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Compassion fatigue, compassion satisfaction and work engagement in residential child care

Dr Kerry Audin, Dr Jolanta Burke, Dr Itai Ivtzan

Abstract

Due to the challenging nature of the setting, residential childcare staff are at risk of developing compassion fatigue, including burnout and secondary traumatic stress. There is also opportunity to experience compassion satisfaction from supporting young people in need. These concepts are under-researched in residential childcare, as is work engagement; a sense of vigour, dedication and absorption at work which is beneficial for employees and organisations. This quantitative study investigated the relationship between compassion fatigue, compassion satisfaction and work engagement in staff working in independent residential childcare organisations in England, Scotland and Wales. The study used a within-participants design using correlational analyses, with a sample of 100 participants who completed a self-report questionnaire. Work engagement was positively correlated with compassion satisfaction and negatively correlated with the burnout aspect of compassion fatigue but not secondary traumatic stress. However, the absorption component of work engagement was positively associated with secondary traumatic stress, reflecting that burnout and secondary trauma are distinct aspects of compassion fatigue that relate differently with work engagement. It is recommended that residential childcare organisations be aware of, and implement support structures to prevent or minimise, both burnout and secondary traumatic stress in their employees.

Keywords

Residential childcare, compassion fatigue, compassion satisfaction, work engagement

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Corresponding author:

Kerry Audin, Consultant Clinical Psychologist, School of Psychology, University of East London, kerryaudin@gmail.com

Introduction

Residential childcare is a challenging profession requiring employees to be resilient in caring for vulnerable children and young people; it is also a potentially rewarding setting with opportunities to help those in need (Barton, Gonzalez & Tomlinson, 2012). Young people in residential care have often suffered chronic neglect and abuse in their early lives, experiencing further losses, disruption and instability in care (Barton et al., 2012). Such early adversity affects children's development, compromising ability to cope effectively, and resulting in social, emotional and behavioural problems including aggression, self-harm, absconding, substance misuse, sexualised behaviour, social withdrawal, and non-compliance (Whittaker, del Valle & Holmes, 2015). Residential childcare staff are therefore exposed to, and required to deal effectively with, high levels of negative emotion and behaviours (Colton & Roberts, 2007), yet must help young people feel heard, understood, validated and cared for (Clough, 2006). Furthermore, staff are exposed to distressing information about childhood trauma, neglect and abuse, and disclosures from children (Zerach, 2013).

Working in residential childcare presents a risk of developing compassion fatigue (Eastwood & Ecklund, 2008), a negative psychological state resulting from helping people who have experienced trauma or are distressed (Figley, 1995). Compassion itself is a complex concept necessitating connection with, and motivation to reduce, the distress of others (Ivtzan, Lomas, Hefferon & Worth, 2016). Compassion fatigue is conceptualised in terms of two distinct factors; burnout and secondary traumatic stress, which both impact on ability to maintain compassion for others (Stamm, 2010) and which are pertinent for the residential childcare role.

Burnout is a general feeling of emotional exhaustion caused by frequent exposure to emotionally challenging situations and leading to becoming detached from those in need and frustrated with the helping role (Maslach & Jackson, 1981). Secondary trauma is more specific, occurring when helpers

experience symptoms of traumatic stress through being indirectly exposed to other people's experiences of actual or threatened injury, harm or death (Figley, 1995). Symptoms of secondary traumatic stress reflect the symptoms experienced by individuals who were directly exposed to traumatic events, and include sleeping problems, anxiety, irritability, hyper-arousal, intrusive thoughts, emotional numbing, and preoccupation with (or avoidance of) the trauma source (Figley, 2002). Secondary traumatic stress typically has a more rapid onset than burnout, which emerges gradually in response to a build-up of emotional exhaustion (Pearlman & Saakvitne, 1995), though both are problematic for staff.

Compassion fatigue impacts negatively on staff well-being (Figley, 1995), and there are consequences for employers, as compassion fatigue is associated with staff turnover and absenteeism, low motivation and morale, and employee performance, including poor judgement, decision-making and quality of care (Bride, Radley & Figley, 2007; Salloum, Kondrat, Johnco & Olson, 2015; Seti, 2008; Yassen, 1995). Ultimately, compassion fatigue in staff impacts on the relationship with those requiring help (Seti, 2008; Valent, 2002), which is concerning when considering the significant needs of children and young people in residential childcare.

Indeed, compassion fatigue presents a challenge for residential care staff due to the interpersonal impact on how helpers feel and behave towards those they care for. As staff become emotionally detached and disengaged, they can be perceived as uncaring by those requiring help (Maslach & Jackson, 1981; Valent, 2002). To be effective, residential childcare staff need to provide consistent and empathic care for young people (Cameron & Maginn, 2008) and build secure attachment relationships as a foundation for children's social, emotional and moral development (Barton et al., 2012). Compassion fatigue reduces ability to provide sensitive, responsive care, which then negatively affects the attachment relationship (Seti, 2008; Zerach, 2013). This can intensify distress and aggression in young people who can experience the detachment of staff as rejection or abandonment, creating a negative spiral of disrupted attachment

relationships for young people, and increasing compassion fatigue in staff (Winstanley & Hales, 2014).

In contrast to compassion fatigue, helping professionals can also experience a feeling of pleasure and success from helping others, known as compassion satisfaction (Figley, 1995; Stamm, 2010). Compassion satisfaction is thought to buffer the impact of compassion fatigue in terms of the emotional exhaustion of burnout, and the symptoms of secondary traumatic stress (Conrad & Kellar-Guenther, 2006; Ray, Wong, White & Heaslip, 2013; Samios, Abel & Rodzik, 2013).

Another positive psychological state that can be experienced by employees is work engagement, defined as 'a positive, fulfilling, work-related state of mind that is characterised by vigour, dedication, and absorption' (Schaufeli, Salanova, Gonzalez-Roma & Bakker, 2002, p. 74). Work engagement is a broad concept, incorporating positive attitudes and feelings about a work role, such as enthusiasm, resilience, pride and commitment, which help maintain effort and motivation (Stairs & Galpin, 2013). Work engagement has been found to be positively associated with staff well-being, attendance, creativity, effort, and performance, plus staff retention and desirable business outcomes for organisations (Bakker et al., 2014; Stairs & Galpin, 2013). Both compassion satisfaction and work engagement involve experiencing positive emotions (Stairs & Galpin, 2013; Stamm, 2010) which are important in building personal coping resources, according to the broaden-and-build theory of positive emotions (Fredrickson, 2001). Therefore, compassion satisfaction and work engagement are important factors when considering the resilience and well-being of staff working with traumatised and distressed young people. In addition, emotions within teams can be seen as contagious in that they spread between team members (Kelly & Barsade, 2001), making it even more important that the emotional climate of a team is positive rather than negative.

On top of the challenges inherent in the task of caring, there are often additional issues for staff working in residential childcare that affect engagement and

persistence in the role, including limited training opportunities, lack of support and supervision, insufficient pay, and inadequate recognition (Colton & Roberts, 2007; Decker, Bailey & Westergaard, 2002; Seti, 2008). Inadequate training, supervision, support, and leadership have been found to be among the factors associated with increased compassion fatigue in residential childcare staff (Decker et al., 2002; Lakin, Leon & Miller, 2008; Pinchover, Attar-Schwartz & Matattov-Sekeles, 2015), particularly the emotional exhaustion and reduced morale which typifies burnout. These organisational factors, along with compassion fatigue itself, contribute to high levels of staff turnover in the residential childcare profession, which has negative consequences for staff, organisations, and ultimately children and young people who experience unstable and inconsistent care (Colton & Roberts, 2007; Seti, 2008; Salloum et al., 2015; Showalter, 2010).

Compassion fatigue, compassion satisfaction and work engagement are therefore relevant to residential childcare staff and organisations. Whilst compassion fatigue and satisfaction have been studied in many health and social care professions there are few studies within residential childcare (Pinchover et al., 2015; Seti, 2008; Zerach, 2013), and the relatively new concept of work engagement has not been studied in residential childcare. This study aims to address the gap by measuring compassion fatigue, compassion satisfaction and work engagement in residential childcare staff, examining the relationship between these variables in line with the following hypotheses:

- Hypothesis 1: Work engagement is negatively correlated with compassion fatigue (burnout and secondary traumatic stress), such that higher levels of work engagement are associated with lower levels of both burnout and secondary traumatic stress.

- Hypothesis 2: Work engagement is positively correlated with compassion satisfaction such that higher levels of work engagement are associated with greater compassion satisfaction.

In addition, a third area is explored; length of time working in a residential childcare role. There are inconsistent findings in the literature regarding the association between years of experience in a helping role and compassion fatigue (Seti, 2008). The present study hypothesised that length of time in a residential childcare role and compassion fatigue (both burnout and secondary trauma) are related, but did not specify the direction of this relationship. Burnout, for example, may be greater with longer exposure to the challenges of working in residential childcare (Salloum et al., 2015), or may be greater in employees with less experience (del Valle, Lopez & Bravo, 2007), as employees with more experience may become resilient, enabling them to continue working (Seti, 2008).

Method

Design

This was a quantitative study, using a self-report survey method, adopting a correlational, within-subjects design to examine relationships between the variables stated in the hypotheses.

Participants

The sample was 100 employees of independent residential childcare organisations in England, Scotland and Wales. The sample comprised residential childcare workers, therapeutic care practitioners and senior care practitioners (n = 51), team leaders, and registered managers (n = 31), and directors and senior managers (n = 18). There were 57 females and the average age was 39.9 (SD = 11.4). The average length of time working in residential childcare was 10.7 years (SD = 9.8).

A sample of convenience was used, recruiting participants from members of the Independent Children's Homes Association (ICHA), and/or The Consortium of Therapeutic Communities (TCTC) via an online survey. Employees working in

organisations known to the first author were also recruited, via the online survey or paper questionnaire. Independent rather than local authority children's homes were used, as this was considered a more direct and accessible route to participants.

The initial sample comprised 70 online participants and 56 completing a paper questionnaire. Nineteen respondents were excluded for submitting incomplete surveys and seven were excluded because they were administrative, teaching or clinical staff and not representative of the target population, giving a final sample of 100 participants.

Procedure

The study received ethical approval from the University of East London. An online survey was created using Qualtrics Survey Software and circulated via email by the ICHA Chief Executive and TCTC Chair to their respective members. Participants were recruited at children's homes known to the first author during delivery of clinical psychology services.

Participants were invited to take part if they were directly involved in the care of children and young people. Informed consent was obtained before participants completed a brief questionnaire. For on-site recruitment, participants returned their questionnaires in blank envelopes and consent forms were collected separately to maintain anonymity. Debrief information was provided. The survey was also emailed to organisations known to, but not receiving services from the first author. As the potential reach of such correspondence is not known, it was not possible to determine the response rate.

Measures

Work engagement and burnout are considered to be opposing but separate concepts that should be studied independently (Demerouti, Mostert & Bakker, 2010) as they have different outcomes; burnout impacting more on health, and engagement impacting more on motivation at work (Bakker, Demerouti & Sanz-

Vergel, 2014). Therefore, two standardised measures were used. The Utrecht Work Engagement Scale-9 (UWES-9; Schaufeli, Bakker & Salanova, 2006) was used to measure work engagement. The nine-item version of the original UWES (Schaufeli et al., 2002) was used for brevity. A seven-point Likert scale captures how frequently employees have felt the way each item describes, ranging from 0 (never) to 6 (always/every day). The UWES-9 full scale is considered a reliable measure of work engagement, with good internal consistency (Cronbach's α = .92) (Schaufeli et al., 2006). It has three 3-item subscales measuring vigour, dedication and absorption, with Cronbach's α = .84, .89 and .79 respectively (Schaufeli & Bakker, 2004). The current sample had alpha coefficients of .89 for the full scale, and .81, .79 and .68 for the vigour, dedication and absorption subscales. The UWES-9 has been used within many professions (Schaufeli & Bakker, 2004), but not residential childcare.

The Professional Quality of Life (ProQOL-5, Stamm, 2010) was used to measure compassion fatigue and compassion satisfaction. The ProQOL-5 is a 30-item questionnaire comprising three 10-item scales; compassion satisfaction, burnout and secondary traumatic stress, the latter two being components of compassion fatigue. The ProQOL-5 uses a five-point Likert scale ranging from 1 (never) to 5 (very often), capturing the extent that participants have experienced the feelings, thoughts or situations identified in each statement. The ProQOL-5 has been used widely in health and social care research (Stamm, 2010) including some studies within child welfare and residential childcare settings (Eastwood & Ecklund, 2008; Salloum et al., 2015; Zerach, 2013). The ProQOL-5's subscales have good internal consistency reliability, with Cronbach's α = .88, .75 and .81 for compassion satisfaction, burnout and secondary traumatic stress and good construct, convergent and discriminant validity (Stamm, 2010). In the current sample, alpha coefficients were .86, .65 and .82 for compassion satisfaction, burnout and secondary traumatic stress.

Demographic information, including age, gender, and length of time working in residential childcare was also collected.

Data Analysis

The criteria of including scale data with less than 10% missing items was adopted (Bryman & Cramer, 1997). After reverse scoring relevant items, the ProQOL-5 data were converted to T-scores as recommended by Stamm (2010). Cut-off scores derived from normative data were used to categorise ProQOL-5 data into low, average and high levels of compassion satisfaction, burnout and secondary traumatic stress (Stamm, 2010). The UWES-9 full scale and subscale data were categorised as very low, low, average, high and very high levels using cut-off scores derived from normative data (Schaufeli & Bakker, 2004).

As the sample was relatively small (Field, 2013), normality tests were used to assess the data spread on each scale, revealing that all except burnout were non-normally distributed. Non-parametric tests were therefore used for subsequent analyses. Spearman's rho correlation coefficient was used to examine relationships between variables; one-tailed for the directional hypotheses (1 and 2), and two-tailed for the non-directional third hypothesis.

Results

Compassion Satisfaction and Compassion Fatigue

ProQOL-5 results are presented in Table 1, including the median (Mdn), range, and percentages of low, average and high compassion satisfaction, burnout and secondary traumatic stress. One-quarter of participants scored low on compassion satisfaction. Almost one-third (32%) scored high for burnout and just over one-quarter (26%) scored high for secondary traumatic stress. These categories are not diagnostic but reflect a method for categorising data based on results from normative data (Stamm, 2010).

Table 1 ProQOL-5 Results (N = 100)

	Compassion Satisfaction	Burnout	Secondary Traumatic Stress
Mdn	51.30	48.35	48.83
Range	19.96-66.97	30.08-76.78	33.30-81.64
%			
Low	25	24	32
Average	52	44	42
High	23	32	26

Work Engagement

Results for the vigour, dedication and absorption subscales and the UWES-9 full scale are shown in Table 2, including median (Mdn), range, and percentages for categories representing very low to very high scores. Vigour had the lowest median, with almost one-fifth of participants (19%) scoring low or very low, compared to only 4% and 2% for dedication and absorption. The dedication subscale had the highest median, with just over one-half of participants (51%) scoring high or very high, though 61% scored high or very high for absorption. On the full UWES-9 scale, only 3% scored low or very low.

Table 2 UWES-9 Results (N = 100)

	Vigour	Dedication	Absorption	UWES-9 Full Scale
Mdn	4.00	5.00	4.33	4.44
Range	0.67-5.67	2.00-6.00	1.33-6.00	1.56-5.89
%				
Very Low	2	0	0	1
Low	17	4	2	2
Average	51	45	37	54
High	27	38	51	37
Very High	3	13	10	6

Correlational Analyses

Work engagement (UWES-9 full scale) and compassion satisfaction were strongly positively correlated ($r_s = .69$, $p < .001$) meaning that higher levels of work engagement were associated with greater compassion satisfaction. The positive correlation with compassion satisfaction held for all three UWES-9 subscales; $r_s = .52$, $p < .001$; $r_s = .68$, $p < .001$ and $r_s = .64$, $p < .001$ for vigour, dedication and absorption respectively.

Work engagement (UWES-9 full scale) and burnout were negatively correlated ($r_s = -.44$, $p < .001$) such that as work engagement increased, burnout decreased and as burnout increased, work engagement decreased. The negative correlation with burnout held for all three UWES-9 subscales; $r_s = -.48$, $p <$

.001; rs = -.45, p < .001 and rs = -.20, p = .02 for vigour, dedication and absorption.

There was no significant correlation between work engagement (UWES-9 full scale) and secondary traumatic stress (rs = .02; p = .44) and this held for the correlation between secondary traumatic stress and the UWES-9 subscales of vigour and dedication (rs = -.13, p = .10 and rs = .00, p = .50). However, absorption and secondary traumatic stress were mildly positively correlated (rs = .18, p = .04) such that higher levels of absorption were associated with increased secondary traumatic stress.

There were no significant correlations between years working in residential childcare and burnout, secondary traumatic stress, compassion satisfaction, or the work engagement full scale and subscales (all p > .05).

The results provide partial support for hypothesis 1; work engagement was negatively correlated with burnout but not with secondary traumatic stress. Hypothesis 2 was confirmed; work engagement was positively correlated with compassion satisfaction. The third hypothesis was not supported; length of time working in a residential childcare role was not correlated with burnout or secondary traumatic stress.

Additional Analyses

To investigate demographic variables and work engagement, burnout, compassion satisfaction and secondary traumatic stress, further analyses were conducted. Mann-Whitney U tests revealed no significant differences between males and females on the above variables (all p > .05). Spearman's rho (two-tailed) analyses identified no correlations between age and the above variables (all p > .05) except for absorption, which was mildly positively correlated (rs = .24, p = .02) such that as age increased so did absorption. Role was analysed by categorising job titles into management (directors, senior managers, registered managers, assistant/deputy managers, and team leaders, n = 49), and non-management (residential childcare workers and senior residential childcare

workers, n = 51). Mann-Whitney U tests revealed that management had higher levels of work engagement (UWES-9 full scale) (Mdn = 4.78) than non-management (Mdn = 4.33), U = 826.00, z = -2.92, p = .003, r = -.29, with management having higher vigour (Mdn = 4.33) than non-management (Mdn = 3.67), U = 903.00, z = -2.41, p = .01, r = -.24, and management having higher absorption (Mdn = 4.67) than non-management (Mdn = 4.00), U = 740.50, z = -3.54, p < .001, r = -.35. On compassion satisfaction, management also scored higher (Mdn = 53.04) than non-management (Mdn = 47.82), U = 910.50, z = -2.34, p = .02, r = -.23. There were no differences on dedication, burnout or secondary traumatic stress between management and non-management (all p > .05).

Discussion

This study measured compassion fatigue (burnout and secondary traumatic stress), compassion satisfaction and work engagement in residential childcare employees, and assessed the relationship between work engagement and compassion fatigue. Whilst the tests for burnout and secondary traumatic stress are not diagnostic, it is concerning that one-third of participants were experiencing high levels of burnout and that just over one-quarter were experiencing high levels of secondary traumatic stress. The results are consistent with previous research indicating that compassion fatigue is a concern in residential childcare (Zerach, 2013). Results for work engagement were more encouraging, with only a small percentage categorised as below average, and one-half scoring high or very high on dedication, reflecting the degree of commitment that is often present in residential childcare workers (Seti, 2008). Similarly, high levels of absorption were found, but given the challenging nature of the residential childcare task it can be questioned whether high absorption is desirable, as discussed below. That almost one-fifth of participants had low or very low levels of vigour reflects depleted energy levels for a significant number of employees, highlighting the demanding nature of residential childcare work (Barton et al., 2012).

The positive correlation between work engagement and compassion satisfaction fits with research in other helping professions (Ray et al., 2013), and makes sense considering both involve experiencing work as rewarding, meaningful, and a source of positive emotion (Bakker et al., 2014). Similarly, the negative correlation between work engagement and burnout is consistent with existing research (Schaufeli & Bakker, 2004) and their position as opposing constructs (Demerouti et al., 2010). Burnout may lead to disengagement from work as a coping mechanism by detaching from the role; conversely staff who are highly engaged in their work might obtain the associated psychological benefits, protecting them from burnout (Bakker et al., 2014). It makes sense that staff who are not experiencing the emotional exhaustion and dissatisfaction of burnout are able to be more engaged in their work.

The association between absorption and secondary traumatic stress can be understood in that residential childcare work exposes staff to significant levels of trauma and distress. Given that absorption includes difficulties detaching from work (Schaufeli & Bakker, 2004), it could be that high levels of absorption, with heightened exposure to young peoples' distress, causes greater secondary traumatic stress. Conversely, it could be that as secondary traumatic stress increases, absorption increases, given that preoccupation with the trauma source is a symptom of secondary traumatic stress (Figley, 2002). Managers scored higher on absorption than non-managers, but there was no difference on secondary traumatic stress. Managers had higher levels of vigour and compassion satisfaction which may buffer against secondary traumatic stress (Conrad & Kellar-Guenther, 2006; Ray et al., 2013; Samios et al., 2013). Also, managers may be less exposed to young people's distress than direct care staff (Pinchover et al., 2015), which may protect against secondary traumatic stress despite higher levels of absorption at work.

The results for length of time working in residential childcare matched existing research, showing no clear relationship between years of experience and compassion fatigue, indicating that further research is needed to understand which staff are vulnerable to experiencing compassion fatigue (Seti, 2008).

Practical Implications

Given that work engagement and burnout are strongly related, residential childcare organisations should implement interventions to promote work engagement and minimise burnout in employees. To facilitate work engagement, several factors are recommended; providing access to support, creating opportunities to use skills, instilling a sense of control, setting clear goals and expectations, introducing variety and diversity to work roles, providing sufficient pay, maintaining physical safety, and helping staff feel valued (Ling, Hunter & Maple, 2014; Stairs & Galpin, 2013). However, as highly absorbed employees reported greater secondary traumatic stress, a balance is needed so that staff are supported to maintain professional boundaries and protect their well-being; regular supervision is an important vehicle for such discussions (Salloum et al., 2015; Seti, 2008). Organisations should encourage staff to maintain a good work-life balance and to detach and re-charge between shifts (del Valle et al., 2007; Figley, 2002). Training is vital for residential childcare staff to feel knowledgeable and skilled in performing their duties, and 'system-wide championing of residential care' is needed to help staff feel valued (Clough, 2006, p.3).

Interventions that promote compassion satisfaction are important, given its association with work engagement, and its buffering action against compassion fatigue (Conrad & Kellar-Guenther, 2006). Staff who find meaning in their work are more likely to experience compassion satisfaction (Stamm, 2010) and therefore residential childcare organisations should encourage reflective practice in staff teams (North, 2014) to develop deeper understanding of young people in their care, and awareness of the significance and value of their work. Being able to identify the progress made by young people is important for feeling that the work is meaningful and satisfying (del Valle et al., 2007), therefore outcomes monitoring is recommended for tracking children's progress (Barton et al., 2012).

Protective factors such as adequate organisational support, regular supervision, and relevant training are important for preventing or minimising burnout in residential childcare employees (Decker et al., 2002; del Valle et al., 2007; Seti, 2008). Reducing stress by providing manageable tasks and workloads is also recommended for burnout prevention (Figley, 2002; Seti, 2008). Managers need to recognise compassion fatigue in their employees, so they can tailor support accordingly; again regular supervision is vital, and incorporating information about compassion fatigue into supervisors' training is recommended (Lakin et al., 2008; Pinchover et al., 2015).

Staff need to recognise the indicators of compassion fatigue in themselves, so they can adopt good self-care and coping strategies, including social, physical, emotional and spiritual self-care (Eastwood & Ecklund, 2008; Seti, 2008; Zerach, 2013). Self-monitoring of compassion fatigue has been advocated (Stamm, 2010), but given the high dedication of professional helpers, staff can fail to recognise compassion fatigue in themselves (Scanlon, 2013; Seti, 2008), and should also be encouraged to recognise when colleagues are struggling and support one another accordingly (del Valle et al., 2007; Figley, 2002). Providing opportunities for teams to engage in group supervision, debriefings and professional development can help sustain employees in their challenging roles (Eastwood & Ecklund, 2008).

Regarding leadership, creating a positive, collaborative working environment and building trust within the organisation are considered protective factors against burnout (Figley, 2002; Pinchover et al., 2015; Seti, 2008) and an open, non-judgemental culture is necessary to enable staff to request help when needed (Sheppard, 2015).

The support for employees with secondary traumatic stress may need to be more intense, specialist and targeted than that required for burnout, including trauma training, clinical supervision and self-care practices that focus on trauma symptoms (Ling et al., 2014; Salloum et al., 2015; Scanlon, 2013). Given the link between compassion fatigue and staff turnover (Salloum et al., 2015),

national policy-makers and regulators should ensure that organisations have adequate, effective systems for minimising compassion fatigue and helping retain staff, thereby protecting attachment relationships with young people.

Limitations

The study was correlational, meaning that causal inferences could not be made. The recruitment method meant the response rate could not be determined and gave limited control over the survey reach, though exclusion criteria were applied to restrict analyses to the target population. The amount of direct contact with children and young people was not measured, and it is possible that some managers will have had more contact than others. More engaged workers may have been more motivated to participate in the study, and those experiencing severe compassion fatigue may have been unable or unavailable to participate.

Given the topic and self-report method, there was potential for social desirability bias (Richman, Kiesler, Weisband & Fritz, 1999), particularly from participants known to the first author who completed paper questionnaires, with less scope for such bias from the online participants who had total anonymity. Attempts were made to manage this using blank envelopes for questionnaires left in a designated place, with consent forms collected separately.

Participants were only recruited from independent rather than local authority homes, which limits the generalisability of the results. Different types of provision face different pressures depending on remit, statutory requirements and available resources, leading to different staff experiences. Therefore, the above practical implications need to be considered by individual provisions in terms of applicability and feasibility.

Future Research

This study contributes to the literature on compassion fatigue in residential childcare and introduces the concept of work engagement. Further research in

this setting is recommended to explore risk and protective factors for compassion satisfaction and compassion fatigue and to identify drivers and barriers of work engagement. The Job Demand-Resources (JD-R) model of organisational well-being (Bakker et al., 2014) may be a useful framework for structuring further research, to highlight demands of the residential childcare role that increase burnout and secondary traumatic stress, and work-related resources that promote work engagement and buffer compassion fatigue.

The literature remains inconsistent regarding the impact of demographic variables and years of experience on compassion fatigue (Salloum et al., 2015; Seti, 2008) and there may be unexplored variables mediating the relationship between compassion fatigue and work engagement. Research exploring differences between roles may highlight specific risk and protective factors and measuring the degree of involvement in direct care of young people is recommended. Incorporating personal factors such as personality, previous trauma and attachment style (Zerach, 2013), and work-related factors such as autonomy, pay and leadership style (Seti, 2008) may help identify variables that impact on compassion fatigue so that staff support can be tailored accordingly. The different relationship of burnout and secondary traumatic stress with work engagement indicates that these elements of compassion fatigue should be measured separately (Stamm, 2010; Zerach, 2013). Longitudinal research is needed to assess the relationship between work engagement and compassion fatigue, and with larger samples to improve generalisability of results (Schonbrodt & Perugini, 2013).

Conclusion

Burnout and secondary traumatic stress which make up compassion fatigue, are a significant concern for residential childcare staff and organisations. Residential childcare staff are typically engaged and highly dedicated to the task of looking after vulnerable children and young people, though greater absorption in the work was correlated with (but not necessarily causal of) greater secondary traumatic stress. Staff need to recognise the signs of burnout and secondary traumatic stress so they can adopt good self-care, and organisations should provide adequate support to sustain their employees, enabling them to provide consistent, compassionate care to children and young people in need.

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About the authors

Dr Kerry Audin, Consultant Clinical Psychologist (Independent Practice) and Masters in Applied Positive Psychology (MAPP) Graduate, School of Psychology, University of East London. Dr Audin specialises in supporting children, young people and their carers in residential childcare settings, including providing psychological assessment and intervention, staff consultation, training and outcomes monitoring. She has a background in research and evaluation of psychological therapies at the University of Leeds.

Dr Jolanta Burke, Senior Lecturer and Associate Leader, MAPP and Coaching Psychology, School of Psychology, University of East London. Alongside lecturing

and lead responsibilities on the MAPP and Coaching Psychology programme at UEL, Dr Burke works with organisations, applying positive psychology with teams and individuals, and has conducted research on the applications of positive psychology in education.

Dr Itai Ivtzan, Senior Lecturer and Programme Leader, MAPP, School of Psychology, University of East London. In addition to lecturing and lead responsibilities on the MAPP programme at UEL, Dr Ivtzan is honorary senior research associate at University College London. His area of special interest is psychology and spirituality, and the links with resilience, awareness, courage and compassion, along with the science and practice of meditation.

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