Center for Advanced Studies in Child Welfare
School of Social Work
University of Minnesota

CW360°

a comprehensive look at a prevalent child welfare issue

Safety | Permanency | Well-Being

Secondary Trauma and the Child Welfare Workforce
Spring 2012

From the Editors

The year 2012 marks the 20th year of service for the Center for Advanced Studies in Child Welfare (CASCW). As a Center funded largely through Title IV-E training funds, our mission and purpose has been to support the training and education of the current and future child welfare workforce. As we prepared for this landmark year we wanted the theme of this year's edition of *CW*360° to focus on the unique challenges faced by you, the dedicated, and often unrecognized, child welfare professionals, undertaking the day to day work of providing safety and stability to vulnerable children and their families. Therefore, the 2012 issue of *CW*360° is dedicated to exploring secondary traumatic stress in the child welfare workforce, including how it develops, how to recognize the symptoms in yourself and colleagues, and a variety of intervention strategies at both the individual and organizational levels.

The preparation for each issue of *CW*360° begins with an extensive literature review and exploration of best practices in the field. Then, CASCW staff and editors engage individuals who emerged as leaders or who had a unique contribution to the issue's topic. While the field of child welfare has been familiar with the concept of burnout for many years, the concept of secondary trauma is relatively new. Considerable research conducted on this topic occurs with emergency responders and mental health practitioners, particularly those working in the wake of large disasters. Child welfare-related research of this nature tends to focus instead on turnover and burnout rather than the impact of secondary trauma. However, it is important to understand that secondary traumatic stress, or STS, can be mistaken for burnout. The distinction is that STS develops as a result of making empathic connections with traumatized individuals, while burnout is the result of administrative stresses, such as too much paperwork and large caseloads. STS can occur from one traumatic instance (e.g. the death of a child by maltreatment) or the accumulated impact of everyday work with traumatized children, youth and families.

Because STS is experienced on such an individual level, the tendency is to deal with it on an individual basis. But, as the authors throughout this publication suggest, STS is a much more pervasive issue throughout the child welfare workforce that is going to require systemic changes at the organizational level. Recognizing and encouraging discussion of workers' experiences with STS is an important first step in making this change. We hope that, after reading this edition, you can apply the research, practice and perspectives to your own work settings. **As a tool to help you get started we have included, for the first time, a discussion guide to help start agency discussions at the worker and administrative levels.**

As in previous editions, CW360° is divided into three sections: overview, practice, and perspectives and collaborations. In the overview section, articles focus on how secondary trauma impacts practice professionals and advocates in the child welfare system, from research on secondary traumatic stress and its causes, symptoms, and potential interventions, to outside influences, such as negative media and reactionary policies. The practice section includes articles on evidence-informed and promising practices for preventing and intervening in instances of secondary traumatic stress. The perspectives and collaborations section presents articles from a variety of child welfare stakeholders, highlighting innovative examples of cross-system collaborations and offering practical suggestions and strategies for system and practice improvements.

We invite readers to join CASCW staff and CW360° contributors Brian Bride and Erika Tullberg for our half day conference on May 1, 2012 at 1:00 pm dedicated to discussing secondary traumatic stress in the child welfare workforce. A panel, including Jennelle Wolf, Lead Child Protection Services Worker from Pierce County Human Services (WI) and Richard Backman, Division Director for Washington County Community Services (MN), will react and interact with our two national speakers on localized impact and application of their work. The conference can be viewed via web stream from any location. The conference will also be archived and available for viewing after the conference. To access web streaming registration information or the web stream archive of the event, visit our website at http://z.umn.edu/2ndtraumacw.

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Helping that Hurts: Child Welfare Secondary Traumatic Stress Reactions

Charles R. Figley, PhD

The foundations for the concept of secondary traumatic stress can be found in early examinations of the phenomenon of worker burnout. Freudenberger (1974) was the first to discuss work-related distress resulting in a bad outcome for the worker in his essay "Staff burn-out" in the Journal of Social Issues. What followed was a period of study regarding the concept resulting in several books (e.g., Cherniss, 1980 and Edelwich & Brodsky, 1980). Next, researcher attention shifted to the examination of worker stress associated with burnout; this condition of increased worker stress was associated with job dissatisfaction, often leading to higher workforce turnover. Maslach (1982) and others applied considerable scholarship to determine early on that when a worker, including but not limited to social workers, experienced long-term exhaustion, it resulted in diminished interest in working. In the case of a child welfare worker, he or she might gradually decide that work-related stress, such as long hours, excessive paperwork, "system" issues, low pay, or lack of supervisor support, is too much. The toxic emotional toll of working with traumatized children in child welfare may be part of the exhaustion and diminished interest in the work (Figley, 1995b).

Now, nearly 37 years later, we understand that burnout is inadequate in describing the negative consequences of work-related stress generally and, more specifically, the emotional costs of caring. Most child welfare workers care deeply about their clients and their families, and many may suffer from the inability to balance their own needs with those of their vulnerable clients. Three terms are often used interchangeably to describe the same phenomenon that occurs when we absorb the stress of the suffering while we are trying to help them: Secondary Traumatic Stress, Compassion Fatigue, and Vicarious Traumatization.

Secondary Traumatic Stress (STS)

STS is a set of observable reactions to working with the traumatized and mirrors the symptoms of post-traumatic stress disorder (PTSD). Rather than the source of trauma emanating from an event directly, it comes to us indirectly. Our effort to manage that type of stressor is a measure of how our life is going at the time: If friends and family who love us and support us surround us, we are more capable of managing any type of stress. But under certain conditions, anyone would

be susceptible to the negative consequences of STS. In 2004, Brian Bride published the first of several papers (Bride, 2004; Bride, Robinson, Yegidis, & Figley, 2004) that framed STS using the symptoms of PTSD applied not to those in harm's way but rather to those who assist them and are traumatized by helping those in harm's way. The most studied traumatized caregivers were families (Figley, 1989), but the book Compassion Fatigue (CF; Figley, 1995a) was the first to focus on professional caregivers' experience of STS, utilizing the idea of CF as the worst consequence of STS.

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Compassion Fatigue (CF)

The book, *Compassion Fatigue,* published in 1995 called for a re-evaluation of the concept of trauma and proposed "secondary traumatic stress" as the real threat to those who care for the traumatized. Caregivers' own needs were overlooked not only by supervisors and fellow caregivers but also by the caregivers themselves.

Child welfare workers and other human service providers absorb the pain they treat, but not until the development of the concept of compassion fatigue in the 1990s did professional and volunteer caregivers realize how much they had in common regarding the health consequences of their caring. Since stress can be measured and linked to the immune system, this hidden stressor can not only cause burnout but also many other unwanted consequences, including secondary traumatic stress reactions (Mikulincer, Victor Florian, & Solomon, 1995).

Vicarious Traumatization (VT)

Vicarious traumatization (VT) is defined as the negative transformation in the self of the helper that comes about as a result of empathic engagement with survivors' trauma material and a sense of responsibility or commitment to help (Saakvitne, Gamble, Pearlman, & Lev, 2000). VT is caused by regular exposure to the traumatized. However, VT can be addressed, prevented to a certain extent, and transformed. In contrast to STS and CF, VT cannot be measured directly, but rather indirectly, using a number of trait-based tendencies in responding to trauma. Helping professionals' awareness of these processes will inform their therapeutic interventions, enrich their work, and protect themselves and their clients.

The Stress-Process Model

Who experiences STS and how? One way to appreciate how STS can affect us is by understanding the "road map" of the journey of stress and stress reactions. A Stress-

Process Model best captures the relationship between job-related secondary stress and burnout (Boscarino, Figley & Adams, 2010; Pearlin, 1989; Thoits, 1995). Applied to the traumatized, the stress caused by the trauma must be processed through cognitive behavioral work resulting in new meanings about the trauma that are less distressing. Thus, the focus is on the person in harm's way who was injured psychosocially while being in harm's way. This person is referred to as the "victim" or the "traumatized person." They are diagnosed to determine the degree of psychological damage by completing an inventory of symptoms associated with PTSD or something less that is currently a stress "injury" (Figley & Nash, 2007). Applied to child welfare workers, the Stress-Process Model contends that workers respond physiologically through changes in the neuro-endocrine and hormonal systems (Boscarino, 1997) and psychologically, usually through changes in cognitive functions (Thoits, 1995). These responses can detract from professional functioning by affecting judgment and impairing clinical assessment and services.

Suffering the Suffering

STS research suggests that other aspects of the caregiver's environment can influence the likelihood of developing compassion fatigue, meaning that professionals exposed to similar stressors are not equally vulnerable to the negative consequences (Adams, Figley & Boscarino, 2008).

Studies of stress suggest that individuals from disadvantaged groups are more vulnerable to stress exposures (Pearlin, 1989). We would speculate, based on a preponderance of reports, that highly vulnerable children are a disadvantaged group who would display more distress, and thus distress for the child welfare worker would likely be higher compared to other children and workers (Lee, 2010; Xu, 2005; Baker, O'Brien, & Saluhuddin, 2007; Radey, 2006). However, this is currently an empirical question that is critical to address, given the risks posed by STS to both children and those who care for them.

In addition to exposure to highly distressed children, child welfare workers with a history of firsthand exposure to trauma have an increased likelihood of developing compassion fatigue (Figley, 1995b; Nelson-Gardell & Harris, 2003). On the positive side, secondary stress resilience is associated with deliberate and strategic coping that includes self-care and the effectiveness with which workers can attract and maintain social support. See the articles by Alison Hendricks and Anita Barbee later in this issue for a more detailed discussion of coping and self-care strategies, including the use of social support. Together these protective factors are believed to reduce or at least moderate the influence of secondary stress on worker wellbeing (Pearlin, 1989; Thoits, 1995).

Finally, there is some evidence that personality or trait tendencies that include emotional competencies are positively related to empathy and negatively related to compassion fatigue. For example, emotional intelligence is positively related to adaptive variables, such as job satisfaction and burnout (e.g., Matthews & Zeidner, 2000; Ricca, 2003).

Conclusion

This brings me to the story of LT COL Dave Cabrera. Dave and I were co-investigators in the final year of a 3-year study funded by the US Army (2009-2012). We were studying combat medics and finding signs of STS among them when we began experiencing STS in ourselves. Like practitioners working in child welfare and hearing stories of fear, confusion, and sometimes hopelessness, Dave and I were beginning to have dreams and intrusive thoughts about our interviewees. We both struggled to completely understand our "guys" by reviewing the videos over and over again, like child protection workers reviewing records over and over again to somehow find the answer and by so doing find peace of mind. Dave Cabrera, PhD, combat clinical social worker, was killed October 29th of 2011 while voluntarily deploying to Afghanistan to serve soldiers as a combat social worker.

Ultimately, it is up to each caregiver to take proper measures to protect themselves and their colleagues. Begin to notice those colleagues who are exhibiting signs of secondary traumatic stress. Give them a copy of this publication. It may save their careers and maybe even their lives. When you find yourself working too hard – being so fixed on going the extra mile when it's not in you, think about Dave Cabrera saying, "You are no good to others if you don't have proper rest and focus."

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Occupational Hazards of Work in Child Welfare: Direct Trauma, Secondary Trauma and Burnout

Kimberly K. Shackelford, PhD, LCSW

Three of the psychological occupational hazards of working in the field of child welfare are direct trauma, secondary trauma and burnout (Bride, 2007; Newell & MacNeil, 2010; Pryce, Shackelford, Pryce, 2007). It is important to recognize the differences to provide appropriate prevention and treatment. Mislabeling what is psychologically happening with a child welfare professional can lead to the person leaving the field or continuing to practice as an impaired professional (Pryce et al., 2007; Samantrai, 1992). Newell and MacNeil (2010) claim there is a need to "understand the risk factors and symptoms associated with these phenomena in order to identify, prevent, and/or minimize their effects" (p. 57). Dickinson and Painter (2009) reported that child welfare workers leave by disproportionate numbers during the second year of work, which appears to be due to lack of support from their agencies. It is imperative to not ignore the fact that child welfare professionals can be damaged by the work that they do (Saakvitne & Pearlman, 1996). Saakvitne and Pearlman (1996) also stated that we, as helping professionals, owe this to our loved ones, our clients and ourselves.

Trauma is part of our lives. Even if the professional has not been exposed to trauma prior to entering the field, it will not be long before she or he is faced with direct trauma. Child welfare professionals work with persons who have been accused of harming their children. The reaction of caregivers to this accusation is usually one of anger, and it is often directed toward the worker. Direct trauma towards workers have included threats on the lives of workers and family members, name-calling, cursing, shouting, assaults, dog attacks, and property damage. Workers may quickly, in the beginning of their careers, exhibit normal reactions to the abnormal traumatic situations of child welfare.

Child welfare work is restoration of the lives of persons who have been traumatized (Bride, 2007; Cunningham, 2003, Pryce et al., 2007). In doing this work, the workers absorb the trauma of others. Secondary traumatic stress symptoms mimic those of direct trauma stress reactions, or posttraumatic stress (Table 1) (Figley, 1995a).

Table 1. Symptoms of Direct Trauma Exposure: Posttraumatic Stress

A. The traumatic event is re-experienced:
1. Recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions
2. Recurrent distressing dreams of the event
3. Acting or feeling as if reliving the traumatic event (e.g., illusions, hallucinations, flashbacks, etc.
4. Intense psychological distress at exposure to internal or external cues
5. Physiological reactivity to internal or external cues

B. Avoidance of stimuli and numbing of general response:
1. Efforts to avoid thoughts, feelings, or conversations about trauma
2. Efforts to avoid places or people that arouse memories of the trauma
3. Inability to recall an important aspect of the trauma
4. Markedly diminished interest or participation in significant activities
5. Feeling of detachment or estrangement from others
6. Restricted range of affect (e.g., unable to have loving feelings)
7. Sense of foreshortened future

C. Increased arousal (not present before the trauma):
1. Difficulty falling asleep or staying asleep
2. Irritability or outbursts of anger
3. Difficulty concentrating
4. Hypervigilance
5. Exaggerated startle response

Adapted from the American Psychiatric Association. (2000). Diagnostic and statistical manual of mental disorders. (4th ed., text revision).

Table 2 is a representation of the symptoms of 666 child welfare workers in five states who responded to a study that spanned ten years (Pryce et al., 2007). In order to be included in the list, the symptom of secondary traumatic stress was required to be found in over half of the workers in the study.

Table 2. Symptoms of Indirect Trauma Exposure found in Child Welfare Workers: Secondary Traumatic Stress

Recollection, dreams, reminders of the events cause anxiety/physical reactions	Feeling flat, emotional numbness
Avoidance of thoughts or feelings	Hopeless
Avoidance of activities or situations	Persistent arousal
Gaps in memory	Trouble sleeping or staying asleep
Intrusive thoughts, sudden involuntary memory of event	Outburst of anger or irritability
Less concerned about client's well-being, preoccupied with more than one client	Difficulty concentrating
Feeling estranged from others	Hypervigilance, exaggerated startle response and startle easily
Feeling trapped in work	Having thoughts of violence against perpetrator

(Adapted from Pryce, Shackelford, & Pryce, 2007)

Burnout takes time to manifest, whereas secondary traumatic stress can occur on the first day of direct work with child welfare clients.

Table 3. Symptoms of Burnout in Child Welfare Workers

Burnout
Physical depletion, chronic fatigue
Feelings of helplessness and hopelessness
Disillusionment
Negative self-concept
Negative attitudes toward work, people, life itself
The ability to cope with the environment is severely hampered
Emotional exhaustion
Depersonalization
Reduction in one's sense of personal accomplishment
Frequent absenteeism, chronic tardiness
Evidence of poor client care
Low completion rates of clinical and administrative duties

(Adapted from Barak, Nissly, & Levin; Maslach & Leiter, 1997; Shackelford, 2006)

Table 4. Sources of Burnout

Demanding and overbearing boss, low peer and supervisory support
Unfairness in organization structure and discipline
Poor agency and on-the-job training
Amount of paperwork/computer work
Non-specific job descriptions
Too many clients, high caseloads
Dilemmas beyond the coping skills of the person
Unbending rules and procedures, lack of control and influence in the policies
Communication problems
Long workdays

(Adapted from Barak, Nissly, & Levin; Maslach & Leiter, 1997; Shackelford, 2006)

Child welfare workers have claimed the symptoms of posttraumatic stress and secondary traumatic stress as well as burnout. This author has conducted numerous workshops across the United States and found that when the list of symptoms of burnout is displayed, the prevalence of these symptoms in workers is pronounced on a consistent basis. Pryce, Shackelford, and Pryce (2007) also found symptoms of burnout among workers. Burnout is strongly associated with human services agencies and is anchored in the work environment (Newell & MacNeil, 2010; Pryce et al., 2007).

Secondary traumatic stress and burnout invoke different feelings and thoughts and come from different sources, but can both be disruptive and harmful to the child welfare professional. One comes from trauma and the other from an unsupportive and demanding work environment (Newell & MacNeil, 2010; Pryce et al., 2007; Shackelford, 2006). Some of the symptoms may look the same, but the traumatized worker often still feels on fire for the work not burned out (Newell & MacNeil, 2010; Pryce et al., 2007). Burnout is insidious. It is portrayed by a slow erosion of energy and motivation to do the job. One way it may be possible to determine whether the person is suffering from burnout or secondary trauma is to ask, "When did you start feeling this way?" If the answer is "I do not know; it feels like I have always felt this way," it is more than likely burnout. If the person answers, "I started having symptoms after I worked a particular case," then the likelihood that the symptoms are stemming from secondary trauma is high. Burnout takes time to manifest, whereas secondary traumatic stress can occur on the first day of direct work with child welfare clients (Pryce et al., 2007).

Recognition and treatment of secondary traumatic stress enables workers to continue in the field of child welfare (Figley, 1995a; Newell & MacNeil, 2010; Pryce et al., 2007; Shackelford, 2006). Burnout that has reached the apathetic stage may require the worker to at least change the type of job they are doing in child welfare or even change to a different field of work (Shackelford, 2006). It is important to recognize the difference in order to keep workers on the job and able to continue to effectively serve children and families.

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Secondary Traumatic Stress and Supervisors: The Forgotten Victims

Crystal Collins-Camargo, MSW, PhD

When vicarious traumatization, compassion fatigue, and secondary traumatic stress (STS) are discussed in child welfare, supervisors are seen as a resource for reducing the impact on workers (e.g. Pryce, Shackelford & Pryce, 2007). The relationship between worker and supervisor is often seen as a mediator. In a four-state study of clinical supervision in child welfare, one state chose to study levels of STS in workers as an outcome measure because of this factor (Bride, Jones, MacMaster & Shatila, 2003). Two studies found moderate levels of STS in mixed samples of frontline workers and supervisors (Bride, Jones & MacMaster, 2007; Conrad & Kellar-Guenther, 2006).

While unintentional, the extent to which these supervisors are themselves susceptible is often overlooked. In Secondary Traumatic Stress and the Child Welfare Professional (Pryce et al., 2007), two paragraphs are specifically devoted to STS in supervisors. There is no chapter on the topic in Child Welfare Supervision: A Practical Guide for Supervisors, Managers and Organizations, an otherwise comprehensive resource (Potter & Brittain, 2009). Ignoring supervisors' response to the stressful and often painful work they do puts the entire system at risk.

The Supervisory Role Makes Them Especially Vulnerable

Child welfare supervisors are not just administrators. They often intervene with traumatized clients, conduct home visits, and share the responsibility for case decision-making with their workers. Shulman (1993) argued that supervisors must develop preparatory empathy and 'tune in' to workers. This important process also opens the door to vicarious traumatization of the supervisor. When traumatic events occur, such as the death of a child, the supervisor is likely as involved as the worker in both the investigation and the internal inquiry if the family had prior involvement with the agency. In one study, a tendency to suppress angry feelings was related to increased stress, dissatisfaction with co-workers, and physical symptoms, regardless of managerial style (Norvell, Walden, Gettelman, & Murrin, 1993). Anger can be a natural response to working with clients, to organizational decisions and bureaucracy, and the inability to create an environment where their workers can succeed. Supervisors may suppress these feelings when they interact with workers. It stands to reason that supervisors are at least as vulnerable to STS as workers.

Cornille and Meyers (1999) found that longer tenure in the field and working beyond 40 hours a week were associated with higher levels of STS. These agencies are in a constant state of reform, and the responsibility for implementing new procedures largely falls on the frontline supervisor. Bride and Jones (2006) found that child welfare workers with lower levels of STS reported their supervisors used a more action-oriented approach, offering to help address problems and providing visible, ongoing support. While important to meeting worker needs, this may add additional pressure if attention is not paid to their own reactions. In one study, child welfare supervisors and managers were found to have high rates of exposure to critical events and high levels of accountability, and nearly 49% were in the high or severe range for post-traumatic symptoms (Regehr, Chau, Leslie & Howe, 2002).

When one considers the complex and multifaceted supervisory role, it is no wonder that supervisors can easily fall prey to STS. In an initiative led by two federally-funded National Resource Centers, supervisors from across the country identified those job responsibilities deemed most important generating 31 separate items. One hundred percent of those interviewed identified preventing/addressing stress, STS, and burnout for supervisors, and 95% included the same tasks associated with workers (Hess, Kanak, & Atkins, 2009).

> Ignoring supervisors' response to the stressful and often painful work they do puts the entire system at risk.

Strategies for Preventing and Addressing STS and Related Concerns in Supervisors

Many supports could help prevent and address this phenomenon. Ausbrooks (2011) studied why child welfare supervisors remain on the job, despite the stressful nature of the work and their susceptibility to STS, and found that possession of a personal calling, support systems, and strong coping skills contributed to retention. Hess, Kanak, & Atkins (2009) urged supervisors to monitor their own stress levels and signs of STS, and seek resources to address them. However, to place responsibility solely on the individual exacerbates the problem.

Child welfare agencies should make a number of resources accessible to supervisors. Dane (2000) recommended self-care training and monthly support groups to discuss trauma issues. Middle manager supervision of supervisors can play an important role in what Figley (1989) referred to as social supportiveness skills, including clarifying insights, correcting distorted perceptions, and offering objective ways of looking at supportive events. Supervisors need the opportunity to process these topics with their manager, their peers, or both before they can undergo a parallel process with workers.

In the aforementioned four-state study of clinical supervision, states used a learning circle model to develop skills, but an important outcome of this strategy was establishment of a peer support process for the supervisors who typically do not have peers in their community to whom they can turn (Collins-Camargo, 2006a). These groups helped to normalize supervisory challenges and promoted peer consultation. However, agency administrative decisions often impeded the process (Collins-Camargo & Millar, in press). In the one state that measured worker STS, it was found to be negatively correlated with peer support (Bride et al., 2007).

Organizations must promote an organizational culture valuing and overtly demonstrating support for supervisors, involve them in the communication chain, recognize and reward good work, and address supervisory STS and burnout (Hess et al., 2009; Bell, Kulkarni, & Dalton, 2003). Choi (2011) found that those with access to strategic organizational information had lower STS levels. Agencies can develop positions that split responsibilities across two positions (such as an advanced practitioner), rotate supervisors from high stress positions to other assignments, and develop peer support teams to conduct critical incident stress debriefings (Dill, 2007). Employee assistance programs should be marketed as a way for supervisors to address vicarious trauma and STS.

A proactive approach is needed. Providing the tools for evidence-informed practice can demonstrate the positive impact staff are making with families and may promote expectancy valance—the belief that it is possible to make a difference in the lives of clients. Another way of looking at this would be promoting compassion satisfaction (Conrad & Kellar-Guenther, 2006) and fulfillment (Radley & Figley, 2007).

This issue is receiving national attention. In 2011, the Social Work Policy Institute sponsored a national symposium on child welfare supervision. One of the challenges observed was trauma, safety, and vulnerability in the agency and community. Recommendations for action included development of peer consultation programs, debriefing processes, and support for middle manager supervision of frontline supervisors.

A comprehensive approach is necessary. Although supervisors are critically important resources for preventing and mediating STS in frontline workers, to fail to take care of these caregivers compounds the problem. In 2006, 36 states participated in the Summit on Child Welfare Supervision. Data collected from those states indicated that few supports beyond training were offered to supervisors at that time (Collins-Camargo, 2006b). The literature demonstrates agencies must not only provide but encourage supervisors to take advantage of resources designed to assist them. To do less than this not only neglects these valuable assets and impedes support to frontline workers but, ultimately, impacts outcomes for the children and families so desperately in need of quality services.

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Are Private Agencies Less Susceptible?

Child welfare happens in partnership between public and private agencies. In many states, private agencies predated public agency involvement. In all states, private agencies provide services such as counseling or foster care to the child welfare population, but some states have also moved case management to the private sector. The National Quality Improvement Center on the Privatization of Child Welfare Services (QICPCW) studies this partnership (see this publication's Resources Page). Interviews with public administrators in 2008 revealed that approximately 23% of states had some privatized case management, and 13% have broad-scale initiatives. So, does contracting child welfare case management to private agencies reduce the risk of STS in staff?

Moving child welfare services to private agencies does not change the nature of the work. Intervening with multi-problem families still brings susceptibility to vicarious traumatization, compassion fatigue, and STS. The families served experience the same trauma. Staff turnover remains an issue. Private agency administrators and supervisors have emphasized this in their interactions with the QICPCW—'the work is the work.'

However, the bureaucratic nature of public child welfare agencies can make the establishment of flexible supports, incentives, and initiatives to address STS harder and slower. Smaller private agencies may be more creative in establishing programs and can minimize the perceived distance between management and the frontline. It may be easier to implement innovative practice techniques, provide staff with data demonstrating outcome achievement, reward employees, and establish peer and professional support mechanisms. If the impact of initiatives could be demonstrated, the public sector could benefit from what is learned in private agencies. This is an area in which public/private collaboration could prove especially productive through sharing strategies or joint support and assistance programs. The susceptibility to STS is inherent in the work, but solutions may be implemented through partnership.

The Vicious Cycle: Policy, the Media, and Secondary Traumatic Stress

David Chenot, PhD, MDiv, LCSW

The author has suggested elsewhere that a vicious cycle recurs throughout the country involving child welfare services (CWS) organizations (Chenot, 2011). The events that trigger the cycle are heinous child abuse/neglect incidents that gain wide exposure such as child deaths or particularly gruesome maltreatment occurrences. The children and families involved in these events have recently been, or are currently, CWS clients. The media runs a series of stories about the incidents (see Richardson in this issue), and the public is horrified by the details. The local governing body initiates an external investigation of the case and internal probes are launched by the administration in the agency. The immediate result is often that a few social workers are fired or placed on leave. Longer term results include policy changes that may be forced upon the agency by the local governing body or produced internally. In time, after the furor in the media and political attention recede, the cycle settles into a trough until the next grievous event triggers a spike in the cycle.

Not only do reactionary policy changes have an effect on the working lives of CWS social workers, they also have an impact on the services offered by these workers and, therefore, on clients. For instance, a phenomenon called "foster care panic" often follows grievous child maltreatment incidents (Crary, 2006; Kaufman, 2006; & Poitras, 2003). This is typified by the reaction to a grievous event in Connecticut: In 1995, a nine-month old was murdered by her mother's boyfriend (Lang, 1996; McClarin, 1995). This horrible event and two other child abuse deaths that followed within an eight-day period prompted direct intervention by the governor and a shift from family preservation-oriented services to a 'safety first' approach. Within a month, 100 children were removed from their families, and there was a 20% increase in children placed in foster care over the four months following these events (McClarin, 1995). Policy changes and visceral reactions to policy changes, like foster care panic, cannot help but have an impact on clients and the social workers that serve them.

Well thought-out policies that focus on improving services to children and families, rather than simply adding accountability measures to social workers' duties, are likely to enhance the long-term health of the agency through improved outcomes and encourage job satisfaction among employees.

The question in this inquiry is: What impact does this cycle have on CWS organizations and their workers? The short answer to this question is that the vicious cycle has a profound impact and contributes to the development of secondary traumatic stress among social workers in these agencies. One way this functions is through reactionary policy changes. For instance, in a policy analysis of state legislatures following severe child maltreatment incidents, Gainsborough (2009) found that laws which mandate new procedures in CWS agencies are often passed in reaction to these events, yet no additional funding is provided to help the agency fulfill the new requirements. Internally, written or "unwritten" policies may also be created that add mandates to the work of CWS social workers in the wake of grievous events. These policy changes create an increase in administrative functions (i.e., paperwork) and a decrease in direct practice with children and families, and seem unlikely to lead to improved outcomes in CWS agencies (Lachman & Bernard, 2006; Malm, Bess, Leos-Urbal, Green, & Markowitz, 2001).

The effects of the cycle may be realized in less obvious ways as well. The cycle increases stress, which negatively impacts the services CWS social workers offer to children and families (Glisson & Green, 2011; Glisson, & Hemmelgarn, 1998; Glisson & James, 2002). The cycle also appears to encourage passive defensive types of organizational cultures, which have negative effects on the retention of social workers (Chenot, Benton, & Kim, 2009).

The impact of the cycle on individual CWS social workers includes internalization of pejorative community perceptions of their agencies and their work (Ellet, 1995; Ellett, Ellis, Westbrook, & Dews, 2007), personalization of problems experienced agency-wide, and a tendency for workers to blame themselves for agency difficulties (Lewandowski, 2003). With all of these findings as the context, the factors in the vicious cycle seem to contribute to STS among CWS social workers (Figley, 1995a; Regehr, Hemsworth, Leslie, Howe, & Chau, 2004).

It is possible for CWS administrators and staff to take a proactive stance in order to mitigate the effects of the vicious cycle (Chenot, 2011) —

Policy

- Positive relationships with politicians and other stakeholders are crucial when there is a spike in the cycle. These potential allies can be "strategic champions" (Ellett et al., 2007) for the agency and CWS social workers during difficult times.
- The relationships mentioned above are likely to open opportunities for input when policies are being created externally in the wake of heinous child maltreatment events.
- Avoid the internal creation of "crisis-driven" policies when public scrutiny swells. Well thought-out policies that focus on improving services to children and families, rather than simply adding accountability measures to social workers' duties, are likely to enhance the long-term health of the agency through improved outcomes and encourage job satisfaction among employees.

The Media

- An emphasis on positive public relations through building relationships with those in the media is valuable when grievous child maltreatment events occur.
- Agency administrators should identify those in the media that are most likely to portray the agency in a positive light (or least negative light) and cultivate professional relationships with them. These relationships may offer administrators the opportunity to present an unbiased view of the agency and its employees in the face of public scrutiny.
- Selected administrators and social workers should be trained in public speaking and how to talk with members of the media *prior* to crises.

Finally, the steps outlined above have the greatest impact when they are implemented during the trough phase of the cycle, prior to a grievous child maltreatment event, when things are relatively stable. Collectively, they can create a buffer when the storm surrounding a spike in the cycle occurs.

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Media Influence on Development of Secondary Traumatic Stress in Child Welfare Workers

Kate Richardson, Dip SW, BA

There is a lack of understanding around how the media may influence the development of secondary trauma in child welfare workers; in UK, a number of child abuse cases have resulted in high profile media reporting, and there are risk factors for those directly and indirectly involved. The emergence of new media is also likely to have an impact on worker stress, and child welfare workers and their supervisors require knowledge and understanding to develop effective support mechanisms.

The subject of child abuse is emotive and media coverage is designed to reflect the abhorrence with which society views violence against children. The UK media view is highly critical where child welfare workers have been involved and are considered to have failed in the task of keeping children safe; the perception of these child welfare workers is that they are incompetent, uncaring, lacking in taking appropriate responsibility, and, in some cases, suggestive of complicity with abusers. A similar perception of incompetence and lack of care is applied when child welfare workers are considered to have removed children from parents inappropriately.

What motivates people to commit acts of child abuse is not well understood, and that means it is unlikely that there will be a punishment deemed adequate by society to fit the crime. This contributes to a level of frustration that in turn results in the need to find someone to 'blame.' Where there has been child welfare intervention, and it fails, the child welfare worker can become the focus for some of the anger and seeking of retribution. The call for child welfare workers to lose their jobs and the media 'name and shame' is not unusual in high profile cases, particularly when a child dies.

Media responses to high profile child abuse cases have been overwhelmingly negative and hostile in their condemnation even where other members of multidisciplinary teams are considered to have missed opportunities to intervene. The media often releases personal details, including photographs of staff involved, and judgments have been made on individuals' personal values and professional competence. Such coverage puts workers at risk and impacts their anxiety; this can increase the risk of suffering secondary trauma. The reporting by The Sun newspaper in 2009 on the murder of baby Peter Connolly included a campaign and petition to fire the child welfare workers involved; over half a million people signed the petition in the biggest ever response to a UK newspaper campaign. The same newspaper advertised for people to tell their stories if they knew any of the child welfare workers involved in the case. Such reporting is more likely to satisfy some need for retribution and public humiliation rather than allow for understanding why a child was abused or neglected. Technological advances have led to the development of websites and Facebook pages that invite dissatisfied service users to post personal details of child welfare workers making the reality of recognition and retribution a day-to-day concern.

Reporting ensures that child abuse cases remain in the public consciousness, and workers live with the constant threat of severe and significant consequences if they make mistakes. Child welfare workers and supervisors share the emotions generated by the abuse of children, and this can result in some internal and professional conflict. It is possible to professionally rationalize some of the issues that contribute to less effective social work, but this may also be compromised by a sense of shame, frustration or futility when social care fails to protect. Workers are affected by secondary trauma issues even where they have no direct involvement in cases portrayed by the media; good quality social work demands the ability to reflect on practice and learn lessons, particularly in cases where children are severely affected.

Negative reporting leading to a public perception of incompetence of child welfare workers means there is less motivation to look for other ways to ensure children's safety despite their vulnerability. Without resolution of these dilemmas the profession remains potentially ignorant of issues that could assist in identifying and protecting the most vulnerable children. Twenty-seven children in the US (BBC, 2011) and one to two children in England and Wales die each week as a result of child abuse and neglect (Coleman, Jannson, Kaiza, & Reed, 2008); criticism of professional behavior distracts from the focus on this reality. When debate does not rely on blaming professionals, the result is likely to be increased public and media understanding of risks to children, which could strengthen public ability to identify children at risk and increase public recognition of the difficult task of child protection. The resulting support could be a protective factor in reducing the risk of development of secondary trauma.

When debate does not rely on blaming professionals, the result is likely to be increased public and media understanding of risks to children, which could strengthen public ability to identify children at risk and increase public recognition of the difficult task of child protection.

Child welfare workers manage distressing issues in a climate of distrust and anxiety that can be perpetuated by overly critical media. There is a need for acknowledgement and better understanding of the issues so that effective responses can be built in to existing individual and supervisory practices and organizational supports.

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Secondary Traumatic Stress in Child Welfare: Multi-Level Prevention and Intervention Strategies

Alison Hendricks, LCSW

Child welfare professionals are chronically exposed to situations that put them at risk for STS. Front-line workers often face threats to their personal safety and routinely have to participate in highly distressing events such as removing a child from his/her parents, separating siblings, or terminating parental rights. Part of the job of a CW worker is to investigate allegations of child maltreatment, which means eliciting and documenting explicit and sometimes horrific details of child abuse and neglect. Ongoing caseworkers and supervisors are exposed to these details as documented in case files and court reports and are faced with the ongoing trauma-related reactions and suffering of children and families in their daily work. As one front-line worker pointed out in a Chadwick Trauma-Informed Systems Project (CTISP, www.ctisp.org) focus group, "Some cases just get to you" (personal communication, 2011). When asked during CTISP-sponsored focus groups how they were being impacted by STS, CW workers and supervisors made the following statements —

- "It affects your family – you can't just stop thinking about work. It's hard to deal with your own family when you are so exhausted."
- "You get tired of reading about abuse all day. It plays on your psyche."
- "You don't realize it because you're just doing your job, but trauma becomes imprinted on you."
- "You bring trauma into your work whether you're aware of it or not."
- "Indifference, detaching, becoming cold and callous due to limited time for processing."
- "You develop thick skin and you don't feel as much."

Prevention Strategies

Although STS is considered to be an "occupational hazard" of CW work, there are some preventive strategies that may help lessen the impact on CW professionals. Catherall (1995) proposed these three steps: Psychoeducation, preparedness, and planning.

Psychoeducation about STS should be incorporated into Bachelor's and Master's level social work training programs to help prepare professionals as they enter the field (Pryce, Shackelford, & Pryce, 2007). As educational level can serve as a protective factor against STS (American Public Human Services Association [APHSA], 2005), CW agencies should recruit and hire professionally trained social workers, preferably those with a Master's of Social Work degree.

Preparedness involves including information about the potential risks of trauma work in the hiring of applicants and training of new hires in order to help create more realistic expectations about the nature of the work and assess their level of resiliency (Pearlman & Saakvitne, 1995b). New staff should be taught coping skills proactively so that these skills can later be used in times of stress or crisis.

Planning should be initiated by individual workers and agencies. Workers can develop self-care plans and support systems early on to help prepare for and reduce the negative effects of future trauma exposure. Organizations should engage in proactive planning to develop support systems to ensure services are in place not only in times of crisis but also on an ongoing basis to address the cumulative effects of chronic trauma exposure.

Intervention Strategies

Personal and Professional

Although the onus should not fall solely on workers, professionals in the field should take an active approach to addressing the effects of trauma exposure to ensure that they are taking care of themselves. Saakvitne and Pearlman (1996) promote the importance of awareness, balance, and connection in addressing STS.

Awareness involves knowing one's own "trauma map" and triggers, and how trauma work is impacting one's life and perspective.

Balance refers to allowing one's self to fully experience emotional reactions, creating and maintaining healthy boundaries between work and personal life, setting realistic goals, practicing time management skills, seeking out new leisure activities, and recognizing and avoiding negative coping skills.

Connection means avoiding professional isolation, seeking out and listening to feedback from friends and colleagues, developing support systems and opportunities for debriefing, seeking training to learn new skills and build competence, and maintaining connection to one's spirituality.

Organizations would be wise to invest time and resources to protect and keep their most valuable asset: The dedicated workers who are in the field, being exposed to trauma and doing psychologically challenging work on a daily basis.

Some organizational strategies to prevent STS include —

- creating a culture that acknowledges and normalizes the effects of working with trauma survivors,
- adopting policies that promote and support staff self-care (see examples from NASW, 2009, listed under Organizational Intervention Strategies below),
- allowing for diversified workloads,
- creating opportunities for staff to participate in social change and community outreach,
- ensuring a safe, private work environment,
- providing trauma and STS education to staff,
- offering group support,
- ensuring effective supervision, and
- making counseling resources available to all staff (Bell, Kulkarni, & Dalton, 2003).

Workers can practice several different types of self-care to reduce the negative impact of STS, as described in Table 1.

Organizational

Organizations also must take responsibility for addressing STS in staff, for the sake of their workers, organizational stability, and the clients. Osofsky and colleagues (2008) recommend the following organizational strategies for mitigating STS —

- explicitly acknowledging STS as a reality and occupational hazard,
- facilitating a cultural shift (creating a safe environment for supporting staff in dealing with STS),
- encouraging ongoing/open discussion of STS among staff and administration,
- reducing or balancing caseloads,
- providing adequate supervision,
- ensuring high-quality mental health coverage and an Employee Assistance Program,

- providing educational workshops for staff to raise awareness of STS and enhance coping skills,
- encouraging professional development, and
- ensuring adequate coverage and back-up for staff in stressful positions.

The National Association of Social Workers (2009) supports organizational policies that promote self-care among social workers, including —

- participatory decision-making,
- workplace safety,
- support and modeling of self-care by management and administration,
- development of individual self-care plans,
- continuing education programs on professional self-care, and
- innovative support services (e.g., retreats, online support groups).

In the CTISP focus groups, supervisors requested STS assessment tools to help them gauge how workers are doing, training on how to support staff in dealing with STS, and more understanding among CW leadership about trauma exposure and its impact on workers and supervisors. One supervisor stated, "It would help to have a door to close." In their CTISP focus groups, front-line workers proposed more empathy and support from supervisors, monthly support groups, and clinical supervision from an outside consultant with STS expertise (personal communication, 2011).

Conclusion

STS poses a tangible and serious threat to the well-being and functioning of CW professionals and the agencies in which they work. It is imperative that CW organizations and staff at all levels are well-informed about STS and its impact. Strategies to prevent and mitigate the effects of STS need to be implemented at multiple levels in order to be most effective. Organizations would be wise to invest time and resources to protect and keep their most valuable asset: The dedicated workers who are in the field, being exposed to trauma and doing psychologically challenging work on a daily basis.

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Table 1: Domains of Self-Care

Self-Care Domain	Examples
Physical	• Healthy diet • Adequate sleep • Physical activity • Health care • Vacations
Psychological	• Self-monitoring • Focusing on positive aspects of work • Journaling • Talking with a trusted person • Decreasing personal stressors
Emotional	• Monitoring and regulating emotions • Laughing and crying • Purging of trauma-related thoughts, feelings, and reactions • Affirmations • Spending time with loved ones • Seeking out pleasurable activities • Participating in prevention activities, social action, and/or community outreach/education
Spiritual	• Striving for inspiration, optimism, and hope • Spending time in nature • Finding spiritual connection or community • Reading inspirational literature • Contributing to social causes of personal importance
Workplace	• Taking breaks during the day • Practicing creative ways to engage in physical activity • Taking time to connect with colleagues • Engaging in mutual peer support • Setting boundaries with clients and coworkers • Seeking out new projects or areas of professional interest • Getting regular supervision/consultation • Balancing daily caseload/workload • Implementing transition rituals between work and home

Vicarious Traumatization and Work in Child Welfare Organizations: Risk, Prevention, and Intervention

Joy D. Osofsky, PhD

All individuals who work with children in the child welfare system are at risk for experiencing vicarious traumatization (VT), secondary traumatic stress (STS), or compassion fatigue (CF). VT, STS, and CF refer to the cumulative effect of working with survivors of trauma or perpetrators as part of everyday work (Figley, 1995b; Pearlman and Saakvitne, 1995b).

Working with and helping to support young traumatized children who have been abused and neglected can take its toll on child welfare workers who continually witness the hardship and suffering experienced by those they are trying to help. Professionals working with the child welfare system, be they front line workers, social workers, home visitors, mental health professionals, judges or lawyers, must maintain boundaries and professional roles while making decisions about children's lives and taking actions to help vulnerable young children and their families (Osofsky, 2011).

Being exposed on a daily basis to both traumatized individuals and disturbing situations can impact one's personal and professional life. People find different ways of coping with these difficult feelings with some reactions being adaptive and others maladaptive. Some try to avoid thinking about the traumatic experiences. Self-care, "time-outs," and a balance between work and family life are crucial to being successful in working with young children and their families in the child welfare system.

Impact on Agencies and Organizations and Helpful Ways to Respond

If employees experience secondary traumatization in a non-supportive environment, it can affect them individually by decreasing their functioning and undermining the working environment in an organization. Research indicates that for organizations, employees' risk for increases in traumatic stress is influenced by organizational issues, policies, and the working environment. Organizations can either promote job satisfaction or contribute to burnout. An organization with an unsupportive administration, lack of professional challenges, low salaries, difficulties in providing client services, and too many cases is predictive of burnout in staff. Such overwhelmed systems frequently experience organizational problems that increase risk for secondary traumatization of staff. The list below summarizes negative organizational effects documented across child protection, police, and mental health agencies with high rates of vicarious traumatization —

- Increased absenteeism
- Impaired judgment
- Unwillingness to accept extra work or assume responsibility
- Low motivation
- Lower productivity and poor quality of work
- Decreased compliance with organizational requirements (e.g., completing paperwork, following guidelines)
- Greater staff friction
- High staff turnover

Awareness of these issues has led to recommendations designed to redress these factors and the knowledge that organizations have much to gain by reducing or preventing secondary traumatization and negative effects.

> Organizations that respond to maltreated young children and families will be most effective if they are trauma-informed.

Organizations that respond to maltreated young children and families will be most effective if they are trauma-informed. Trauma-informed systems acknowledge and respond to the role of trauma in the emotional, behavioral, educational, and physical difficulties in the lives of children and families and work to avoid inflicting additional secondary trauma (Howard & Putnam, 2009). A trauma-informed organization will recognize stressors of the work as legitimate, provide a non-punitive work environment, and recognize the impact of occupational exposure to pain and trauma rather than seeing it as individual weakness. Such an organization will include not only ongoing supervision but also encourage and support training, education and development. They will also "normalize" the responses of staff who may become stressed or discouraged as part of the experience of working with traumatized children and families.

Recommendations for Support, Prevention and Treatment when Working with Traumatized Young Children and Families

There are both personal and professional recommendations for prevention and treatment suggested by experts in secondary traumatic stress. Organizational recommendations focus on what institutions and agencies can do to minimize secondary traumatization (and burnout) in their workers. Supervision, especially reflective supervision is important (Weatherston & Osofsky, 2010). A first step for organizations is to recognize that secondary traumatization is possible and may be occurring. Unless administrators and managers in an agency or organization are in day-to-day contact with traumatized staff, they are often slow to recognize the problem. In order to reduce the risk of VT, it is important that organizations recognize the need to implement changes; Alison Hendricks discusses this in her article in this publication.

For all who work with either child or adult survivors of traumatic experiences, it must be recognized that many of these individuals do well. In fact, the traumatic experiences may be short-lived, and their symptoms may remit rapidly. Clinicians, therapists, judges, lawyers, and child welfare workers must find their own ways to deal with the overwhelming emotions that accompany this work. And each needs to find a way to gain support through self-care, a supportive team, or some other methods to work most effectively. In addition to agency and/or system efforts to address VT, all professionals working with young traumatized children need to find individual ways to reduce the risk of ongoing vicarious traumatization in order to ensure that their decisions, interventions, and treatments are effective and helpful.

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Preparing MSW Students for Practicing in Child Welfare

Ronald Rooney, PhD

Social work students who aspire to become child welfare workers need to be prepared for such predictable pressures as secondary trauma by schools of social work, or they will be unlikely to last long in the field (Blome & Stieb, 2004a; Anderson, 2000; Perry, 2006; Whitaker & Clark, 2006). In this article, I will put into context the kind of assistance the University of Minnesota's School of Social Work can provide in educating future child welfare workers regarding secondary trauma prevention. Specifically, I will discuss how, within the context of the Advanced Child Welfare Practice course, students are prepared in terms of learning individual, family and systems level practices; the relevance of parallel process and pro-social modeling to such practices; and finally how I have attempted to foster pro-social modeling with child welfare students.

Learning Promising Individual and Family Practice

Through courses such as Advanced Child Welfare Practice, Child Welfare and the Law, and Advanced Child and Family Welfare Policy, social work students at the University of Minnesota become knowledgeable about the history, laws and policies that have shaped the past and present of child welfare system. They then learn to practice and evaluate current practice modalities according to their evidence base. The concept of evidence-based practice in child welfare is challenging as the highest levels of evidence require randomized assignment, which is rarely feasible in child welfare practice (Barth, 2008; Blome & Stieb, 2004b). Therefore, students at the University of Minnesota's School of Social Work learn to assess those modalities according to the best available knowledge to guide practice (ibid.). In that regard, even this best available knowledge may not be transferable to new environments if those practices are not delivered with similar clientele, caseload sizes and other supports existing in the models producing those practices. In this context, secondary trauma is introduced as a frequent occurrence among child welfare workers given their proximity to trauma experienced by children and families (CATS Consortium, 2007; Figley, 1995a, 2002; Bell, 1995; Bell, 2003). Students learn to expect such stress and to seek supervision. They also learn to examine norms in practice settings that can facilitate support for workers and normalize their response not as an indication of work malperformance or burnout, but a predictable, normal secondary response to trauma. They are additionally more likely to be successful in coping with secondary trauma if they receive appropriate supervision in which parallel process is used and pro-social modeling.

Parallel Process

If child welfare workers are expected to model appropriate coping with secondary trauma, they need to experience a model of supervision (either individual or group) that encourages sharing of emotional responses to trauma and solicits appropriate support from co-workers and supervisors. If the supervisor can model appropriate dealing with secondary trauma individually or though groups, then supervisees are likely to cope better with it. The concept of parallel process assumes that the dynamics that occur between clients and practitioners will be reproduced in the relationship between supervisor and supervisee (Morrissey & Tribe, 2001).

[Students] learn to examine norms in practice settings that can facilitate support for workers and normalize their response not as an indication of work malperformance or burnout, but a predictable, normal secondary response to trauma.

Pro-Social Modeling

Research by Trotter on effectiveness in child welfare practice found that clients did better if they reported that their social workers returned their phone calls promptly (Trotter, 2006). Trotter refers to this phenomenon as pro-social modeling. Similar to parallel process, clients have had better results if they have been served by social workers who are effective role models, and child welfare workers are more likely to appropriately cope with secondary trauma if their supervisor models such coping.

Fostering Parallel Process and Pro-Social Modeling

I have made efforts in the Advanced Child Welfare Practice course to expose students to effective pro-social models. For example, recently four MSW graduates of the program spoke with students in this course about practices in carrying out assessments and developing service agreements as well as coached those students through videotaped role plays depicting assessment and contracting practice. They also spoke about strategies they had employed to cope with the emotional pressures of the position. At the next level, students watched videos related to effective supervision in child welfare (Jud & Bibus, 2009). Finally, students watched videos describing effective managerial practices consistent with the themes of pro-social modeling developed by Rob Sawyer and Reggie Bicha (Rooney & Kaka, 2011; McBeath, Briggs, & Aisenberg, 2008). These latter videos put into an organizational context the kind of supports child welfare workers need in a structure that emphasizes worker support as well as addressing other organizational goals.

Summary

Secondary trauma occurs in both practice and organizational environments. Child welfare workers can best be supported to address secondary trauma through organizational environments that support good practice, provide outlets for stress, and generally address the environment for service delivery. If families are engaged in a respectful fashion that focuses on common goals of child safety, less hostility is likely to be generated, and the form of secondary trauma that comes from stressful client engagement is reduced. Such respectful practices are more likely to occur when they are embedded in an organization that models the practice in a parallel fashion in its supervision and management; among organizational goals, pro-social modeling and parallel process must include worker supports for dealing with secondary trauma.

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Withstanding Secondary Traumatic Stress: The Role of Realistic Recruitment

Nancy S. Dickinson, MSSW, PhD

Children, youth and families served in the child welfare system face complex and life-changing conditions, frequently marked by exposure to traumatic events (Kolko, et al., 2010). Child welfare staff are entrusted with the stories of these trauma experiences, and how staff react denotes the difference between a high performing stable workforce and one marked by pervasive levels of secondary traumatic stress (STS) and soaring turnover rates. Increasing numbers of resources have been developed during the past two decades to help child welfare staff deal with STS in ways that enable workers to ease others' suffering without taking on the pain themselves (e.g., Dane, 2000; Horwitz, 2010). But what strategies can help to prevent the development of STS among workers? Realistic recruitment is an over-looked approach for building a resilient workforce that can withstand secondary traumatic stress.

Realistic Recruitment

Recruitment practices describe and target information about open child welfare positions in ways that attract a large pool of applicants. Sometimes traditional recruitment practices "sell" the agency and the job to applicants through information that glosses over the difficulties of child welfare work. Staff hired with misconceptions about the work often leave their jobs soon after being hired (Faller, et al., 2009). Realistic recruitment activities that present accurate information about the nature of child welfare work, on the other hand, produce a pool of applicants who truly understand the nature of the job and apply for all the right reasons (Dickinson & Painter, 2009). Staff hired under those conditions tend to remain employed in child welfare (Dickinson & Painter, 2011).

Rather than selling the organization, realistic recruitment presents outsiders with all pertinent information without distortion. Wanous (1992) describes four ways in which realistic recruitment works —

- **Vaccination against unrealistic expectations reduces on-the-job disappointment.** Potential applicants without experience in child welfare often imagine only the rewards of helping families and children, a fantasy which, if not realistically confronted, sets them up for feelings of disillusionment and failure—and likely STS—when they encounter clients' traumatic experiences.
- **Coping.** Realistic recruitment allows applicants to develop coping strategies, including those that weaken STS, so that they will not fail in the new job.
- **Self-selection.** Realistic recruitment helps job candidates make a more informed choice. When applicants understand that exposure to trauma is a risk of the job, they can choose whether or not to continue their application.
- **Personal commitment.** When individuals believe that they have made a choice without coercion or misrepresentation, they are more committed to the decision and see the agency as trustworthy.

Realistic recruitment is an over-looked approach for building a resilient workforce that can withstand secondary traumatic stress.

Realistic Recruitment Strategies

Conducting Job Analyses

Child welfare job descriptions are often outdated leading to the possibility that the wrong person will be recruited and hired for a job that is significantly different from the description. Agency supervisors, managers and HR personnel should clarify current job expectations, review job requirements, identify minimum qualifications and the knowledge, skills, abilities and competencies that the agency seeks. For child welfare staff who will encounter traumatic situations, the competencies should include those that may bolster a worker's ability to withstand STS, such as motivation, self awareness, confidence, persistence, and teamwork. Finally, updated job descriptions should include specific tasks of trauma-informed practice.

Developing the Agency Marketing Plan

Child welfare workers who remain in their jobs understand the agency's mission, have values that are congruent with the mission, and feel valued as contributors to that mission (Keefe, 2003). An early step in the recruitment process requires the organization to identify the specific values, vision, and mission that define its approach to service delivery in general and to trauma-informed child welfare work more specifically. Using its mission as the focal point, the agency should re-design its marketing materials to portray its message in concise and eye-catching brochures, flyers, websites and slide presentations. An agency can tailor its recruitment practices and develop a campaign to recruit people who can withstand secondary traumatic stress by using descriptors of desired applicants who are "hardy," able to "rebound and persist in

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stressful situations," and "want to make a critical difference in the lives of others."

Traditionally written newspaper advertisements are less appealing and effective than once thought. Using its marketing plan, the agency should write an ad about the uniqueness of the agency and the characteristics of the applicant most likely to fit with the job. The following sample ad views the agency and the applicant through a trauma-informed lens —

> [CW Agency] is a fast-paced yet supportive place to work. We are looking for child welfare workers who want meaningful work that is challenging and often stressful but who can persist in making a difference for families, youth and children, many of whom have been exposed to traumatic events.

Developing Realistic Job Previews (RJPs)

RJPs come in many different forms: videos, verbal presentations, job tours, and written brochures. Over 20 states have produced RJP videos, depicting realistic scenes of the difficult as well as the positive aspects of child welfare work. The visual impact of showing examples of child abuse injuries, threatening clients, nighttime home visits, and removal of children from unsafe environments—even when performed by actors—can be a realistic and effective way to recruit applicants who are more likely to withstand STS.

Using Inside Recruitment Sources

New child welfare workers recruited by inside sources (current and former employees) have more realistic expectations about the benefits and challenges of the job and the agency while it is likely that recruits from outside sources (job fairs, advertisements, employment agencies, websites, etc.) may have considerable amounts of misinformation and inflated expectations (Larson, Lakin, & Bruininks, 1998; Wanous, 1992).

One note of caution is that the focus on STS in child welfare is relatively new and relying only on inside recruiters may not tap into pools of applicants who have been trained in trauma-informed practices and self-management skills that would create resilience to secondary traumatic stress.

Conclusion

Preventing STS in the child welfare workforce is impossible; mitigating its devastating impact is not. As Jon Conte writes in his Foreword to Trauma Stewardship (Lipsky, 2009), "In the same way that oils splatter on the painter's shirt or dirt gets under the gardener's nails, trauma work has an impact" (p. xii). The realistic recruitment process is a tool to broadcast the message that there is important work to be done with trauma exposed children, youth and families in the child welfare system. There are recruits who would willingly apply to battle the stress and setbacks inherent in the work in order to make a difference in the lives of people.

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Realistic Job Previews (RJP) in Child Welfare MSW Student Recruitment

Elizabeth Snyder, MSW

At the University of Minnesota's School of Social, the Center for Advanced Studies in Child Welfare (CASCW) began using the University of North Carolina's RJP in child welfare as a recruitment and selection tool for MSW Title IV-E Child Welfare Scholars in 2009. MSW students interested in receiving Title IV-E funds, they are asked to watch UNC's Realistic job preview of North Carolina Child Welfare Work as part of the application process (see Resources Page in this issue). The 34-minute video features child protection social workers in a variety of roles, ranging from intake and investigations to on-going case management and in-home service provision. Staff featured in the video give a candid explanation of their jobs, including the challenges and rewards. They candidly share stories of removing children, seeing difficult living situations, being confronted with conflict and the impact it has on them as workers. MSW IV-E applicants are then asked three questions in which they reflect on and respond to the RJP: What aspects of child welfare work are most attractive to you? Which parts of the job would be the most difficult for you? What do you think would be the most rewarding to you as a child welfare worker?

The goal of including a RJP in the MSW IV-E application process is to introduce newly admitted MSW students to the realities of child welfare practice. Knowing the rates of turnover within the child welfare workforce, the hope is that students will have the opportunity to select the IV-E program with a realistic expectation of the career to which they are committing. The RJP allows potential IV-E students to hear about the struggles confronted by workers that can contribute to burnout or secondary traumatic stress. With an understanding of the realities of the job, students understand the importance of learning strategies and incorporating self- care into their practice from the earliest possible stages. Through coursework and field placements in public and tribal child welfare settings, and with the support of field staff and university faculty, IV-E students have the opportunity to develop STS reduction approaches with supervision and support.

Screening for Secondary Traumatic Stress in Child Welfare Workers

Brian E. Bride, PhD, LCSW

Of the many professional groups that are at risk for secondary traumatic stress (STS), child welfare workers have the highest prevalence rates. One study found that one-third of child welfare workers experience significant symptoms of STS at a particular point in time (Bride, Jones, & MacMaster, 2007). Given the nature of the work this is not a surprising finding; however, it underlines the importance of regular monitoring of the emergence and/or exacerbation of STS symptoms. A number of standardized instruments have been used in research on STS; however, the Secondary Traumatic Stress Scale (STSS; Bride, Robinson, Yegidis, & Figley, 2004) and the Professional Quality of Life Scale (ProQOL; Stamm, 2010) have emerged as the two that are most useful for screening purposes.

Screening Tools

Secondary Traumatic Stress Scale

Consistent with Figley's (1995a) conceptualization of secondary traumatic stress as a syndrome of symptoms identical to those of posttraumatic stress disorder (PTSD), the STSS was designed to assess the frequency of intrusion, avoidance, and arousal symptoms associated with indirect exposure to traumatic events through clinical work with traumatized populations. Each of the 17 items of the STSS is congruent with one of the PTSD symptoms specified in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (American Psychiatric Association, 1994). To complete the STSS, respondents rate how frequently they have experienced each symptom in the past week. The instructions and items are written to focus on indirect exposure to client traumas and minimize the possibility that respondents will report symptoms due to their own direct experience of traumatic events. While there are several options for scoring the STSS (Bride, 2007), the most straightforward approach is to simply sum the scores on each item to obtain a total score which can be used to estimate the current level of secondary traumatic stress. The STSS is available free of charge by sending a request to bbride@uga.edu.

Professional Quality of Life Scale

The ProQOL reflects Stamm's conceptualization of professional quality of life. According to Stamm, professional quality of life encompasses positive and negative aspects of professional helping. The positive aspect is compassion satisfaction, defined as the pleasure derived from being able to do one's work well. The negative aspect is compassion fatigue which is comprised of two components, burnout and secondary traumatic stress. It is important to note that this conceptualization of compassion fatigue differs from that endorsed by myself and Figley, who consider compassion fatigue to be a synonym for secondary traumatic stress and distinct from burnout. However, consistent with Stamm's model of professional quality of life, the 30-item ProQOL consists of three subscales: compassion satisfaction, secondary traumatic stress, and burnout. Scoring of the ProQOL is more complicated than for the STSS and users are referred to the ProQOL Manual available along with the instrument at http://proqol.org.

Therefore, monitoring and attending to STS is an ethical imperative shared by individual workers and the organization.

At the individual level, workers should regularly monitor their levels of STS. While it is expected that many child welfare workers will experience some STS during the course of their careers, regular monitoring will help determine if action should be taken to prevent or ameliorate the negative effects of STS. For example, consistent high levels of STS or a clear trend towards higher levels would indicate that the worker should attend to self-care activities such as stress management, seeking peer support, and discussion of their STS with a clinical supervisor. At the organizational level, child welfare agencies can institute a periodic screening protocol for their workforce with the goal of monitoring aggregate levels of STS. Identification of high or increasing levels of STS would suggest an appropriate organizational intervention, such as provision of training and supervision on working with traumatized children.

> [M]onitoring and attending to STS is an ethical imperative shared by individual workers and the organization.

Discussion

STS is an occupational hazard of child welfare work; most workers will at times experience symptoms of STS as these are normal reactions to trauma work. However, for some the experience of STS may interfere with their personal mental health. For this reason alone, ongoing monitoring of STS levels is indicated. However, in addition to the negative impact on worker well-being, the effects of STS may impair the ability of child welfare workers to effectively help those requiring their services (Figley, 1995a). Child welfare workers experiencing STS are believed to be at higher risk to make poor professional judgments such as misdiagnosis, poor treatment planning, or abuse of clients than those not experiencing STS (Rudolph, Stamm, & Stamm, 1997). Further, STS is associated with turnover, high rates of which negatively impact the quality of services.

In summary, the STSS and ProQOL are useful, brief screening measures for secondary traumatic stress that can be easily incorporated into a regular program of individual and organizational monitoring. While the STSS is shorter and easier to score and interpret, the ProQOL allows an assessment of burnout and compassion satisfaction in addition to STS. Regardless of the instrument that is used, it is important to underline that both the STSS and ProQOL are screening rather than diagnostic tools.

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A Psychoeducation Model for Teaching Child Welfare Practitioners to Dump Their Secondary Traumatic Stress Buckets

Josephine Pryce, PhD, MSW

Secondary traumatic stress (STS) has been identified as a phenomenon that can negatively impact helping professionals, especially those working with children, but that can be managed by affected individuals. STS is not preventable because connecting empathically with clients is critical to effective trauma interventions. Consequently, administrators have an ethical responsibility to see that the system's providers are knowledgeable about STS and are using professional and personal coping strategies.

In the appendix of *Secondary Traumatic Stress and the Child Welfare Professional* (Pryce, Shackelford & Pryce, 2007) there is a chapter dedicated to a comparison of compassion fatigue data collected in five states. The results of the analysis demonstrate that participants had low levels of burnout and high levels of STS. The item analysis demonstrates that 50 percent or more of the participants reported having STS symptoms and that many symptoms were shared by the participants. There was a high degree of consistency in the pattern.

The STS and Child Welfare Professional Workshop was developed as a psychoeducational model. The goal is to increase knowledge about STS and differentiate it from burnout. STS comes from the empathic relationship with client(s); in contrast, burnout comes from the organizational climate and culture and is controlled by the administrators of the agency (for more, see Shackelford article in this issue). The workshop employs psychoeducation theory for the foundation. Christopher Griffiths (2006) notes that psychoeducation interventions for mental health address "therapeutic, cognitive and sociability benefits through education, goal setting, skill teaching, challenging thinking patterns, and social interaction." Psychoeducation focuses on increasing knowledge and improving supportive behaviors among participants. This method of education requires a high degree of interaction among participants to increase the power of learning.

The STS workshop has limited lecture content and many application exercises where participants work in groups to apply the lecture content to questions and trauma scenarios involving real cases with the identity of clients changed. The "Train the Trainer" manual format makes the workshop easy to deliver in a six-hour day with short and lunch breaks. We recommend having two trainers, one male and the other female. Because of the limited number of male workers in child welfare, a male trainer may support the men in expressing differences in the way they experience STS from the typical majority of women providers. Also, in the event a participant decompensates due to a present or past traumatic experience, he or she can receive individual attention without stopping the workshop.

The STS workshop manual has three components or sessions. The goal in the first session is to increase knowledge about STS, differentiate it from burnout, and identify the psychological and interpersonal impacts. The next session identifies professional and individual coping skills. The last session explores professional and individual social support. All of the sessions have application exercises where participants are given opportunities to work collectively on an application and then share what they concluded in their group. Participants report that they enjoy the high degree of interaction and that it enhances learning. One metaphor we use is to inform workers that they are like a bucket that can get filled up with traumatic stress and that what we are learning to do in this workshop is to become effective in "dumping the bucket."

Follow up booster sessions are recommended in the months following the original training. Booster sessions have been shown to support people maintaining behavior changes (Whisman, 1990). The positive effects of booster sessions have been documented in a variety of studies on a wide range of problems. Booster sessions also demonstrate that the agencies' leadership acknowledges that STS is a concern for direct service workers. A booster session can take place within a unit of workers or in large groups. It can also be a component of supervision. Each agency can evaluate what frequency and duration of booster sessions works best for their workers as that is yet unknown.

It is strongly advised that trainers become familiar with the STS literature and in particular the book *Secondary Traumatic Stress and the Child Welfare Professional* (Pryce et al., 2007). This book has in-depth content that supports the use of the manual. The workshop's creation had ongoing input from seasoned child welfare practitioners.

The STS Psychoeducation Model helps practitioners to understand and have words to describe phenomena they are experiencing. It also prepares providers to engage in anticipatory coping knowing that STS is part of the work.

The book describes the challenges we found while providing the workshop and how we learned to cope with them. The manual has information that can be included on PowerPoint slides. The book also contains individual workbooks.

The STS Psychoeducation Model helps practitioners to understand and have words to describe phenomena they are experiencing. It helps them learn to identify when they or a colleague are impacted by STS and know what to do about it. It also prepares providers to engage in anticipatory coping knowing that STS is part of the work. STS is manageable, whereas burnout is not without a major change in organizational culture. It is a moral imperative to provide this information to practitioners who do this important work.

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What Can Child Welfare Workers Do about Vicarious Trauma?

Laurie Anne Pearlman, PhD

People who do child welfare work are heroic individuals who do some of the hardest and most important work in our society. Every day, they risk connection, and often their well-being, to promote the welfare of others while receiving very little recognition of the value or hazards of their profession. I would like to use this space to share what I've learned about the effects of trauma work and ways of addressing a specific set of negative effects identified as vicarious traumatization (VT; McCann & Pearlman, 1990a; Pearlman & Saakvitne, 1995a; Pearlman & Saakvitne, in press; Saakvitne, Gamble, Pearlman, & Lev, 2000).

Vicarious trauma is the cost of caring for and caring about traumatized people. It is a transformation in the self of the helper that comes about as a result of engaging empathically with traumatized people and feeling responsible to help. Its hallmark is disrupted spirituality, or meaning and hope. When we enter into the experience of our clients with open minds and open hearts, when we are committed to helping them, we are vulnerable to VT.

While the terms vicarious trauma, secondary trauma, compassion fatigue, and even burnout have been used interchangeably, there are meaningful differences. VT is based in constructivist self development theory (McCann & Pearlman, 1990b; Pearlman, 2001). This trauma theory base allows us to understand the parallels between direct and indirect (or vicarious) trauma and guides us to areas of the self that both affect. It also points to links among each individuals' contributing factors, signs and symptoms, and needs for recovery.

The research on vicarious trauma has examined many possible contributing factors. The one that is most robust, appearing across studies, is exposure. Researchers have operationalized exposure to trauma material in many ways, usually as the number of hours per week spent with traumatized clients or the percentage of one's caseload that trauma survivors constitute. But there are other ways to think about exposure (Pearlman & Saakvitne, in press). How do we experience what our clients say to us? How do we interact with them? What are we thinking about when they report their experiences—are we imagining what it would be like if these bad things happened to us or are we thinking about what it was like for them (Batson, Fultz, & Schoenrade, 1987)? Are we visualizing the bad things that happened to them or not? Are we intensifying the experience in our minds (as a sensitizer might) or are we dampening it (as a repressor might)? Are we mimicking their body postures, their affect, their facial expressions, their gestures (Rothschild, 2006)? Are we telling ourselves that this child's life is unbearable or thinking about the amazing resources she has used to survive? Preventing or minimizing VT requires that we attend to trauma exposure. Managing caseload size is valuable but often not within the worker's control. But workers can choose how they engage, and what they imagine and tell themselves as they engage.

I want to mention two additional important potential contributors to VT. First, trauma re-enactments are inevitable in trauma helping relationships and in agencies that support survivors. When these are outside the worker's awareness, the potential for VT and for burnout is increased. Second, in my opinion, the loss of control is the central dynamic of trauma. What makes an experience traumatic? The victim's experience of loss of control. In parallel, it is likely that trauma workers' experience of lack of choice and control might contribute to VT.

Working from a trauma theory foundation is a potential protective factor against VT. The Risking Connection trauma training curriculum (RC; Saakvitne et al., 2000) provides a theoretical foundation for a trauma-informed approach to working with survivors. In outlining ways abuse and neglect affect survivors (one of its five modules), it enhances workers' understanding of common trauma adaptations. This allows workers to be and to feel more effective, less victimized by the work. RC devotes another module to ways of managing crises within a relational trauma framework, focusing on the humanity of both clients and workers and the need all parties have for control. One of RC's unique contributions is its emphasis on vicarious trauma, another entire module. The curriculum provides information about VT as well as worksheets for workers' use in understanding, coping with, and transforming their VT.

> [Vicarious trauma] is a transformation in the self of the helper that comes about as a result of engaging empathically with traumatized people and feeling responsible to help.

As of 2012, RC has been adopted as a mandated training program by more than 30 agencies in the United States and Canada, and there are over 200 credentialed RC trainers at these agencies. A recent empirical study found that RC training significantly increased trainees' knowledge, beliefs favorable to trauma-informed care, and self-reported staff behaviors indicative of trauma-informed care (Brown, Baker, & Wilcox, 2011).

Each of us has the potential to minimize and address our own VT. We owe this to our clients, our families, and ourselves.

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Social Support in the Workplace and Secondary Trauma

Anita P. Barbee, MSSW, PhD

Social support has long been known to buffer people from stress (Cohen & Wills, 1985). Our own research and that of colleagues has emphasized that different types of support may work in different types of situations (Cunningham & Barbee, 2000; Cutrona & Russell, 1987). In one prospective retention study in child welfare, we found that supervisor support, especially in the form of attachment (emotional closeness and sense of security) and guidance (advice and information) affected retention overall. For those in rural settings, attachment, guidance, reliable alliance (assurance that one can be relied upon for emotional support), competent supervision and having a positive relationship with the supervisor was higher among rural workers who were retained longer (Yankeelov, Barbee, Sullivan, & Antle, 2009). A study of Kentucky's Public Child Welfare Certification Program (PCWCP) did replicate the findings of this study in that all of these types of supervisor support were correlated with intentions to stay (Barbee et al., 2009).

The fact that attachment was key in all three results is reminiscent of work by Mikulincer and colleagues. He has conducted research on the effects of supervisor attachment style on employees in high stress jobs (such as firefighters and Israeli soldiers). His work shows that a supervisor who serves as a secure base buffers his or her employees from the trauma of the work in which they are engaged (e.g., Davidovitz, Mikulincer, Shaver, Izsak, & Popper, 2007). Thus, our attachment measure picked up on the degree of security felt by workers who stayed. The implication was that the supervisor buffered the new worker from the stresses of the job to such an extent that the worker stayed longer in the job. These employees also received more guidance in the form of advice and information from their supervisors and felt as if they could rely on them for tangible support when it was needed. These forms of support meant that the supervisor was helping his or her employees approach the problems they encountered on the job with a clear sense of direction, information and tangible aid, when necessary.

In both studies we also examined the effects of coworker support on retention. In the Yankeelov study, we did not find that it was differential in stayers versus leavers, and in the Barbee study we actually found a negative relationship between coworker support and job satisfaction. Furthermore, we just completed a study on culture and climate in an urban child welfare office and found that the rate of workers and supervisors experiencing clinical levels of PTSD (as measured by the Bride Secondary Trauma Scale and analyzed based on his 2007 paper in Social Work) was three times larger than other social worker samples. Interestingly, more supervisory support was associated with less trauma, but more coworker support was associated with more trauma. What we could not tell was if those with trauma seek more support from peers or if something else was going on in peer relationships in child welfare. Our previous research on support may provide a clue.

Our studies showed that mood affects the type of support that is given in close relationships. When those in a negative mood are approached for support, they are more likely to give negative forms of "support" which we entitled 'dismiss and escape' (Barbee & Cunningham, 1995; Barbee, Derlega, & Crimshaw, 1998; Yankeelov, Barbee, Cunningham, & Druen, 1995). If many people in the workplace are experiencing high levels of stress and secondary trauma, they will have high levels of anxious and depressed emotions and will not likely be very good givers of social support, which may be why trauma is exacerbated rather than relieved by peers.

Our Sensitive Interactive Systems Theory of interactive coping outlines the delicate interplay between seekers and givers of support and how a multitude of variables can derail positive transmissions of support from one person to another, particularly in close relationships at home and at work (e.g., Derlega, Winstead, Oldfield, & Barbee, 2003). For example, one form of ineffective, indirect support-seeking is complaining. While supervisors may be in a role to help workers redirect their distress into productive problem solving, coworkers, who are also stressed themselves, may avoid the complainer (escape) rather than give them the needed solace or problem solving that will alleviate the distress. Or, they may join in the complaining and send both into greater levels of negativity than when the conversation began. Over time the cumulative effect of these types of negative transactions undermines the very relationships that are necessary to cope with tremendous stress.

However, the converse can also be true. When supervisors create a sense of teamwork in their units, coworkers feel better and can attend to one another's needs by helping their colleagues complete tasks, coaching newer workers on how best to approach a particular type of client, and assuring someone in distress that this too shall pass.

When supervisors create a sense of teamwork in their units, coworkers feel better and can attend to one another's needs.

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Going Beyond Self Care: Effectively Addressing Secondary Traumatic Stress Among Child Protective Staff

Erika Tullberg, MPA, MPH, Roni Avinadav, PhD and Claude M. Chemtob, PhD

Secondary traumatic stress (STS) is a large concern for the child welfare field. Unaddressed STS can lead child welfare staff to feel helpless, avoidant and isolated from their colleagues and supervisors; have reduced perspective and critical thinking skills; adopt a negative world view; and have difficulty recognizing and monitoring their emotions.

As STS causes people to isolate themselves and breaks down communication and collaboration, the intervention uses the work unit and larger work area as the context for learning and applying new workplace skills and practices.

Being in a constant state of "survival mode" can also make it difficult for child welfare staff to recognize true emergencies and prioritize their work accordingly, which can impact the quality of their work and the safety of their clients. If several people in a work unit are highly short-tempered, argumentative and pessimistic, it is bound to negatively affect the people around them leading the entire work area or organization to function like a traumatized person. This is particularly the case at times of heightened stress and public scrutiny where the focus – both within the agency and from outside stakeholders and the public at large – is overwhelmingly on the negative, and decisions may be made in a pressured and reactive way.

The New York City Administration for Children's Services and the New York University Langone Medical Center established the ACS-NYU Children's Trauma Institute to use trauma-related knowledge to improve child welfare practice and help the child welfare system meet its goals on both the individual client and system levels. One of the Institute's first projects, the Resilience Alliance, focuses on addressing secondary traumatic stress experienced by staff responsible for investigating allegations of child abuse and neglect and making decisions regarding child removal.

Between 2007 and 2012, we have conducted the Resilience Alliance intervention with four groups of staff: an initial pilot with newly hired child protective specialists and their supervisors, and subsequent rounds with both new and veteran child protective staff at all levels of the organizational structure (child protective specialists, supervisors, managers and deputy directors) in three areas of Manhattan and one area of Brooklyn. Our hope is to eventually extend the Resilience Alliance to all child protective staff in New York City and to other child welfare agencies and systems around the country.

The Resilience Alliance is focused on three core concepts – optimism, mastery and collaboration – and uses a combination of didactic and interactive components to first teach and then help staff to apply resilience-related skills. We believe having staff learn such skills is a necessary part of developing a trauma-informed child welfare system as staff who are struggling with the impact of STS on themselves will have more difficulty in recognizing and/or addressing trauma experienced by their clients.

The intervention is 24 weeks long and follows a 4-week cycle that allows participants to have both same-peer sessions and work unit-based sessions. This variety provides participants with a safe space to discuss challenges and concerns with their peers while maintaining a focus on the team. This focus is very intentional; as STS causes people to isolate themselves and breaks down communication and collaboration, the intervention uses the work unit and larger work area as the context for learning and applying new workplace skills and practices. This is one of the things that differentiates the Resilience Alliance from a "self-care only" approach to STS. Since the workplace is a source of much of the stress and secondary trauma that staff experience, the intervention seeks to support staff both through improving their own coping skills and improving the overall functioning and culture of the workplace.

We have collected data to measure the intervention's impact on participating staff compared with child protective staff from other work areas who only received a two-part training on STS. Our intervention had the greatest impact with newly hired staff, perhaps because they had fewer negative coping skills to "undo," but even with groups of veteran staff we were successful in significantly increasing self-reported resilience and perceived coworker and supervisor support and decreasing negative emotions and perceptions of themselves and their work. In our last round, over 80 percent of participating staff said that they would recommend the intervention to colleagues in other areas of the agency.

We recently posted the Resilience Alliance training manual on the National Child Traumatic Stress Network website and encourage child welfare agencies to use the materials to address secondary traumatic stress among their staff. (For more specific information about how to access this document, please see the resource list at the end of this publication.) We are also bringing our intervention to the NCTSN's Trauma-Informed Child Welfare Practice Breakthrough Series Collaborative. As part of this Collaborative, nine teams from around the country are working to improve foster care placement stability through the adoption of trauma-informed policies and practices. We are heartened that all teams have identified STS as a critical aspect of trauma-informed system change and an important issue for their jurisdiction, and we look forward to working with them to identify aspects of the Resilience Alliance intervention that can be adapted to meet the needs of their staff and agency.

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The Secondary Trauma Prevention Project: A Multilevel Systems Approach to Protect Child Welfare Staff from Secondary Trauma

David Conrad, LCSW

Child welfare workers are at significant risk for secondary trauma for a number of different reasons, including empathy, exposure to reminders of their own trauma, insufficient recovery time from trauma exposure, working with vulnerable children, and relentless criticism by the public and press.

In a study we conducted with 367 Colorado child welfare workers we found that 49.9% suffered from "extremely high risk" or "high risk" of compassion fatigue or secondary trauma (Conrad & Kellar-Guenther, 2006). In a similar study, conducted by Meyers and Cornille (2002), they reported clinical levels of emotional distress by up to 37% of their respondents.

In 2008-2009, the Child Welfare League of America reached out to 32 states to determine if and how they were assisting their staff with their secondary trauma. Most states reported that they were offering only debriefings after major crisis events or assistance through Employee Assistance Programs. Some states reported providing one-time trainings on secondary trauma. Only a few states reported providing "a multileveled approach including numerous supervisory and worker trainings, ongoing support groups, individual supports and debriefings."

Secondary Trauma Prevention Project

In 1996, following a dramatic surge in child fatalities in Texas, I created the Secondary Trauma Prevention Project. At the time, I was Director of Programs for the CIVITAS Child Trauma Program. CIVITAS was founded by trauma expert Dr. Bruce Perry. Initially my work was limited to providing group stress debriefings for child welfare staff involved in child fatalities or other serious events. However, I soon concluded that secondary trauma was inevitable for all child welfare workers and began offering trauma prevention training as well.

In 2000, my family and I relocated to Colorado where I assumed my current position as a secondary trauma consultant for the Colorado Division of Child Welfare. During the last 12 years, in response to the needs expressed by caseworkers and based on the recommendations of the best available literature, I have expanded the services I offer. Below is a description of the program I created in Colorado.

Colorado: Secondary Trauma Prevention Project

The purpose of the Secondary Trauma Prevention Project in Colorado is to provide emotional support and psycho-educational training for Colorado child protection workers and supervisors impacted by both acute and long-term trauma. There are three goals of the Project —

1. Provide acute care and preventative training to child protection workers traumatized by their work with abused and neglected children and their families.
2. Offer child protection staff information and strategies so they can better understand and combat the negative effects of secondary trauma.
3. Provide a forum where staff feel safe and comfortable discussing their emotional reactions to the trauma they encounter in their jobs.

In order to fulfill these goals, the Project offers both training and consultation services to child welfare staff. Stress debriefings are available for groups of 2-10 caseworkers acutely traumatized by the death or serious injury of a child on their caseload or by another traumatizing event. Additionally, individual consultation is available for staff wishing to meet privately about trauma-related issues encountered or triggered by events at work.

Trauma and stress reduction sessions are two hours in length and are offered to teams of child protection professionals on a bi-monthly basis. There are two primary objectives with these sessions. The first is to give staff an opportunity to "process" the trauma they are exposed to on the job in a safe and supportive environment. The second objective is to provide participants with tools and insight so they can better protect themselves from the trauma and stress of their work. The facilitator uses a variety of training methods to accomplish this, including surveys, questionnaires, and films.

Training services provided include both introductory and advanced seminars on secondary trauma. The Introductory Secondary Trauma Training Seminar is available to all new child protection caseworkers in Colorado. This seminar is a supportive, psycho-educational training that utilizes didactic, experiential and therapeutic interventions to explore the impact of secondary trauma on staff. Strategies for protecting one's self are also provided. Advanced secondary trauma training is available for supervisors. In this one and a half day training, supervisors learn about the dynamics of secondary trauma and are provided with skills and strategies to better protect their workers. Video vignettes of real workers talking about secondary trauma provide fodder for skill development as well as add a poignant reality to this training.

Child welfare workers do this work because they care deeply about children and families. They recognize that there is nothing more important than keeping children safe. However, their passion for their work and compassion for their clients increases their risk for secondary trauma. We must therefore put protective strategies in place to protect them.

The purpose of the Secondary Trauma Prevention Project in Colorado is to provide emotional support and psycho-educational training for Colorado child protection workers and supervisors impacted by both acute and long-term trauma.

David Conrad, LCSW is Coordinator of the Secondary Trauma Prevention Project and Senior Clinical Instructor with Distinction in the Department of Pediatrics at the University of Colorado School of Medicine. He can be reached at David.Conrad@childrenscolorado.org or www.secondarytrauma.org. He would like to dedicate this article to his Grandmother, Helen Currie Conrad, who graduated from the University of Minnesota in 1910.

Developing, Continuously Improving, and Disseminating Culturally-Appropriate Workplace Policies to Prevent and Mitigate Secondary Traumatic Stress among Child Welfare Workers

James C. Caringi, PhD and Hal A. Lawson, PhD

Secondary traumatic stress (STS) is, for child welfare, a new phenomenon. Fortunately, researchers and STS specialists are developing specialized interventions (Bride, 2007; Pearlman & Caringi, 2009; Pryce, Shackelford, & Pryce, 2007).

Most interventions are person-centered. As they are developed, another need is apparent: Child welfare organizations need to become more *trauma-ready*, *responsive*, and *effective*. This requires STS-related organizational policies. Because these policies are new, they need to be designed. Once designed, they need to be implemented, continuously improved via evaluations, and then disseminated to benefit the field. The ensuing analysis is framed to advance this agenda.

Organizational Culture, Climate, and Structure as Priorities

The design of new STS policies begins with two related constructs: Organizational *culture* and organizational *climate*. Organizational culture encompasses norms, values, and operational routines, especially historical artifacts, meaning systems, and traditions. Because culture is an historical construct, it often outlives individuals who come and go, and it is difficult to change.

Culture influences climate, and, reciprocally, climate has the potential to influence culture. Even so, climate is unique. Like the weather, climate can change quickly. It is a here-and-now construct used to describe how child welfare professionals feel about their organization (Glisson & Hemmelgarn, 1998). It is a target for new STS policies because studies link organizational climate to workforce STS (Bride, 2007; Caringi, 2008; Caringi & Hardiman, in press).

Organizational structure impacts both climate and culture and also STS-related interventions and policies. For example, Catherall (1995) found that the "hierarchical nature of the organization, impersonal nature of the bureaucracy, the mission statement of the institution, and group dynamics" were related to workers' STS levels (p. 242). Also, front line professionals and supervisors are subjected to "people-processing technologies" (such as "cookie cutter" supervision mechanisms, scripted and inflexible practice protocols, and rigid personnel evaluation systems) rather than "people-changing technologies", which may ignore and devalue workers' cultural identities and needs (Lipsky, 1980).

Imperatives and Improvement Strategies for Culturally-Appropriate STS Policies

The literature on the intersection of cultural diversity and policies addressing STS offers mostly silence. STS policies must be developed with an eye toward making the *cultural diversity of the workforce* a priority and an asset. More concretely, the design of new STS policies begins with due recognition that the workforce's cultural diversity must be taken into account in all organizational policies; that STS-specific policies must be culturally appropriate; and that workforce cultural diversity and uniqueness stand as important resources for STS policy development and organizational redesign.

The main STS question mirrors a sister question for practice with children and families: *Which workplace and workforce interventions are generic and generalizable, and which ones must be specific, tailored, and adaptable to the point where they are truly culturally appropriate?* Part of the work that lies ahead is getting the conditions right for addressing this question and providing alternative frameworks and new interventions.

For example, an organization that is open to cultural exchange and practice in the workplace may offer a means for workers to use culturally relevant activities in order to prevent and mitigate STS in the workplace. Top-level leaders and managers can develop new policies that reflect and promote cultural diversity in the workforce as a resource to be protected and utilized instead of a problem needing to be managed in service of "one size fits all" personnel and leadership systems.

Closer to the front line, supervision is top priority for new STS policies and practices. Culturally appropriate, STS-sensitive, responsive and effective supervision protocols and strategies are part of the new frontiers for organizational redesign—and with benefits accruing to the organization overall.

> [T]he design of new STS policies begins with due recognition that the workforce's cultural diversity must be taken into account in all organizational policies.

Supervision offers a realm for supervisors to promote workers' use of cultural practices to prevent and mitigate STS. Recent research indicates the context-specific challenges of readying supervisors for the work needing to be done (Claiborne & Lawson, 2011).

Two other STS priorities involve child welfare teams, and both entail new organizational policies. One involves team practice models in which STS prevention and intervention are embedded in everyday practice with children and families. The other involves organizational redesign teams

Practice

(Caringi et al., 2007) in which the cultural diversity of the workforce is instrumental in the development of new organizational policies that reshape organizational climate and culture. Both kinds of teams mark a major transformation in how child welfare organizations are structured and operate, and also how workers at all levels of the system are treated and feel about their organization.

Finally, work with Tribal Child Welfare emphasizes the needs for cultural consultants and community guides. Indigenous leaders, independently and as members of teams, play special roles in the development of STS-conducive policies for three related domains: (1) Intra-organizational structures and dynamics; (2) Inter-organizational dynamics (e.g., with mental health, juvenile justice) and (3) Community dynamics involving families and tribal councils. This expansive agenda is a reminder that STS-ready child welfare organizations depend on others' contributions with the added benefit of cultural competence attributable to their leadership. Culturally appropriate workplace polices offer promise as an intervention to prevent and mitigate the impact of STS.

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Social Work in a Rural Community

Julie Krings, MSW, CSW

I have been a child welfare social worker in a rural community for over fifteen years. A few years ago, I noticed some signs of secondary trauma in myself. Every year around Christmas, I enjoy driving around with my husband and admiring people's Christmas lights. One particular year, as we were looking at the lights, I found myself wondering if anyone in that house had been sexually abused. Then, as we drove by the next house and the house after that, I asked myself the same question, had anyone in that house been sexually abused? I even made a comment to my husband about whether or not sexual abuse occurred within a home. With the look he gave me, I immediately knew something was definitely going on with me.

Being a child welfare worker in a rural community means my risk of developing secondary traumatic stress is higher due to the challenging aspects of the work. Some unique characteristics of rural child welfare practice that contribute to this risk include the lack of resources for clients, workers' visibility within the community, and dual roles of the worker.

Lack of Resources

Many of my clients need resources that are limited in the community where I work, such as public transportation, day care providers, mental health professionals, and alcohol and drug treatment services. As a rural social worker, I often need to take a generalist approach to practice and become the "jack of all trades," compared to urban social workers who tend to specialize. This puts added pressure on me to have to "know about everything" and, in some cases, be the sole service provider to families.

It breaks my heart when I am working with a family and they are in absolute dire need of services that just aren't there. I've had numerous clients over the years go with many unmet needs, especially regarding their mental health. Of course, this has caused me great worries and many sleepless nights. The lack of resources has caused me to be quite creative in my social work practice, but creativity can only go so far. The worrying, concern, and care has certainly contributed to my risk of secondary trauma.

Worker Visibility

When you work and live within a small community, there is a high probability that you will encounter clients while out in the community. Several years ago, I would often go for walks and would frequently meet a particular client. This client was a ten-year-old boy who experienced significant trauma in his life. While I was out walking, he would often follow me around on his bike. He meant no harm, and I had conversations with him about boundaries, but he continued to follow me around. I even changed my walking times and where I walked. But, living in a small town, he was still able to find me! Walking was a way for me to get away from work and reduce stress but because I kept encountering a client, I stopped going for walks. This was really disappointing, but it was less stressful to use a treadmill in the privacy of my own home.

I also frequently encounter clients while out grocery shopping, at the medical clinic, and gas station. I never know when or where I will encounter a client in the community; I just know it will happen frequently. Because of these encounters, I feel the need to keep my guard up. This reduces the degree of separation between my professional and personal life and creates additional stress as it is hard to get away from work and to stop thinking about it.

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Dual Roles

It is almost a given that if you practice child welfare in a rural setting, you will engage in a dual role. For example, I needed to interview a father for a child protection referral, and he happened to be our family mechanic for years. Another example of a dual role is that my daughter attended the same day care as one of the children that I worked with. My daughter would come home and talk about playing with my client. This client was a victim of sexual abuse, and the first thing I thought of was that I didn't want my daughter to be victimized in any way. Due to the nature of my job, I am aware of many of the details of my neighbors' lives and of other members of my community. This has caused me to be hyper vigilant about my family's safety and to be overly cautious about my interactions in the community.

In conclusion, rural social work certainly brings many rewards but also many challenges. It is important for me to continue to have an awareness of STS and find ways to mitigate secondary trauma in my life. I try to find a good balance between my personal and professional life and to incorporate self-care activities, such as walking, into my daily routine.

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A Supervisor's Perspective on the Importance of Addressing Secondary Traumatic Stress in Child Welfare

Julie Collins, LCSW

Former and current child welfare supervisors with whom I have spoken have at least one case that still haunts them, as with myself, even though 20 years have passed. Back when I was a supervisor, no one was talking about using a trauma lens in their work with children who had been abused and neglected, and definitely no one was talking about or even recognized that secondary traumatic stress (STS) existed for the child welfare workforce. I thought I was a good supervisor even during the year of the tragic case of the child who was murdered by his uncle who was babysitting. This case was not even in our unit, but the child was a sibling of a family with whom we worked. The more I am exposed to the research on trauma, the brain and STS, I realize that I could have done much more for the workers as well as the children and families. I wish I had known then what I know now.

The unit I supervised covered a community considered high risk not just for the children and families but often for the workers. Most of the prior unit staff, including supervisors, ended up on long-term sick leave. During the period I was supervisor, the workers remained the same, and it was a rarity for anyone to take sick time. The period leading up to the child's death was very stressful due to some very difficult cases, workers being threatened and not enough people to take on the increasing number of cases. I had begun having nightmares about a child being severely abused that kept me up at nights. I had a drawer full of cases I could not assign for follow-up as all the workers were at more than full load and very stressed. My manager heard my cry for help, and other units were asked to help with the back log. The last case was assigned on a Thursday, and I thought the nightmares would stop. But this was not to be. That night a child was severely abused and murdered and found in a dumpster the next morning. Until the murder was solved, the situation proved to be very stressful as there was concern for the siblings that were assigned to our unit.

I thought I knew, on one level, the toll the stress of the case was taking on me, the workers in the unit, and the other workers and supervisors across the agency, but in retrospect I really did not. The agency responded to the crisis and put a support infrastructure in place. But I believe we missed a very critical aspect: the cumulative impact of the STS not just from this one case but rather resulting from the constant exposure to the children and families and their stories of various traumas, past and current, and its impact across the whole organization.

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When I first became aware of the research on trauma, and more specifically STS, the brain, and the work of the National Child Traumatic Stress Network (NCTSN), I was very excited. I thought, here was some hope for the system that everyone claimed was so broken. Here was some hope for those who soldiered on in a system that itself had become traumatized. Tragic events such as 9/11, hurricanes, floods and earthquakes have significantly highlighted the immediate and long-term impact the traumatic stress of these events has on those who directly experience them, those who witness them and those who are the first responders. Emerging research has further highlighted the risk of working in an environment with people who are experiencing STS. Given that it can lead to everyone working in the same environment experiencing STS themselves, even when they are not the ones directly dealing with the victims and families, this should give us much pause to consider what is happening in our own agencies.

While the nightmares subsided long ago, to this day the mere mention of that case brings tears to my eyes and a lump in my throat, and I struggle to find the words to speak, caught in the swell of emotion and the continued feeling that somehow I failed a child for whom I was not even responsible. I now suspect that the real reason the prior unit staff ended up on long-term sick leave was related to the impact of STS. The death of the child has been a driving force for the work I do: working with the NCTSN to develop new tools, training, and materials to help child welfare systems to become more trauma-informed; and encouraging child welfare systems to recognize the need for and put in place the appropriate agency wide infrastructure to address STS and to provide their child welfare staff with the protective gear needed to effectively do their work and thrive.

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The Trauma of Working with Victims of Torture

Patricia Shannon, PhD, LP

Secondary trauma refers to the adverse impact of working with trauma survivors on the social worker who cares for them. It is the deliberate listening and caring, the empathic connection between you and the individuals, children and families whom you hope to help that ultimately becomes too much to bear at times. This empathic connection is how you come to know what trauma feels like to others, how it can be overwhelming and what it feels like to be helpless, hopeless, and consumed by sadness and rage. This is also how you can succumb to feeling overwhelmed by the pain of others, so overwhelmed that you may become unavailable to your clients, remote to your family and friends, and disconnected from yourself.

I know these feelings as I faced them all and more during my ten years caring for torture survivors and their families at the Center for Victims of Torture in Minneapolis. I will never forget one of my first clients who watched her child die during a war. Helpless to protect or save her child, she was forced to witness his murder. I listened with great attunement to her feelings of helplessness, rage and despair. I listened to her story to help her face the painful reality of her loss and begin to heal. And as I listened, I thought of my own child and how frightened I would feel if I could not protect my child. I thought about what it must have been like to hear your child scream and be unable to help. I felt both guilty and relieved to have my child at home safe and to have escaped the horror of war. I imagined that the torture and loss of a helpless child would be more than I could bear and I wondered how to offer hope to this mother, hope that I didn't know I could find if I faced a similar loss. Yet, it was my job to help her face her life and find a future. How could I do that when even I did not want to face her loss? The terror and the details of these sessions stuck with me long after they ended. I couldn't relate to ordinary complaints of my child when I would finally return home from work. I couldn't concentrate on conversations with family and friends, nor did I really care about the plans we were making for upcoming vacations. At night, when I put my child to bed, sitting quietly in the dark, I thought of this mother who would never put her child to bed again. And then, in the darkness, I cried. I cried for her and for the mothers I listened to who were separated from their children.

As child welfare workers, you may have child clients on your caseload whose parents are refugees with similar experiences and who are now being charged with child maltreatment. More than likely you have non-refugee clients on your caseload whose stories are equally as painful as the one I've told. So often we try to be strong for our clients. We don't share our feelings as we try to attend to them and our professional role. But we are touched by their stories nonetheless and we are human. If we don't take our humanity seriously and take care of our own feelings as carefully as we do those of our clients, we may suffer the same painful symptoms and be unable to be present for our clients or the profession we chose.

The effects of secondary trauma are cumulative and insidious. We are often affected without knowing it. Others may notice that we avoid our paperwork, have lost our sense of humor, snap at others more easily, miss appointments, or tend to space out during meetings. But we may not be aware of any of these problems. People who are struggling with too much trauma tend to isolate themselves from others rather than ask for help. They might work longer hours in an attempt to catch up or avoid dealing with difficult clients. Coworkers who are overwhelmed together can fail to support each other or become cynical about their cases and the world in general. Child welfare workers who are dangerously affected by secondary trauma can stop caring for clients and may make faulty judgments that lead to serious consequences for families under their care.

Learning to address secondary trauma reactions effectively starts with the awareness that they are an inevitable part of any social work practice in life-threatening situations such as child welfare. Child welfare workers need to understand that their repeated exposure to traumatic life events predisposes them to adverse secondary trauma reactions.

So often we try to be strong for our clients. We don't share our feelings as we try to attend to them and our professional role. But we are touched by their stories nonetheless and we are human.

If you don't know why you can't put that story or client behind you, you need to seek professional help. Knowing about secondary trauma and how traumatic stories affect you, as well as which stories are most difficult for you and why, is an important first step toward coping with trauma.

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Utilizing Traditional Anishinaabe Cultural Practices to Reduce Secondary Traumatic Stress in the Workplace

Ryan L. Champagne, Social Service Director for a Tribal Agency

In the field of child welfare it is no surprise that the average length of employment is approximately one year. There has been a plethora of studies to diagnose, assess, and cast blame onto this phenomenon that is affecting our children and families. The crucial roles that social workers play in our communities have a generational affect upon the community in which they serve. Minnesota has experienced an epidemic for the last thirty years concerning the disproportional rates of American Indian children involved in the child welfare system. This generational trauma that has been perpetrated against American Indian communities by the child welfare system has caused long term social dysfunction. For example, in Minnesota, American Indian children were as high as six and four times more likely to be subjects of child protection assessments and investigations, were placed in out-of-home care in 2008 at a rate more than twice that of any other group, and were 12 times more likely than a White child to spend time in placement (Minnesota Department of Human Services, 2010).

State, tribal, and non-governmental social service agencies alike have struggled with social worker turnover. While there have been studies that show effective methods for reducing turnover, few studies have truly looked upon the intricate relationship of secondary traumatic stress and turnover ratio for workers serving Indian Country. Establishing policies to combat the tangible aspects of worker turnover and secondary traumatic stress (STS) will assist an agency with retention, but it will not effectively accomplish the goal. Some policies that I have implemented in various child welfare agencies to aide in the reduction of turnover and STS have been to cap the limit of families on a worker's caseload to 12; incentivize weekly face-to-face contact with children and families; offer extensive in-house monthly trainings; provide mentoring/grooming to workers who are interested in management; plan employee retreats, appreciation events, and positive recognition programs; provide an intensive 8-week training and orientation to all new social workers; allow flexible scheduling; give paid education leave and tuition reimbursement; and actively partner with local universities to recruit BSW and MSW students. While I have found that worker morale rose, there was still the 'burnout' factor that was not being taken into account.

In Indian Country, past traumatizing events perpetrated on our ancestors, grandparents, parents, uncles, aunts, and the community as a whole are affecting generations that have not experienced this trauma first hand but through the vibrant detailed oral accounts of our relatives. This in turn has caused generations to feel anger, fear, paranoia, and depression, and that their families and communities are 'falling apart.' When working with tribal communities, workers often experience symptoms of burnout and/or STS; the difference is that when these symptoms affect Native communities it is known as historical trauma.

The understanding that historical trauma and STS are interrelated in child welfare work with Native families is the core to developing possible solutions. In order to work effectively in Native communities, it is essential that social workers are well prepared both academically and socially. Social workers should not have just the basic knowledge of the community they serve but should be socially and spiritually connected to that community. Many Native communities have a distrust of governmental systems, outsiders, and social workers due to the historical trauma experienced by that community. This barrier needs to be overcome in order to ensure that social workers properly engage with their client families.

Some practices have been established in tribal agencies that address historical trauma among tribal families and secondary traumatic stress among workers. Mandating social workers to attend community functions with their client families will allow for bonding to occur while promoting acceptance and a greater understanding of the community and people they serve. Encouraging workers to incorporate their personal families with community events will allow for the community to view the worker in a different light and offer greater acceptance in the community. Further, the worker will develop less fear of being an outsider while still allowing a healthy balance in their personal life. Encouraging workers to engage in ceremonial and cultural events with their personal family or client family will allow for the worker to have a sense of appreciation and spiritual connection to the community. Social workers who have attended ceremonies in the community that they serve have reported a greater sense of pride and hope. Agencies serving Indian Country should seek to understand the community they serve. Measurable achievement of this factor can be

Social workers who are connected socially and spiritually to the community will develop a strong support network that will allow for reduction of the effects of secondary traumatic stress and increase the years of service to their community.

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Secondary Trauma and the Work of the Minnesota Child Mortality Review Panel

Esther Wattenberg, Professor

Authorized by the legislature and under the direction of the Minnesota Department of Human Services, the Minnesota Child Mortality Review Panel is our surveillance system for reviewing fatal child injuries due to abuse and neglect. Major sectors of public services have representation on the review panel. This multi-disciplinary panel is derived from child welfare, early childhood agencies, the medical field, public health, education, law enforcement, and the judicial system.

The Minnesota Child Mortality Review Panel works within a particular framework: Searching for error and fixing blame when an infant or child has died while under the protection of the county child welfare system. The content of the agenda is determined by reports from the counties on the circumstances of infant and child deaths in an active child protection caseload, where "safety" is the primary obligation. In many ways, the Mortality Review Panel operates with the knowledge that the tragedy has public attention, and they must respond to the public's outrage that a child has died of injuries while under the supervision of child protection.

In reviewing the county reports, inquiries are guided by the pursuit of the errors that led to the tragedy. To some extent, it is an inquiry into the practice skills of the child protection worker: Is this caseworker sufficiently trained and knowledgeable to know when marginal care crosses the line into imminent harm? Can this child protection worker predict when a violence-prone partner will slip into an uncontrollable rage while caring for an irritable baby? In sum, did the caseworker fail to grasp a clear and complete picture of imminent harm?

It is a great temptation for retrospective inquiries to slip into the culture of blame, focusing on the child welfare worker for a lack of knowledge and skill. In the midst of dealing with the concern and anxiety following a tragedy, the worker must then deal with the assertion that he or she is the sole source of error, which in turn may intensify symptoms of STS. However, the failure to predict what will happen in a case is what is at the heart of uncertainty in tracing the pathway to a tragic outcome. By enlarging the scope of inquiry in which the worker is but one member of a larger inquiry, the panel can reframe the issue from one of individual responsibility to community or systemic responsibility.

Questions related to the environmental context of organizational behavior found in the child welfare agency are not routinely central to the panel's investigation. Is the staff working under adverse conditions? Was quality child care available, so that the violent and abusive boyfriend is not caring for the distressed baby? Questions of available resources are not directly addressed.

In the search for the context of human error, Eileen Munro, a noted British expert and advisor to international systems in child welfare, observes that these inquiries are like "picking over the bones of other people's disasters" (Munro, 1996). Munro warns against the temptation to blame the social workers without seeing the error in a wider context of the practice environment and organizational behavior that limits responses to "imminent harm" (Munro, 2005).

Perhaps it is reassuring to the community that a "child mortality review panel" exists. Most service-delivery systems are on guard for reducing errors. Child protection is not alone: Heart surgeons routinely have sponges counted; orthopedic surgeons have an "X" drawn on the limb to be removed; air traffic controllers check in on specified times to assure pilots' or their own wakefulness. Hospitals are encouraged to show training films on soothing irritable babies. Films on "safe sleeping" are recommended to be routinely shown for mothers of newborns.

Whereas there is a community expectation that the Child Mortality Review Panel exists to fix blame for errors implicated in the tragedies of child deaths, the panel also asserts a leading role in providing valuable insights that can be drawn from their inquiries in order to improve services for vulnerable children in high-risk families. The community itself must step forward to acknowledge its support for basic social services such as child care, mental health treatment, and services to stabilize families. By having the community shoulder some responsibility, the worker's sense of "I'm alone" can be alleviated.

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The Child Mortality Review Panel can help to reduce the risk for child welfare workers developing STS symptoms by advocating for ways to strengthen and support the child protection worker in the awesome task of assuring safety for a child in high-risk circumstances —

- for practice, encourage group supervision and improvements in risk assessment that underline prevention efforts;
- for policy, attention must be paid to providing quality child care for low-income families;
- for the community, crisis nurseries and helplines are indispensable resources.

In sum, enhanced community awareness and sharing responsibilities in prevention efforts should, to some extent, reduce the burden of guilt that envelops the child protection worker when tragedy occurs and, thus, alleviate the potential for secondary trauma.

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A Judicial Perspective on Secondary Trauma in Child Welfare

Judge Kathryn Quaintance

A child protection worker arrives at the hospital to find a severely premature baby struggling for life and checks each day to find that the parents have not visited.

An attorney files a petition alleging sexual assault by a father against his daughter and the entire family turns against the daughter.

A judge has to decide whether a toddler will stay in the foster home where she has been since birth or go to newly met relatives in another part of the country where she will be with siblings and extended family.

These are the kinds of situations that present daily in Juvenile Court. It is our job to make decisions that hugely affect the lives of others. That is a compelling responsibility. We do our best to be compassionate and fair and clear. Often what we get back is anger or hurt or despair. And then we move to the next case.

What happens to the professionals who face this kind of tragedy and stress daily? What training do we have about how to absorb or deflect all this pain? We focus on providing therapeutic services for others, but what about ourselves?

While there has been some significant research about secondary trauma experienced by mental health professionals, very little has been done to research or address the toll of ongoing exposure to trauma among professionals in the criminal justice system. One study done with a group of Wisconsin Public Defenders indicated substantially higher rates of post-traumatic stress disorder symptoms and secondary traumatic stress compared with a control group of administrative staff from the same office that did not have the same direct exposure (Levin et al., 2011). Additionally, the secondary trauma indicators increased based on the number of hours worked in a given week and the number of cases handled.

It is not difficult to see some symptoms of STS and burnout among co-workers. How often do we hear colleagues opining that a strategy "will not work with these people," that a situation is "hopeless?" How many of us gain weight because comfort foods are constantly around to make us feel better? How many of us end up with injuries or illnesses that are stress related? How many of us lose track of our own needs in the constant effort to take care of other people's crises?

Lawyers and judges are probably the worst. Our training is directed at analytical solutions. We often lack good communication skills and fall back on legalese that makes what we are saying inaccessible. Some of us retreat to our intellect to avoid the emotional aspects of these cases. Many of us think we are too tough to need help with these issues. I have seen extremely intelligent judges "lose it" in juvenile court. The tools we use for other kinds of cases are not sufficient here. Some have nightmares. Some do not want to do "social work." Some are simply repulsed by the "messiness" of it all. But this is very important work and we owe it to ourselves to find a way to be healthy while doing it. How do we do that?

- **Set reasonable goals (Skovholt, 2001):** Trying to eliminate child abuse is an enormous mission that no single person could accomplish. Find smaller attainable goals which give you the opportunity to experience success. For example, you might set a goal of finding permanency for every child within the statutory time lines. You will likely not accomplish this goal on every case, but you can monitor how many cases are out of compliance on a monthly basis and work to improve your percentages over the course of a year.
- **Find support:** This is not something you can seek out at social gatherings or family holidays. In fact, you may want to consider making it a rule NOT to discuss your work with your children or your spouse because it is toxic and scary to people who are not prepared to hear about it. Rather, find a way of taking time with colleagues to talk about cases and strategies, but also about your own responses and frustrations.
- **Relieve stress:** While food, wine, and television may be comforting, they do nothing to renew us. We need to find ways to recharge our depleted batteries, such as through healthy connections with supportive people and tangible accomplishments. Using completely different parts of ourselves and/or changing our environment can be more refreshing than a nap.
- **Humor:** Laughter, especially shared laughter, is hugely healing. There is absurdity in even the most difficult situations and finding that absurdity keeps us sane. Kids are funny. Sometimes the only way to connect with adolescents is to appreciate their sense of the absurd.
- **Curiosity:** Ask questions. Ask more questions. Find out who these kids are and what is most important to them. Make no decisions about them without them. What do they want to see happen? What are their dreams? What will assist them in getting closer? We need to give them permission to talk about these things and to ask questions. These cases are about them. (For more on these strategies, see Hendricks in this publication.)

I find that when I engage genuinely with the kids and families, I see a lot of strengths. Seeing strengths that we can build on grows hope. And hope is the antidote to burnout.

Judge Kathryn Quaintance is currently Presiding Judge in the Hennepin County Juvenile Court, as well as a fellow of the Georgetown University Center for Juvenile Justice Reform. She can be reached at kathryn.quaintance@courts.state.mn.us.

Secondary Traumatic Stress and Child Welfare: A Foster Parent Perspective

Phill Klamm, Jodie Klamm, and Crystal Peterson, MSSW, APSW
Edited by Amelia Franck Meyer, MS, MSW, APSW, LISW

Phill and Jodie Klamm have been licensed as treatment foster parents with Anu Family Services since 2003. Treatment foster parents care for children and youth with more intensive needs than other foster children; therefore, these parents generally have more experience and training than other foster parents. Collectively, the Klamms have fostered 11 foster children and recently adopted their foster daughter. They also have two young biological children. Phill Klamm is a high school teacher for at-risk youth, and Jodie is a social worker and writer. Phill's parents fostered from the time Phill was 10 years old, and Phill has had over 60 foster siblings. These experiences and other international outreach they have performed have given the Klamms varied perspectives on secondary traumatic stress (STS).

According to Phill, the experience of witnessing trauma through another person's eyes is a powerful experience. Helping individuals, like foster parents, to view these experiences as opportunities to help others is exhilarating. Treatment foster parents' exposure to STS takes on many forms. For Phill and Jodie, it includes their foster children's and foster siblings' stories of abuse and neglect, the suicide of their adopted daughter's brother, and witnessing tears from families torn apart. The key to reducing the impact of secondary trauma is for foster parents to learn from the challenges and struggles of others while they pour their own hearts into other people's trauma.

The experience of a treatment foster parent is unique from other professionals in the field because of the intensity and frequency of the exposure to secondary trauma in a home setting. When children are placed into foster homes, they bring with them their past history of experiences and trauma to be shared with their foster family at every moment. Unlike working in a clinic with regularly scheduled appointments, foster parents can't predict when they must support a child in crisis. Instead, they are there to witness every trauma reaction, every flashback, every disclosure and every breakdown—often right there in their own homes. Creating a safe space for a child often means you see their most painful memories and wounds. This intense and unpredictable exposure to someone else's trauma with a goal of supporting that person's healing is a privilege, but it can inflict trauma to the healer. As Jodie Klamm puts it, "Their pain is our pain, their joy is our joy."

Most of the foster parents we surveyed for this article reported seeing the effects of STS in themselves or in other foster parents. Unfortunately, the effects of STS play out most significantly in the safety of our own family system, which, in the case of foster parents, directly impacts the children placed in their homes. Foster parents can become less empathetic to the struggles of foster youth and, thus, less understanding of their resulting behaviors. An experienced treatment foster parent says you can see the effects of STS when "…foster parents…can no longer see anything positive in the children they are working with…Then the foster parents blame the child for the discontinuation of placement and refuse to see how they could have changed."

When children are placed into foster homes, they bring with them their past history of experiences and trauma to be shared with their foster family at every moment.

As one foster parent recalled,

We go into the field with vigor, determination, and commitment. Our goal is to make a difference in the child's life. However, the problems foster children face are never an easy fix. With several layers of disappointment, emotional, psychological, physical and most times sexual abuse, the children are extremely resistant to believe in anyone or anything. In turn, they give up. The same dynamic can cause professionals to burn out.

The following are some strategies our foster parents recommend to prevent the negative impacts of STS and continue to be compassionate, empathetic providers —

- Take advantage of respite care or trade kid care with other foster families.
- Visualize the world through your child's eyes.
- Get enough sleep, good nutrition, and play.
- Get outdoors as much as possible with the kids.
- List 3 positive things about the child each day. Put them on paper and LOOK at those items on challenging days.
- Review child's goals. Ask yourself what you are doing to help support each goal.
- Do something on your own. Take a break such as a "night out with the girls."
- Sometimes just a hug—a long hug—will do it.
- Use proven techniques that are strengths-based and get good training.
- Develop a strong support system- family, social workers, etc.
- Spend family time with your foster kids.
- Get new ideas and support from other experienced foster parents individually or in groups such as "share and supports."

Jodie Klamm sums it up beautifully when she shares, "I have said… 'This is the last kid we will ever foster!' And a few months later you start to crave it again. You love it. It is your life! But you can't take care of others if you aren't taking care of yourself first."

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We Need to Pay Attention

Joan Riebel, LICSW

Just as it is important to understand how secondary traumatic stress impacts those who work in child welfare, it is equally as important to understand how STS in a worker might impact the worker's clients. Although youth in foster care may not know if their workers suffer from STS specifically, they do know the importance of having an emotionally engaged and stable worker. I recently had the opportunity to interview some teens who live in foster care about their experiences with, and perceptions of, their social workers. Their perspectives can influence our practice. "Follow-through" is one of the most important ingredients these teens identified in a "good worker." They want their workers to be organized and supportive, doing what they say they will do. One of the teens said, "If I can't trust my worker, I get cynical and defensive." Being able to rely on and trust their worker is the most significant ingredient in the relationship. Beyond being organized and following through, they identified the skills of listening, being supportive, and offering advice. I was struck by how important their relationships with their social workers are to these teens. They want a relationship that is also caring and understanding.

One of the teens said, "If I can't trust my worker, it makes me feel they're like everybody else – everybody else who has already left me." And another said, "It gets all mixed up, I just keep trying to not get hurt or disappointed, trying to protect myself." It is all about the relationship and being able to rely on, or count on, their workers being there for and with them. Another important aspect of the rapport with their social worker was how important it is for them to have a worker who does not have only a "professional demeanor." They want their workers to be more personal, stay connected, and do "more than just the bare minimum." Perhaps the most poignant statement from these interviews was, "You have to trust your worker even when you don't because they control your life."

When I asked what they would like that they do not get from their workers, they universally said, "We want more time." One of the teens said, "Eventually letting people in takes time, and workers need to respect that." Time is something we all treasure, time to just be with them, go to sporting events, band concerts, and confirmations. Within this context, of course, is a yearning for connection, a yearning to feel important. They want their social workers to be truly present during their interactions not just attending to the required work. None of the teens with whom I talked wanted less time with their social worker. As we have learned throughout this publication, when secondary traumatic stress goes unaddressed, workers are more likely to emotionally detach from the children and families they serve as a way to shield themselves from further trauma. This is the exact opposite of what these kids need from us.

All humans have the same needs, for time and for connection. As social workers, it is important that we pay attention to how we are getting our own needs met, especially our mental health needs, so that we can give our best to these kids who long for the best from us. We know that being present and listening to their stories of trauma and loss is challenging. Our self-protective instincts can cause us to detach, distance ourselves and avoid the connection. In my years as a social worker, the most frequently asked question is, "How do you do it?" That question comes from a realization that it is much easier to detach from pain and suffering than it is to engage with those who experience it. In order to be there for and with these children and youth who have experienced serious trauma, we must attend to our own well-being; one way to do this is by continuously assessing and addressing our own experiences of secondary traumatic stress. The kids have said when we are fully present, our service helps them heal. One of life's greatest mysteries is that their healing also restores us. I think that's how we do it.

The basic premise of social work is service, and we serve with ourselves. Sometimes we inadvertently cause harm as we are attempting to serve. It is not intentional harm, but the consequences are no less serious and that is why it is important for us to be aware of how we are being perceived. We can inadvertently cause harm to ourselves and others when we neglect, try to control, or make mistakes when working with youth. As child welfare workers, we must pay attention to whether or not our efforts are re-traumatizing already traumatized children and youth. This is particularly important in the field of foster care, as the removal of children from their families is intrinsically traumatic. In the next issue of CASCW's *CW*360°, the trauma experienced by the children and families we serve will be examined, as well as how child welfare systems across the country are using research on trauma to guide more effective practice with this population.

As social workers, it is important that we pay attention to how we are getting our own needs met, especially our mental health needs, so that we can give our best to these kids who long for the best from us.

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Utilizing Traditional Anishinaabe Cultural Practices to Reduce Secondary Traumatic Stress in the Workplace

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defined when the social workers in the agency no longer consider the community as the community they serve but rather that they are serving their own community.

Tribal social service agencies have a higher chance of success in preventing turnover and reducing the effects of STS amongst their social workers when they focus their recruitment efforts on social workers who are willing to reside in the community that they serve. Tribal communities are deeply rooted in family and extended family connections with the basic understanding that their people are spiritually connected to each other and their community. The concept of 'abandoning one's community when they need you the most' is a social taboo that would cause a worker to feel unaccepted in their community. Tribal agencies should strive to develop policies to prevent tribal workers feeling alienated from their community or that their families are suffering due to the obligations of the job, a commonly reported source of stress for many tribal child welfare workers. Agencies can support their workers by promoting the practice of incorporating social workers' families at community and spiritual events; allowing workers to use traditional medicines in the workplace and with their client families in order to promote a sense of holistic healing; promoting attendance at traditional native ceremonies amongst workers; encouraging workers to seek cultural guidance from spiritual leaders for both professional and personal reasons; and allowing adequate paid time off to attend traditional ceremonies and community service functions.

Social workers who are connected socially and spiritually to the community will develop a strong support network that will allow for reduction of the effects of secondary traumatic stress and increase the years of service to their community. This in turn provides stability for our families involved in child welfare systems which results in positive outcomes in child welfare. The long-term effects on the community are noojmohaad or healing.

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Resource List

Specific to Secondary Traumatic Stress

- NCTSN. (2011). *Secondary traumatic stress: A fact sheet for child-serving professionals.* Retrieved from http://www.nctsn.org/sites/default/files/assets/pdfs/secondary_traumatic_tress.pdf
- ACS-NYU Children's Trauma Institute. (September 2011). *The Resilience Alliance: Promoting resilience and reducing secondary trauma among child welfare staff.* Retrieved from http://www.nctsn.org/sites/default/files/assets/pdfs/resilience_alliance_training_manual.pdf
- ACS-NYU Children's Trauma Institute. (September 2011). *The Resilience Alliance Participant Handbook.* Retrieved from http://www.nctsn.org/sites/default/files/assets/pdfs/resilience_alliance_participant_handbook.pdf

Recruitment Resources & Realistic Job Preview (RJP) Examples

- National Child Welfare Workforce Institute. (October 2011). *NCWWI resource list #11: Recruitment, screening & selection.* Retrieved from http://www.ncwwi.org/docs/NCWWI_ResourceList_11-RecruitmentScreeningSelection.pdf
- Arizona RJP: https://www.azdes.gov/main.aspx?menu=154&id=4297
- Colorado RJP: http://www.coloradorjpvideo.org
- North Carolina RJP: http://ssw.unc.edu/jif/rr/rjp.htm
- Michigan RJP: http://www.vimeo.com/9856486

Select Notable Organizations

- National Child Traumatic Stress Network: http://www.nctsn.org
- National Quality Improvement Center on the Privatization of Child Welfare Services (QICPCW): http://www.uky.edu/SocialWork/qicpcw/
- National Child Welfare Workforce Institute: http://www.ncwwi.org

Agency Discussion Guide

The editors of *CW360°* have been told over the past couple of years that supervisors and managers use articles in the publication to generate discussions in their unit/staff meetings. We thought this was a terrific idea. In order to assist busy supervisors and managers in thinking through how they might engage others around the information presented in this edition on STS, we offer several discussion questions to get the conversation started —

Between Supervisor/Workers

- What are some implications for the families and children that we serve if we as workers (or other adults such as foster parents and judges) do not address the possibility that we may have secondary traumatic stress? How can screening be implemented in our agency? Should it? See Bride, Riebel, Judge Quaintance, & Klamm, Peterson, & Franck Meyer.
- Shackelford and others stress the importance of distinguishing between secondary trauma and burnout. Why do you think this is important? What is the difference?
- How might STS be experienced differently among workers in our agency, based upon our diverse backgrounds (e.g. race, culture, socioeconomic status, education)? See Champagne and Caringi & Lawson.
- Co-worker, or peer support is discussed by Barbee, Hendricks, and Judge Quaintance in contrasting ways. With which perspective do you agree most? Why?
- The "Best Practices" section highlights some interventions for STS, while Hendricks gives a brief overview. Which, if any, of these interventions seem applicable to our work? Do you think any should be implemented in our agency? What steps can you personally take?
- Richardson, Chenot, & Wattenberg discuss the impact the media has on worker well being and policymaking. Can you point out any possible "reactionary" policymaking in our state or our agency? How can we influence how the media discusses child welfare work?

Between Manager/Supervisor

- Shackelford and others stress the importance of distinguishing between secondary trauma and burnout. Can you see the difference among people in your unit? How does understanding this difference help you in your work as a supervisor?
- How would you describe the organizational culture and climate in our agency? How does this impact your risk of developing STS? How does it impact your workers' risk? See Caringi & Lawson, Chenot, Krings, & Collins.
- What are some ways you can promote culture and other forms of diversity as an asset in agency STS policymaking? See Caringi & Lawson.
- In thinking about the workers within your unit, as well as the agency as a whole, which interventions described in the "Best Practices" section seem to be interventions that could work here?

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ail each issue to our regular cribers plus others whom we k might be interested. If you'd to receive every issue of *CW*360° o charge, call 612-624-4231 or il us at cascw@umn.edu. Give us name, address, email and phone ber, and let us know whether d like a print copy or e-mail ion. *CW*360° is also published on Web at http://z.umn.edu/cw360.

About *CW*360°

Child Welfare 360° (*CW*360°) is an annual publication that provides communities, child welfare professionals, and other human service professionals comprehensive information on the latest research, policies and practices in a key area affecting child well-being today. The publication uses a multidisciplinary approach for its robust examination of an important issue in child welfare practice and invites articles from key stakeholders, including families, caregivers, service providers, a broad array of child welfare professionals (including educators, legal professionals, medical professionals and others), and researchers. Social issues are not one dimensional and cannot be addressed from a single vantage point. We hope that reading *CW*360° enhances the delivery of child welfare services across the country while working towards safety, permanency and well-being for all children and families being served.

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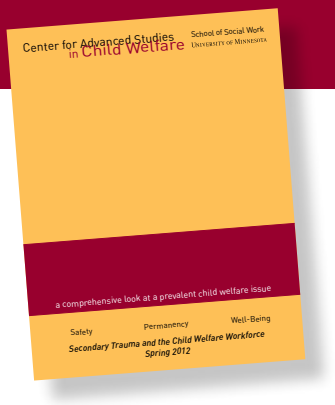

Download previous issues of *CW*360° at http://z.umn.edu/cw360

In This Issue of *CW*360°

- An overview of how secondary trauma impacts workers, supervisors, organizations, and advocates in the child welfare system and how this may hurt client outcomes
- How outside forces, such as negative reports in the media and reactionary policies, can increase one's development of secondary traumatic stress
- An overview of prevention and intervention strategies on both individual (personal and professional) and organizational levels
- Specific interventions and supports that agencies can use to ameliorate secondary traumatic stress among workers
- The use of Realistic Job Previews in both schools and agency recruitment in order to prepare workers for the field
- Cultural considerations in determining agency-wide policies to address secondary trauma among staff, including specific examples from a tribal social service agency
- How secondary trauma can affect foster parents, and why it is important to foster youth for foster parents and workers to address possible secondary trauma

*CW*360°
a comprehensive look at a prevalent child welfare issue

Feature Issue: Secondary Trauma and the Child Welfare Workforce, Spring 2012

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