting in the house smelling the smells or taking in visually what you are taking in…" (F, FG 3)*

Other concerns related to how staff new to the industry deal with traumatic events. Indeed, this is indicative of what is sometimes viewed as the false division between trauma and its vicarious presentation (Pack, 2013). Case Study 2 below illustrates how experiences for recent graduates are formative in that they become an anchor or touchstone for that worker's experience dealing with trauma. Vital to situations of this nature are appropriate and ongoing supports. How both formal and informal supports respond to early career experiences of trauma will likely correlate with longevity in the industry.

However, it is Case Study 1 that captures a textbook example of vicarious traumatisation. It is not just the shock and the absorption of trauma, but its direct impact within the worker's homelife. There is an empathetic bonding that stems from the disclosure of the experiences of

Vicarious Trauma

Case Study 1

"… at the time they had residential houses that young people lived in, you that, had been removed from their family and there was an intake where there was a toddler, I think she was two years old or 18 months."

"… normally it was older kids. So they brought this toddler in and at that stage I had a daughter similar age and they gave us a briefing, there's kids in here been removed and they said they had to tell us and said when you're on the system and log in on this or your database kind of carry on, don't click on such and such links because that's photos of her when she was taken into care and she's bruised from being beaten. This is a two-year-old."

"So, at the time I'm bathing my two-year-old, drying her off with a towel and lovingly caring for her and then I'm working with a child that's been beaten by an adult. And that to me was like, kind of a tipping point, like I didn't have time off work, but I was a bit - my faith in human nature was pretty much shaken." (M, FG 1)

Case Study 2

"I think for me the one that always sticks out, and I was a bit of a green graduate social worker at this point, but the first time I saw a young girl really off her face. She'd come into our … program because it was a safe place and this older man had shot her up, and I was just beside myself. I couldn't imagine that an adult man would help this little girl inject drugs. She was just really visibly just messed up, and we were waiting for the ambulance and I remember just being very, very shocked by that, that state that she was in. Being such a green social worker as well I was just really like, I'm just going to call an ambulance, I really do not know how to handle this situation." (F, FG 2)

Case Study 3

"I think it was my last client of the day. It was a really traumatic story. The young person was clearly quite traumatised by what had happened and got very descriptive with me about what had happened, and I walked out of that appointment and I just felt so heavy and I thought, "I need to talk to somebody about this." My manager wasn't around, and I am like; I don't want to burden my colleagues with hearing about something that is really horrific, because I feel like that is burdening them. And so, what meant was that I took that home and I was really upset. It was probably a day or two later, I just was not – I felt like I wasn't really myself because I hadn't let go of that story, and I was really worried about this young person coming back in, and things like that." (F, FG 3)

an abused toddler in their care that is transferred into how that worker responds and interacts with their own child. This experience – not captured through the ProQOL survey – illustrates the need for deep qualitative engagements. The worker in question was fortunate enough to have excellent informal supports. However, organisationally, this should not be the primary solution for incidences of this nature. Case Study 3 illustrates why this is not necessarily a reliable approach.

Compassion fatigue

The exhaustion and emotional impacts that come from empathetic engagement have been shown to have adverse effects upon workers (Adams, et al., 2006). Many of the participants spoke about the impact of their work upon their families and home life; of children and partners who could read the situation when they walked through the door: "… I don't even have to say, and these people know that I'm really not a good place" (F, FG 1). And, again, the cumulative nature was well understood by participants:

> *"…compassion fatigue and, you know, because we're in the helping profession every day you go to work and try to be like, a person of hope and that in itself can get very draining and then – what's that saying about you can't pour from an empty cup? I love that saying. Yeah, so it can be like a gradual thing rather than oh, I've hit vicarious trauma…"* (F, FG 1)

The need to be aware of desensitisation was also commented on and that compassion fatigue can impact work practices. *Generally, there was an opinion that workers needed to be aware of, and respond when they self-identified desensitisation*.

Burnout

It is well established in the literature that burnout increase staff turnover, which in turn impacts organisational efficiency through to client trust (Middleton & Potter, 2015). Participants identified the risks around burnout in respect to themselves and to the organisation:

> *"You are going to get experienced workers that will be burning out, and all that expertise and resource and knowledge, skills, etcetera, just walking out the door. I am getting close to it myself. I am serious. Because of those demands, of; you need to be seeing five clients in a row and then you have got to do the data" (F, FG 3)*

A number of participants linked their sense of feeling overwhelmed and that they "just can't do anything about any of it" (F, FG, 3) with having a direct impact upon their productivity. These ideas were commonly linked to sector, organisational and/or unit expectations that underpin workload models. However, workers were clear that workload expectations cascaded down or were informed through funding models and associated KPIs

Theme 2: Workload

Workload is an issue that is connected to burnout and vicarious trauma. Workload imbalance – so, not just the amount of work, but the many hats that need to be worn by workers – is a significant factor. Furthermore, a sense of control within the work environment is vital (Wilson, 2016). An example of the many hats and a lack of control is illustrated by the following example:

> *"I feel like the cases where I am taking it home and thinking about it are the ones where I feel not equipped. An example would be maybe over a year ago a lady I was working with suicided. I was upset when I found out, I spoke with my manager and I got a lot of immediate support. I probably didn't need all of that support, I was just grieving and sad for the death of someone. I have only just thought about that now, I probably have not thought about that person for six*

> *months. The weight I'm carrying around at the moment is a lady I'm working with who is dying, and I feel I don't have the skills to work with her and I feel I don't have the support around that."* (F, FG 2)

As an example, it speaks to vicarious traumatisation and burnout, but the root of the issue highlights concerns around workload and work imbalance. The individual in question felt well-equipped to deal with serious situations within which they were trained and was within the job description and their overall expertise. While the suicide of the client was tragic and sad, the worker understood the complexities of what they were dealing with. Workplace support was in place, but not necessarily required in this instance as the situation matched the worker's expectations of what *might* happen through the course of their work.

However, due to changing working practices and having to wear 'more hats' the person found themselves working in a palliative care-type scenario that they felt unprepared for and found that to be a troubling experience. The unfamiliarity of the situation – that is, the changed work practices – directly impacted the wellbeing of the worker. While flexibility and the ability to change is required within the workplace, consideration of expertise as they map against potential traumatic situations should be a consideration.

The cult of busy

Another concern that was raised across all focus groups is what we have termed the 'cult of busy'. The interiorisation of a logic around work as a primary driver in some peoples lives was identified as a problem. This, of course, is not unique to this sector and reflects a broader issue within our society's political economy (see Louth & Potter, 2017).

Participants called for the need for well regulated boundaries, clear lunch breaks and sustainable workloads. What was evident was the level of variation across the organisation, with some units employing strategies to better deal with workload boundaries, while others had to self-manage. Yet a common sentiment was that too many workers had bought into the cult of being busy:

> *"…I know other people that book back-to-back visits, no lunch break and they kind of celebrate it and I just think man, a year from now you're going to be in a different industry because you just can't last like that"* (F, FG 1)

> *"… I feel like some workers, their identity is in doing everything and working hard and not complaining … Doing overtime and case notes on a Sunday morning. So, then you're up against that."* (F, FG 2)

The quotes above show two points of concern. The first relates to how burnout is an actual workplace hazard that needs to be managed. There will always be too much work to do and if workflow is not appropriately managed it will likely impact those who work without consideration to their wellbeing. The second point of concern is how this 'cult of busy' potentially impacts all workers. As a phenomenon, it creates a situation where workers are compared to one another with the overall completion of tasks becoming a yardstick (that continually changes in magnitude). The potential consequence is that workloads increase overtime as more outside of workhours become normalised and even accepted practice.

Risk

While risk is multifaceted and presents across a number of differing scenarios, two key points of concern emerged:

1. Exposure to potential media events

Risk outside of the workplace:

"I was on my first day of my holidays … My first day, I went to an auction house that I sometimes go to, and I am walking around and there is this guy, and as soon as I saw him I just froze because it had me go back – This client was a client that there were some major issues of concern of what he had actually expressed in the session, to me. … So, it was really quite traumatic actually seeing this client, but to then see him there on my first day of holidays, and I just froze. I thought, "God, I can't even go out here." That is my first day of holidays"

Female Helper, FG 3

2. Clients outside of the workplace

Workers felt that any mistakes that were made – real or perceived – were at risk of ending up on the frontpage of the newspaper. That it is the social workers fault if something goes wrong. While there may be instances where workers are and should be held to account, the risk raised in the focus groups reflected a sense that broader social issues and structures that underpinned the very nature and production of vulnerabilities in certain communities were routinely ignored. Instead, the risk of 'blame' and 'fault' was all too often blamed on the worker. This risk fed into the day-to-day practices of some workers and was taken home as an additional stressor.

The second concern of clients outside the workplace was a concern for several participants. While not necessarily avoidable it should be noted as a risk that contributes to increased anxiety for some workers.

One interesting observation was that regional or formerly regional-based workers were less concerned with bumping into clients outside of work than their metropolitan counterparts.

Theme 3: Support

Support – whether formal or informal – emerged as a predominant theme over the course of the three focus groups. When reflecting on the ProQOL baseline of no organisational vicarious trauma, it is these support structures that can be zeroed in on as fundamental to the overall health of Centacare and the individual wellbeing of workers. Indeed, this has been repeatedly identified within the literature where:

> "The overwhelming finding from these studies is that supervisory and peer supports are significant factors which influence commitment, organisational culture and intention to stay or leave" (McFadden, et al. 2014)

The low turnover rate within Centacare reflects a culture where support is enabled. However, what was also clear is that there is a division between formal and informal support structures. In addition, there was a level of cynicism towards self-care. Self-care is considered vital, but also an area where the responsibility for a worker's wellbeing can be pressed upon the individual by the organisation. This finding comes with a range of caveats, but it is worth paying careful attention to,

Formal Support

Formal structures from the Employee Assistance program (EAP) through to clinical supervision and reflective practice were identified by all participants. Supervision needs to be an empowering and collaborative process, where trust and choice in safe space allows the supervisee to disclose and reflect (Berger & Quiros, 2014). There was a clear evidence of this:

> *"We have a clinical supervisor onsite that we can access and book appointments with. That works quite well actually I find, I really enjoy my relationship with that supervisor. I have a standing appointment, but you could also if you needed to on a day call and say, "Can I have a chat?" I don't think that's across Centacare as an option."* (F, FG 2)

However, as is evident in the final line above, it was noted in all focus groups that clinical supervision was not equally available to all employees.

> *"…I think in our unit, unless you're kind of saying hey, I really want to have a clinical supervisor, it took about a year and a half from when I first started until one was allocated to me."* (M, FG 1)

Similarly, there were feelings that services like EAP were recommended in order to push the responsibility for care and support elsewhere. One participant felt that this was equivalent to saying: "I don't want to hear it but go talk to someone else."" (F, FG 2).

Self-care as personal responsibility:

"Did you self-care? Well then, you have got no one to blame but yourself."

Female Helper (FG 3) on how workers are sometimes made to feel about their self-care practice.

Self-care

Ongoing training around self-care is a fundamental requirement (Wilson, 2016). Self-care is an integral element of preventative and protective practices, and supervision – while allowing for debriefing in a non-judgemental and safe space – must also incorporate self-care (Cox & Steiner, 2013; Dombo, & Whiting Blome, 2016; Everly, Boyle & Lating, 1999; Howlett, & Collins, 2014; Kapoulitsas & Corcoran, 2015).

Participants identified the need to practice self-care and spoke about the need to recognise 'symptoms', including 'how they were feeling about work' and of the importance of 'looking after oneself' through an episode. This is commendable behaviour that illustrates the professionalism of the workforce and Centacare's commitment to their employees.

Yet, at the same time, some participants noted that self-care could be viewed as 'tokenistic' and reflected a broader shift around personal responsibility (see Liebenberg, et al., 2015; Bober & Regehr, 2006). Indeed, there was an undercurrent that self-care advice was, in some instances, being told to "just go home and take care of yourselves" (F, FG 2), with activities like 'dog walks' and 'bubble baths' being the primary suggested course of action. Not tasks, as one participant pointed out, that could be performed while at work.

Informal support

Peer support is vital (McFadden, et al. 2014). One of the primary findings of this research is just how significant informal support networks were to many of the participants. It was made clear that without those supports many would not have been able to continue within their roles. Often this was expressed in terms of small networks of very strong relationships or the development of an informal mentoring process. One participant noted that:

> *"Yeah, I think it's more informal support. I have a couple of workmates that I'm quite close with that I will probably talk to daily or every second day and we share – it's pretty much supervision. I don't know how I'd go without that."* (F, FG, 2)

Another participant spoke at length about how vital and inspiring an informal mentor was for their development and continuing work practice:

> *"I can just speak to the relationship again with that colleague, having worked in a separate program and not knowing them very well, but then it was just like shadowing on visits … and just yeah, really fantastic work and that again inspired me and that's led to I guess having that relationship that I have now, because I respect the way that this person works and can always go there to talk stuff through any ethical dilemmas, because I respect the way that they work."* (M, FG 1)

> *"… just the opportunity when I first started for us to be able to co-work together because we were able to build our professional relationship friendship but having that opportunity to debrief because it was quite complex, high risk person."* (M, FG 1)

Informal support networks – and the space to have those networks – should be considered as a fundamental reason as to why the ProQOL results for Centacare were so positive. To put it bluntly: there is space for workers to support one another. Yet this finding comes with a warning. Informal support comes with its own risks, including the 'dumping' of traumatic material or events on other staff. As one of the workers made clear:

> *"I think that there is another side to that which is a bit dangerous, as well, and that is that on top of your own caseload you hear the stories of other cases, and I know for myself, I have been at points where, "Please don't talk to me at all about anybody else because I have got enough here without hearing another story."* (F, FG 3)

This secondary trauma from other staff is a serious consideration. With increasing workloads – especially with the focus on KPIs and other outcome-based deliverables – the ability for healthy and mutually agreeable informal support networks to be sustained or even desired becomes fraught.

Key considerations around support needs to be around the availability of clinical supervision, an authentic organisational voice around self-care, and a policy approach to managing informal support, without necessarily 'formalising' it in the process. On the latter, this means developing a policy that identifies what is appropriate to ask of colleagues, that expectations are managed, and ensuring that there is no requirement for anybody to provide informal support. In respect to all of this, it is the 'space between' that matters. Time between clients, boundaries between work and home, time for lunch, reflection or chatting with colleagues *all* matter. The cult of busy, whether self- or sector-imposed diminishes the effectiveness and likelihood of meaningful support practices.

Theme 4: Job Satisfaction

As has been noted elsewhere, despite the risks and actual episode of burnout and traumatisation, many workers speak of their love for the work and the profession (McFadden, et al. 2014). The situation is no different in Centacare.

The empathetic worker.

"I always think to myself did I become a social worker because I'm naturally inclined to help, and I always took on that role in my family, or do I have that role in my family because I'm a social worker. Which came first, the chicken or the egg. I definitely find it hard to separate, I'm a helper at work and I'm a helper at home. I don't even have kids but if there's ever a crisis or something going on [I'm] doing the counselling"

Female Helper FG 2

While there is an emphasis within the literature around the adverse consequences of empathetic labour – and this must be acknowledged – there is the counterpoint that the empathetic nature of the work is one of the key elements that also makes the work so rewarding. Job satisfaction is in part tied to the *empathetic abilities* of staff. These are abilities that need to be celebrated within the organisation. Moreover, they reflect a unique alignment with Centacare's purpose and mission and the abilities of staff and many workers' very notion of 'self'. This is the nexus between the risk and reward of undertaking a caring role within social service provision:

> *"Part of being empathetic is that ability to be able to really sit with and understand the position of someone else which puts us in a place of experiencing what they've been through in a sense, or putting ourselves in that to be able to give that empathy back and to be able to build that rapport and relationship with clients."* (F, FG 2)

Again, and again, the point was made by participants about the strength of their clients and how this was a point of admiration for them. One participant described it "as an honour to sit and hear those stories" while just thinking "how amazing" they are. (F, FG 3). In addition to this admiration, is how the work contributes to a feeling of self-worth for the employee. Noting the curious, novel and sometimes peculiar elements to their job, there is an attachment to a sense of doing good by helping clients to identify their own strengths:

> *"… I like my job. It is an odd job, but particularly because I am a counsellor that people come to. They have to come into the room, and it is a funny thing. For an hour they will come and they will talk and I listen, then they leave, You know, sometimes existentially you look at this as a role, so it works for me if I can sift it down to; what is the crucial thing that I am doing, which is just creating a space and a relationship where someone learns that they have got more capacity than they might think they have at the moment, but that it is about relationships. So, if I can sift down my job to something simple and say, "That is a good thing to do in the world. That is worth doing," then I do, and that is how I do it. That is, kind of, how I get self-worth out of it, is sifting it down to the simplest thing."* (F, FG 3)

The tension between the emotional risk factors and the emotional rewards of the work, is a recurring theme in the literature and this has been similarly reflected in the data here (see McFadden, et al. 2014). Identifying self-worth as 'reward' links with emerging debates around vicarious resilience.

Vicarious Resilience

With the exception on one participant, the term vicarious resilience resonated with the focus groups. The term was not necessarily familiar, but easily understood once explained by the researchers. Two predominate themes emerged from this discussion. The first was admiration for clients:

> *"It's like if I went through even a quarter of what you went through, I wouldn't be getting up and smiling and walking into work".* (F, FG 2)

> *"And so, I feel real resilience from that. … it has been a small part just creating enough space that someone could talk, and that women are amazing, and people are amazing. Children are incredibly resilient, and that is a good thing to know about the human being, the human spirit. We are incredible."* (F, FG 3)

> *"We don't know what we don't know, and to be part of a bridge of that, I find that is amazing and I love that. They do have such strength to keep going, so I take that strength, and sometimes you have just got to show up to just listen and be part of them getting their story out. Just show up and keep going, sometimes."* (F, FG 3)

The second was on the need to focus on small wins. One participant made the point that "there is a minimum amount of success you need to experience to keep working," (M, FG 1), while another reiterated this sentiment in that "it is those little wins or those stories" (F, FG 2) that keep workers going. The case studies below not only offer further insight to how resilience inspires hope and small wins fuels a sense of purpose and accomplishment, but they can speak to a broader agenda of utilising vicarious resilience across the organisation.

Taking strength from client stories and the impact of small wins are important dimensions of vicarious resilience. Coupled with "increased self-awareness and self-care practices, "client inspired hope" and "an increased capacity for attentiveness to the patients' narratives of trauma" (Killian, et al., 2017), there is an opportunity to operationalise these dimensions within day-to-day working practices.

Vicarious Resilience and Small Wins

Case study 4

"One thing that really stands out in my mind … they guy I was working with would have been in his late 40s. I remember … every visit he would just be crying, very high suicide risk so I was – he'd had a lot of overdose attempts, I felt really like out of my depth and I was having my team leader come out and support me because I was just so confronted by how unwell he just presented every time I saw him. No hope for the future and just really wanted to die."

"Over about a year and a half of our relationship building slowly … I guess, me just being consistent and turning up every week and doing the things that I said I would do, yeah, he made leaps and bounds and yeah, he started engaging with a psychologist. He changed his living situation, like there was lots of things that happened that like, just with that post traumatic growth he had kind of no hope in terms of work or anything that he could."

"There was … at the time … a peer work course, so people with a lived experience of mental illness could then learn about how they can share their story or their experiences in a way to help other people and he engaged in that, went through the course and then like, ended up working as a peer worker. So just over that time, then he sent me a letter to the office like two years later just letting me know, that he was going well and like I think that probably stays in my mind."

Female (FG 2)

Case Study 5

"It is very, very tiny, and I have always felt it is just sowing the seeds in a family, and I might never see any change at all, but I have hopefully planted some tiny wincey little seed. You might have lots of clients who it might only be – I have got one moment that still sits with my memory. A single mum with a child. Domestic violence. She came over very – the dad was in jail, being released. It was all very scary situation she was in, with one child. This woman was a drug dealer as well, so it was – but she was a lovely woman and she was really trying to keep this child."

"It was coming up Christmas, and I said to her, "What are you going to do for Christmas?" and she sort of went – I said, "We could get some decorations and we can make some Christmas things," with the little child. So, we did all that. I said to her, "This is about making memories with your child. This is something when your child is 40 and someone says, "What did you used to do for Christmas?" she will have this story about Christmas at home." So, we did it all. This family – because we stay 12 months, and sometimes over 12 months, so this family I was still with when next Christmas came around. I was just leaving her house and she said, "Oh, I forgot to tell you, I went and got the Christmas tree the other day, because I remember what you said." You know, I went all – I got goose bumps. And so, it looks like nothing but that was one of the seeds where you thought; well, there, she has got some idea now about the impact on her child's life when she does these things with the child. That is worth a lot."

Female (FG 3)

Case Study 6

"I was at [service] the other day and the young lad that has moved out and he's living independently is in a relationship with somebody that still lives there and he came to the door and he was so excited to see me there and he gave me this biggest hug and he just said, "Oh it's so great to see you." And just he was telling me how well he was doing in life and I said to him, "I'm really proud of you" and he's like, "I'm really happy and my life's great" and he said, "Thank you" and I was like, "No." We've come a long way with this young lad."

"We had some terrible moments and I experienced lots of aggression and stuff from him, so to be able to suddenly stand in front of you basically abusing you and he was practically spitting on me, it was horrible. To be able to sit and share a really nice life moment after that and repair that and move on is really great. But I think we need to do a bit more of that, we get so tied up in who we're with now and, you know, I think we need to still touch base because these people have grown and they do well, but they have a trauma history and it only takes a couple of small things"

Female (FG 1)

Theme 5: Structural Issues

A significant point of intersection within the focus groups were wider structural issues and the way these factors cascaded down to program level (this was particularly pronounced in one group). The cluster analysis illustrated how this 'higher level' concern framed many of the considerations around workload and vicarious traumatisation.

Whether in reference to changes in government, tendering of contracts, policy development, or workplace or sector-wide cultures, there were repeated references to the tension between service provision and organisational or sector requirements to achieve specific outcomes and to fulfil KPIs.

This shift in managerial focus has been identified within social service provision more generally, with, at first glance, the experience bearing similarities to the South Australian context. Indeed, it is a process that is reminiscent of the impact of neoliberalisation:

> "For front line workers, this potentially results in a tension where clients' needs for support and intervention are balanced against the structure of a system that requires individuals to self-regulate and self-manage. This tension extends to front line staff themselves who are positioned between the demands for efficiency and the needs of their clients" (Liebenberg, et al., 2015, p. 1008).

Funding stress was seen as a factor that directly impeded program provision. While sympathetic of the position that management were increasingly forced to navigate, staff could readily identify these factors as directly contributing to workload stress:

> *"… one of the escalations we noticed, because our programs are all connected. They are all coming up for funding in 2019 … it looks like we will be tendering. We won't be just rolled over, so all the managers in that area are quite under stress right now, and having to get a lot of paperwork done, a lot of evidence stuff. They want a lot from the workers so that they can make this tender strong."* (F, FG 3)

This line of thought permeated many of the conversational threads but entwined was an equally strong notion that Centacare was an employer of choice. While frustrations were aired, so too were sentiments that highlighted an overall appreciation for their employment environment:

> *"The pay is not as good as what you get in government, but for what you miss over there they just do nice things. I think they do stuff that makes you feel like you're valued as part of the organisation."* (F, FG 2)

> *"… what I like about Centacare is Centacare has a lot of pride and everybody that I've come across in Centacare holds that really close. And we all know that and we all think we're pretty great, but if you go out into other organisations they may not always acknowledge that, so when they [Centacare] do I think it's really important to share it and to hold onto it when other people are acknowledging … Centacare do some really good stuff."* (F, FG 1)

This sense of a culture of appreciation also helps explain the ProQOL results. One of the key questions for the organisation, then, is how to protect and continually reinvigorate this culture (and expand on it where some feel that it is inadequate). By obtaining an organisational baseline there is the opportunity to track vicarious trauma and burnout over time; this will answer the 'what' question, but not the 'how'. It is here that the staff voice is powerful.

The staff voice also provides an insight into future concerns. Given that system and structural factors were an overarching and prevalent theme, then – as a listening exercise – there is value in capturing staff concerns:

> *So, you know, I think if an NGO starts to say, "It has gone too far, we are now operating like somebody who produces tables, and we don't produce tables. We actually work with people, so forget the numbers." You could really take that line; we want to have good quality therapeutic services out there, because that is what the clients need."* (F, FG 3)

Engaging qualitatively with staff enables an organisation to consider ground up and co-designed answers to the 'how' questions around staff well-being. For instance, participants expressed a need to build on workplace cultures, to increase training opportunities, to ensure that policies are accessible and relevant and, importantly, to consider enhancing innovation and advocacy. The breadth of the response show how staff consider differing points of scale – from the individual or unit through to broad government policies – when looking at vicarious trauma within the workplace. It is this mindset that can add value to the future iterations of Centacare's vicarious trauma policy and its ongoing implementation.

Vicarious Trauma Policy

Clearly organisational culture matters and, moreover, this can be linked to staff retention (McFadden, et al. 2014; Middleton & Potter, 2015). Acknowledging the potential and real vicarious traumatisation that helping professionals face is a necessity for community sector organisations (Bober & Regehr, 2006; Cox & Steiner, 2013; Choi, 2011; Howlett & Collins, 2014; Kapoulitsas & Corcoran, 2015). Centacare is to be commended for its forward-looking approach through its development of a vicarious trauma policy.

However, there was still staff uneasiness. One participant noted that "…even with those things in place … which are better than at previous organisations, there's still a vulnerability to say, "Actually I don't feel safe going into this home"" (F, FG 2). Of course, it is not possible, nor reasonable to expect all issues that pertain to vicarious trauma to be solved, but a common refrain among participants was that the policy document needs to be better implemented. This included a scepticism in that the policy was an extension of the broader structural trend of individualisation and self-regulation, with one participant asking: "Tell me what the organisation is going to do, not just what I am doing." (F, FG 3). Further, some participants felt that having the policy was a good thing, but that it needed to be more than a 'tick box' exercise:

> *"I think it is the same as any policy document. It is all very well to have a policy on something, but … if it doesn't actually work in reality, on the ground, for the workers, then it is a useless piece of paper, and I don't think anybody has seriously taken it and looked to see; are we actually following through on that policy and making sure that workers don't have back to back clients, etcetera. That has never been followed up. It is just, "Yes, we have got a policy on it." But then, we can't say that fixes it."* (F, FG 3)

Indeed, it is about bridging the gap between policy and culture, as one participant made clear: "I think there's a difference as well between having the policies and procedures and the way that you should do things verse actually having a culture" (F, FG 2).

Innovation was key for many staff. One of the more popular ideas was the setting up of an online portal – separate to the current online space – that specifically deals with staff well-being. A space that provides:

- Trauma informed and trauma responsive toolkit for staff

- Policy updates – with explainers
- Information for EAP
- Small win stories
- Feedback and consultation opportunities

A separate online space that exclusively deals with staff wellbeing could be more than just ‘dealing’ with vicarious trauma. It offers the chance to embrace the core principles of vicarious resilience. This would build a client informed strength-based organisational strategy that is not simply premised on the individualised needs of clients, but on the shared strengths of client resilience.

This is a strategy that also offers advocacy opportunities. Positive client outcomes are desired by funding bodies. Staff well-being and retention in one of the fastest growing sectors is required in order to attain those outcomes. Advocacy that connects staff wellbeing with achieving KPIs could have multi-scaler effects across macro (the sector), meso (the organisation) and micro (workers and clients) levels.

Concluding Remarks and Recommendations

Centacare Catholic Family Services presents as an employer of choice within South Australia's community sector. The survey results conclusively show that vicarious trauma is not an issue for staff at an organisational level (i.e. when considered as a cohort).

We note that:

1. Centacare has a well-developed vicarious trauma policy.
2. Centacare is committed to research and learning as it relates to vicarious trauma and that Centacare is a sector leader in working to ensure the well-being of staff.
3. At an organisational level, vicarious trauma does not present as an endemic issue.
4. Centacare staff are dedicated and show immense empathic support for the individuals and families that they work with on a day-to-day basis.

While the ProQOL results were most positive, the qualitative element of the research provided clear indicators of what underpinned that result. Informal support networks and the need for time and space when conducting empathetic labour resounded as core themes. Job satisfaction was high among the participants who took part in the focus groups, but with structure and system pressure – notably around funding and KPIs – there is potential for this satisfaction to be eroded. Finally, the strength and resilience of clients was a source of strength for workers.

We offer the following recommendations:

1. That there must be an ongoing commitment to both formal and informal support networks and practices. This should include:
    a. Ensuring that clinical supervision or reflective practice sessions are available to all staff who feel that they may require sessions;
    b. Acknowledging the importance of and the pitfalls associated with informal support networks;
    c. Developing an informal support guidance policy that details what is and is not appropriate and protecting the rights of those who do not wish to be a part of informal support processes; and,
    d. Ensuring that employees have appropriate protection of their time and space (e.g. lunch breaks, time between clients, home and work boundaries).
2. While commending Centacare for the development of its Vicarious Trauma Management Guidelines. We recommend that:
    a. It is better aligned with all HR / WHS documents;
    b. Greater care is taken with respect to references of 'individual responsibility';
    c. That the document refers to the importance of and potential issues of informal support networks;
    d. Better operationalising of the document; and,
    e. Outlining vicarious trauma training opportunities for key personnel.
3. (Re)invigorating a culture that celebrates 'wins' and the client voice:
    a. Sharing good news stories – within and between teams;

b. Focus on ‘small win’ stories; and,

c. Explore the development of a vicarious resilience lens.

4. That Centacare consider the (re)development of an online portal specifically aimed at self-care, support options and practical advice:

    a. Include relevant policies, policy updates and policy explainers (in an easily searchable form);

    b. Resource hub for burnout and vicarious trauma support related materials (including EAP);

    c. The sharing of wins, client stories and the establishment of a vicarious resilience lens (see recommendation 3);

    d. Develop or acquire a trauma informed and trauma responsive model or toolkit; and,

    e. Provide opportunities for feedback and consultation.

5. Commit to undertaking the ProQOL survey every two years to track the vicarious trauma baseline of the organisation

    a. Consider repeating the focus group exercise every four years.

6. Advocate to funding bodies to recognise the risks to the workforce and the sector of:

    a. Burnout and workforce turnover; and,

    b. The potential and actual economic and health costs of vicarious traumatisation.

    And to advocate:

    c. That KPIs must align with frontline workers’ need for space and time to accommodate the empathetic nature of their labour; and,

    d. That a vicarious trauma rubric is developed for funders to identify how future KPIs in policy or tender documents may impact the well-being of frontline workers.

    e. That preparedness for the NDIS framework – with its individualised funding approach – incorporates the concerns related to vicarious trauma, compassion fatigue and burnout identified herein.

The research undertaken in this report reflects a fearless partnership between The Australian Alliance for Social Enterprise at the University of South Australia and Centacare Catholic Family Services. In the interests of supporting and promoting staff welfare and wellbeing, unrestricted access to staff and policy documents means that the findings contained within this report provide an important insight not only into a single organisation, but a template for the sector to consider and respond to the impact of trauma upon the caring professions.

The ‘ticking timebomb’ of vicarious traumatisation requires immediate and ongoing attention. The commitment of Centacare to commission this research is to be commended and the forthrightness of staff must be acknowledged as the single most important factor in the production of robust and meaningful findings. The onus is now on the sector and funding partners to take up the challenge of responding appropriately to vicarious trauma, compassion fatigue and burnout.

Appendices

Appendix 1 – Focus Group Protocol

Vicarious Trauma Focus Group Protocol *Questions in bold followed by possible follow-ups/probes* *An organic approach with two researchers present to observe and compare field notes will be central to the approach*	
Introduction	Ensure recording device is turned on. Introductions, where we are from/where they are from. Build rapport Discuss purpose – it is about discussing experiences in a supportive environment. The sharing of stories is central to this focus group, with a focus on an organic interaction between participants. A discussion around the participatory emphasis of the focus group work. Researchers will: 1. frame the focus group (what is the purpose; what is the aim of the research); 2. talk about the importance of the participant voice in not only the answering, but in the asking of questions; 3. relinquish control – where possible – to allow participant voices to change questions, ask new questions, to lead the discussion. 4. Discuss staff investment in the research; 5. Discuss key themes at the end of the sessions, encouraging participants to assist with identifying the themes. *The questions below are a guide only.*
Consent	Ensure consent forms are signed. Read out script in relation to consent to ensure all participants understand. Clarify any questions and discuss confidentiality.
Ground rules	Establish the ground rules: - Respectful dialogue - No right or wrong answers - Use first names - Participants should talk to each other - Phones off
Question 1	**Is anybody aware of Centacare's Vicarious Trauma policy?** - Can you tell me what you know about it? (in general terms) - Can somebody explain what vicarious trauma is?

Question 2	**Is burnout an issue in your job?** - What factors contribute to burnout?
Question 3	**Consider some of the ProQOL questions (negative):** - I find it difficult to separate my personal life from my life as a [helper]. - I feel as though I am experiencing the trauma of someone I have [helped]. - I feel "bogged down" by the system - I am not as productive at work because I am losing sleep over traumatic experiences of a person I [help].
Question 4	**Consider some of the ProQOL questions (positive):** - I get satisfaction from being able to [help] people. - I have thoughts that I am a "success" as a [helper]. - I believe I can make a difference through my work. - I feel invigorated after working with those I [help].
Question 5	**Is anybody familiar with the term vicarious resilience or posttraumatic growth?** - Do you feel a sense of strength or purpose from the work that you do?
Question 6	**Is self-care an important part of your working practice?**
Question 7	**What could be done better within your organisation to manage vicarious trauma / burnout / compassion fatigue**
Question 8	**What could be done better to capture or celebrate stories of strength?** - Do positive narratives help? - Can they be transferred or translated?
Review	Identify key themes – echo or clarify them with the participants. This will be akin to an on the spot verbal coding exercise (In vivo). Ask: **Is there anything else you wish to tell me?**
Conclude	Thank them for their involvement. Remind them that their responses are confidential and will be anonymised (within the context of a focus group). Copies of the report and a simple explainer will be made available to the community and a debriefing session will be offered if the community would appreciate hearing directly back from the researchers. End.

Appendix 2 – ProQOL survey

Professional Quality of Life Scale (ProQOL)

Compassion Satisfaction and Compassion Fatigue
(ProQOL) Version 5 (2009)

When you *[help]* people you have direct contact with their lives. As you may have found, your compassion for those you *[help]* can affect you in positive and negative ways. Below are some-questions about your experiences, both positive and negative, as a *[helper]*. Consider each of the following questions about you and your current work situation. Select the number that honestly reflects how frequently you experienced these things in the *last 30 days*.

1=Never	2=Rarely	3=Sometimes	4=Often	5=Very Often

_____ 1. I am happy.
_____ 2. I am preoccupied with more than one person I *[help]*.
_____ 3. I get satisfaction from being able to *[help]* people.
_____ 4. I feel connected to others.
_____ 5. I jump or am startled by unexpected sounds.
_____ 6. I feel invigorated after working with those I *[help]*.
_____ 7. I find it difficult to separate my personal life from my life as a *[helper]*.
_____ 8. I am not as productive at work because I am losing sleep over traumatic experiences of a person I *[help]*.
_____ 9. I think that I might have been affected by the traumatic stress of those I *[help]*.
_____ 10. I feel trapped by my job as a *[helper]*.
_____ 11. Because of my *[helping]*, I have felt "on edge" about various things.
_____ 12. I like my work as a *[helper]*.
_____ 13. I feel depressed because of the traumatic experiences of the people I *[help]*.
_____ 14. I feel as though I am experiencing the trauma of someone I have *[helped]*.
_____ 15. I have beliefs that sustain me.
_____ 16. I am pleased with how I am able to keep up with *[helping]* techniques and protocols.
_____ 17. I am the person I always wanted to be.
_____ 18. My work makes me feel satisfied.
_____ 19. I feel worn out because of my work as a *[helper]*.
_____ 20. I have happy thoughts and feelings about those I *[help]* and how I could help them.
_____ 21. I feel overwhelmed because my case [work] load seems endless.
_____ 22. I believe I can make a difference through my work.
_____ 23. I avoid certain activities or situations because they remind me of frightening experiences of the people I *[help]*.
_____ 24. I am proud of what I can do to *[help]*.
_____ 25. As a result of my *[helping]*, I have intrusive, frightening thoughts.
_____ 26. I feel "bogged down" by the system.
_____ 27. I have thoughts that I am a "success" as a *[helper]*.
_____ 28. I can't recall important parts of my work with trauma victims.
_____ 29. I am a very caring person.
_____ 30. I am happy that I chose to do this work.

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