

The limitations of vicarious trauma prevention strategies when applied to residential child care

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Abstract

Vicarious trauma is recognised as a potential consequence of supporting clients with trauma. Research into vicarious trauma, its impact on professionals and the consequences for clients has been limited to date, however, strategies have been developed to assist in identifying, preventing and managing symptoms. To date these strategies are not easily applicable to the residential child care setting, despite residential care staff working alongside young people with complex trauma.

Keywords

Vicarious trauma, trauma prevention, residential child care, care staff

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As the coronavirus pandemic took hold, and unprecedented procedures for managing it were put in place, we learned that care staff are essential workers. Care work is not well paid, or even understood by the broader public. Residential child care work seems simple; provide care for young people who cannot remain within the family home. There are few more ordinary tasks than raising children. However, these essential workers have a far more extra-ordinary task. They offer relationships, every day, for days on end, to young people so traumatised by past relationships that their rejection of new relationships is forceful and fearful in equal measure. Residential child care workers understand that the young people need them, and need the offered relationship, to begin healing from their trauma, and yet they must withstand everything in each young person's arsenal of challenging behaviour.

Pearlman and Saakvitne (1995) define vicarious trauma as an individual's internal response to hearing about the trauma experienced by others. Vicarious trauma can affect therapists, social workers, foster and residential carers and other professionals involved with traumatised people, as well as in personal relationships. In professionals, vicarious trauma can occur following exposure to a single traumatic event or can occur cumulatively through hearing different trauma stories from a multitude of clients. Izzo and Miller (2010) believe the issue of vicarious trauma among helping professionals is underestimated and underreported. To extend this opinion, research into vicarious trauma prevention strategies shows that few can be meaningfully applied to residential child care, particularly in extended shift patterns of 24 or 48-hours. Residential child care is often isolating for those working in it; due to confidentiality they cannot share much of their job with their loved ones, and due to widespread prejudice against young people in care, the realities of caring for these young people is neither valued nor understood by wider society. At the least care staff can expect those designing strategies to support them to understand and cater for the realities of their working life.

The terms vicarious trauma, compassion fatigue and burnout are often used interchangeably by service providers, however, one can occur without either of the others, or the three can occur at the same time and exacerbate the impact

of each. The staff turnover rate in residential child care is high (Colton & Roberts, 2007) and undoubtedly impacts upon the young people involved, as they must reconcile themselves with yet another adult choosing to leave. There are many advantages to using a 24 or 48-hour shift pattern when looking after children and young people, however, it could serve to make staff turnover feel more personal; the adults lived alongside the young people in a shared home environment, and still wanted to leave. The focus on creating as much of a family atmosphere as possible in care may further compound the loss of staff, as young people feel rejected by some of the pseudo-family paid to care for them following their separation from their biological family. Staff leave residential care for diverse and complex reasons must seldom be directly related to a single young person, but adult justifications mean little to children who feel abandoned.

All of those working with traumatised people are at risk of vicarious trauma, however, if it is recognised as an issue in those seeing their clients in set, time-limited appointments, we must recognise the potential impact on those living alongside young people for two days in a row. Therapists are required to undergo some form of therapy as part of their training, and those who are registered with a regulatory body are required to have an external supervisor, and often have further supervision within their workplace. Many therapists hear about their client's trauma in extensive detail and carry the burden of helping the client heal. Residential child care workers also hear about trauma, often with little or no notice and additionally, may be present at the time of re-traumatisation or new traumas. For example, a young person may be rejected by their parent; the therapist will assist them in unpicking this in their next session, but the residential child care worker is there at the time of the rejection, and responsible for the young person's wellbeing as their distress plays out over the following days.

The purpose of this paper is not to explore which job is harder, as both of these professions come with their own unique challenges, similar challenges and multitude rewards. However, in the case of vicarious trauma, the limited information and strategies available are often written by and for therapists. Attachment theory teaches us that nurturing relationships with caring adults

provides potential for young people to heal from their attachment-related trauma. Secure, consistent relationships are required to support young people through the difficult process of trauma-integration therapy. The staff team's main task is to offer these relationships, remain steadfast through countless, and often literally painful, rejections; they sit beside the child at their highest peak and their lowest trough, the target of their rage, their anxiety, their endless fear. Often, they work in houses with two or three equally complex young people; their deceptively simple job descriptive of offering relationships belies the reality.

The foremost measure to guard against vicarious trauma is awareness of the concept; without this, practitioners cannot translate the signs they may be experiencing. It has been noted that the individual can often misdiagnose the symptoms of vicarious trauma, as many of the primary symptoms are similar to those of ordinary stress (Trippany, Whitckress & Wilcoxon 2004). Therefore, education on both vicarious trauma itself and its manifestations is the first and most important measure to guard against its occurrence. In order to have an awareness of emerging symptoms of vicarious trauma, practitioners need to have established solid self-awareness and familiarity with their internal environment; this will allow them to notice changes in thoughts and feelings as early as possible. Shapiro (2012) believes mindfulness practice may be a protective factor against vicarious trauma, through improving the psychological health of practitioners. Young people with disrupted attachment can find time alone, self-soothing and independence challenging, and many of them experience impulsivity and lack of safety awareness to the extent that they need supervised throughout their waking hours. Staff must remain as alert and vigilant as their traumatised young people if they want to keep them safe and to read subtle emotional cues well enough to intervene quickly on the behaviour escalation curve. This precludes them from using mindfulness during hours when the young people are with them. An abundance of paperwork, phone calls, meetings, and organising a busy household can quickly take over those times where the young people are sleeping or occupied, meaning mindfulness practice may be hard to fit it then either. It is all too easy for authors to say that time will only be found when mindfulness is prioritised by staff; unfortunately,

prioritisation is also often demanded by line managers, social workers and family members and there are only so many hours in a shift.

It seems that mindfulness practice may only fit in during time off as it is an important measure in self-care, it may be that staff should choose this option. As Izzo and Miller (2010) point out, this implies the individual has responsibility for fixing any issues that arise. Organisations hold responsibility for creating a culture among their staff where vicarious trauma is part of the daily language and opportunities are created to assess for it and address it when it occurs. It is becoming popular for employers to educate their staff on vicarious trauma and self-care, and this is an important first step. Organisations can cement this first step by providing formal training for all staff on mindfulness practice and other forms of self-care, and then embedding this learning through mandatory, protected time for self-care breaks built into each shift.

Following on from self-care as a measure against vicarious trauma, staff are advised to talk about their feelings. Client confidentiality prevents staff from relying on their friends and family for emotional support, as they are bound by policy to only share general feelings around their work, rather than specific events or information about individuals involved. However, sharing even vague information from their work life may prove problematic. Bell, Kuskorni and Dalton (2003) note that working with trauma survivors can challenge our societally shaped perceptions on the nature of the world around us, and our fellow human's capacity for cruelty. Staff experiencing an acknowledgement of the darker side of society may be reluctant to share even general feelings with friends and family, due to not wanting to change their loved ones' perceptions of the world. Within certain parameters, staff are allowed to share information within their organisation, such as through single or group supervision. During times of low staffing, holidays or increased stress in an organisation supervision is often one of the first practices to be pared back or dropped altogether when arguably it is more important than ever in crisis. As with self-care, supervision should be mandatory and protected for all employees, and when performed well, it provides not only a space for staff to unpack their feelings separately from their persona as selfless caregiver, a therapeutic supervisor can spot signs of

vicarious trauma early before the individual themselves can see them. Just like intervening early on the behaviour escalation curve to prevent an incident, intervening at the first signs of vicarious trauma can prevent it from taking hold.

Current literature allows residential care staff to educate themselves on vicarious trauma but falls short of representing them in the many strategies given to limit its impact. Care workers cannot follow advice to take five minutes out when they feel themselves becoming overwhelmed. It is more difficult for them to set boundaries around challenging behaviour. If the young person becomes distressed and makes verbal threats against their social worker, they may be asked to leave until they have calmed down. The care worker is required to leave the room with the child and assist them in calming down. If the young person throws a chair at their therapist during a session, the therapist can leave the room to maintain boundaries. The care staff need to walk into the room, withstand assaults and find the right words, at the right time, to calm the child down. At the end of a long and fraught Looked After and Accommodated Child Review it is only the care worker who needs to consider how to help the child recover from what they have heard, how to get them safely to the car, get them both back to their house without incident, and sit up with the child and comfort them for as long as it takes the child to fall asleep. There is no doubt that all the adults around a young person with disrupted attachment and complex trauma have difficult jobs, and that none of their challenges compare to the ones the child faces. However, most of their professions are valued, and their challenges are spoken about, even published, and this cannot be said for care workers. Too often they are overlooked, underappreciated, not asked for their opinion of the child they spend so much time with. It is not difficult to imagine that this atmosphere of under-recognition allows issues like vicarious traumatisation to grip tighter. Rather than waiting for the recent recognition of their roles as essential to lead to meaningful change in the way residential child care is perceived and supported, care staff should find their voice and lead that change from within. By recognising their own extra-ordinary practice, they can begin their own research into the issues entangling that practice; they can open up necessary discussions with their colleagues, their employers and the wider industry on what strategies have worked for them and where more research is

needed. In short, care staff should discover the expert within themselves and fill the gaps in literature and understanding from a place of unique insider knowledge.

Care-experienced children and young people are not readily accepted by British society. That is clearly and loudly evidenced by the abundance of petitions that are formed in response to residential child care homes being opened. Houses which are rural and secluded can still be subjects of community gossip long after they have been established. The message is clear; care experienced young people are 'other', out with the safe and the norm, and as such are to be rejected and feared. The staff who choose to spend their lives looking after these young people are 'other' by association. It can be difficult for staff working 24 or 48-hour shifts to find relatable conversation as so much of our society and our social repertoire is geared towards the traditional nine to five job. Residential care staff can be bitten, spat upon, sexually assaulted and must shift between dozens of roles per day with little warning. The positives are as hard to relate to as the negatives; that tiny moment of success when a child makes eye contact for the first time, or the note of apology after an all-night incident. Yet their roles are not valued, or understood, or supported, by the society they live in. The very least these staff can expect, as they navigate their extra-ordinary jobs, is for the literature designed to support them, the strategies devised for their emotional well-being, to be written inclusively and with understanding. Young people in residential care have long and painful trauma histories, which in some cases begin at birth and carry on to the present day, and it is their care staff who sit with that trauma and the defensive behaviours used to guard it and continue to offer nurture and praise and role-modelling, for as long as it takes; extra-ordinary adults helping to raise extra-ordinary young people, in an essential role.

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About the author

Marianne Macfarlane is the Therapeutic Services Co-ordinator for Common Thread, a residential child care provider with houses and schools across Scotland. Marianne has worked for Common Thread since 2011 and is particularly interested in complex trauma, and its impact upon young people. The following article represents the author's own view.