

SECONDARY TRAUMATIC STRESS IN CHILD WELFARE WORK

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Abstract

This project examines secondary traumatic stress (STS) and related concepts in the context of the child-welfare system. The relationship between child protection work and STS is highlighted, as well as the impact that STS has on workers in this field. To gain a more accurate understanding of the condition, I argue that existing terms related to helper trauma responses be classified more consistently under the rubric of STS. By synthesizing the classification of helper responses in such a way, an increased understanding of the condition may lead to enhanced professional education that addresses STS. A sample Table of Contents and STS assessment measure is included for the future development of a desk manual tool for child protection workers.

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Chapter One

Purpose of the Project

This project aims to raise awareness of the effects of trauma work, specifically secondary traumatic stress (STS) in child-protection social work. There are two components to the project. The first component is a paper that analyzes the current status of STS in child-welfare social work. The second component of the project is an outline of a Table of Contents and sample scale for the future development of a desk manual to assist frontline social workers to understand, assess, and manage their STS experiences.

The main thesis of the paper is that trauma work in the field of child-protection social work is under-recognized and misunderstood, and as a result the well-being of child-welfare social workers may be at risk (Nelson-Gardell & Harris, 2003). Although there are indications of deleterious effects on social workers related to STS (Caringi, 2008), there is a weak association regarding the causes of the problem. This writer's hypothesis is that child-protection work is misunderstood as stressful, causing burnout rather than identified as traumatic, resulting in STS. The goal of this project is to strengthen the association between STS and child-protection social work so as to promote a wider recognition of the scope of the problem. Ultimately, it is hoped that increased recognition of STS will generate additional training and education that will better prepare professionals and workplaces to deal with the condition. Employers and university training programs can only provide the necessary support to social workers once the real risks to frontline child-protection workers are clearly understood. This project is intended to generate further inquiry into the experiences of frontline child-protection social

workers so that opportunities to mitigate the negative effects of STS in the workplace are maximized.

Overview of the Project

Chapter One of this project outlines the characteristics of STS, including a definition of STS in the context of child welfare. This section includes a discussion of empathy, an important component of the condition affecting child-protection social workers.

Chapter Two reviews research on conditions that are similar to STS, such as burnout and vicarious trauma (VT), which are prevalent in the field of child welfare. These related concepts also cause emotional and behavioural disturbances for professionals. Chapter Two also includes a discussion of constructivist self-development theory (CSDT), a framework developed to help one understand the underlying assumptions of secondary trauma (McCann & Pearlman, 1990).

Chapter Three summarizes relevant literature related to factors that contribute to STS. These are Individual, Organizational and Incident factors that contribute in various ways to the experience of STS felt by front-line social workers in child protection.

Chapter Four deals with the subject of measurement and STS, a topic that reveals methodological problems relative to defining the concepts associated with traumatic stress (Caringi, 2008). Chapter Four identifies different psychometric problems associated with current STS measurement tools, and suggests a suitable alternative assessment tool for child protection social workers.

Chapter Five outlines ethical issues that are discussed in terms of individual and professional practice considerations related to STS. Ethics are also addressed in the context of individual and organizational accountability relative to STS.

Chapter Six provides an overview of practices that help transform the negative effects of STS, also known as transformative models, into positive growth experiences for protection social workers. Although this topic is somewhat neglected in the literature, Chapter Six reviews some of these opportunities for those child protection social workers who experience STS.

Finally, in Chapter Seven, an integrated summary focuses on trauma-informed systems (Ko et al., 2008) as an important future direction for child-welfare agencies. Recommendations for creating a manual for use by child-protection social workers are included in this final section.

Characteristics of Secondary Traumatic Stress

The concept of STS emerged when post-traumatic stress disorder (PTSD) was included in the American Psychiatric Association's third edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III) in 1980 (Figley, 1995). According to the DSM-IV-TR (2000), the six diagnostic criteria of PTSD are: (a) both exposure and reaction to a traumatic event(s); (b) persistent re-experiencing of the event(s); (c) persistent avoidance of stimuli associated with the trauma; (d) symptoms of heightened arousal, such as loss of sleep, hyper-vigilance, or anger; (e) duration greater than one month, and (f) significant changes in functioning related to employment or social status (American Psychiatric Association, 2000). Although STS is not a recognized diagnosis in the DSM-IV-TR, Figley (1995) argued that the criteria are virtually the same

as in PTSD. The main difference between the two conditions is that PTSD is diagnosed when individuals experience a traumatic event directly, and STS is exposure to trauma indirectly, through shared experience with a trauma survivor.

Secondary Traumatic Stress in Child-Welfare Workers

Definition

Figley (1995) described STS as a phenomenon that occurs to people affected by the victims of trauma. In this paper, STS is defined as a condition that is the result of working with trauma survivors. STS is defined in a broad manner to include the symptoms commonly associated with PTSD as described above, and also to incorporate the cognitive changes associated with working with trauma survivors. This working definition of STS is unique to this project because it includes both PTSD symptoms and cognitive changes. Cognitive changes can consist of altered beliefs about self, others, and one's world (McCann & Pearlman, 1990). Typically, the symptoms associated with trauma exposure and the cognitive changes are viewed as separate conditions, namely, STS and VT respectively. Instead of promoting a bifurcated understanding of these conditions based on the separation of symptoms (STS) and cognitive changes (VT), the goal of this project is a convergence of concepts in the case of child-protection social workers. Uniting the concepts permits an accurate understanding of the reality of protection workers - that they risk experiencing a unique set of circumstances that is based on their exposure to traumatic material that is due to the client group they serve. By naming the exposure as one widely defined condition called STS, the child-protection field can better assess the magnitude of the problem.

The approach taken in this project is based on recent research (Caringi, 2008; Ko et al., 2008) that confirmed this writer's direct experience of over 15 years in the field. Child-protection social workers can suffer from both the symptoms (STS) and altered beliefs (VT) associated with exposure to traumatic material, but neither is recognized in the field. Instead, social-worker morbidity in child protection is understood as burnout, a condition that is caused by different circumstances and not unique to child-protection work. Regardless of whether the social worker experiences symptoms (STS) or cognitive changes (VT) associated with exposure to trauma, the well-being of workers is at risk and the field continues to misunderstand the causes. Naming the problem under the rubric of STS creates renewed understanding of the problem child-protection social workers face. More importantly, this renewal creates opportunity for the child-welfare system to recognize the magnitude of the problem and make the necessary changes to support protection social workers. For this reason, combining the concepts of STS and VT is a better way to begin to assess the degree to which social workers are being negatively affected by the daily trauma work that they perform. Once the child-welfare field assesses and responds appropriately to the impact of trauma work on child-protection social workers, further research into the specific nature of the causes and effects will be warranted.

Early accounts of STS described the condition almost exclusively in professions such as emergency personnel (Bride, 2007), lawyers, medical staff, and therapists (Adams & Riggs, 2008; Arvay, 2002; McCann & Pearlman, 1990), that worked closely with trauma survivors in cases of natural disasters. However, subsequent studies revealed that other professionals, such as child-protection social workers, also experience STS

(Caringi, 2008; Clemens, 2004; Figley, 2002; Howe & McDonald, 2001; Ko et al., 2008; Nelson-Gardell & Harris, 2003; Regehr, Hemsworth, Leslie, Howe & Chau, 2004). As more STS research is conducted in the context of child-welfare social work, its impact on the profession is becoming increasingly evident.

One of the few early studies related to STS and child-protection social work was conducted by Nelson-Gardell and Harris (2003). Their research measured whether the risk of STS increases when social workers have personal abuse histories. Nelson-Gardell and Harris found that abuse history does increase risk for STS. However, the study also concluded that all child-protection social workers are at risk of STS, regardless of their histories. This valuable research was one of the first to establish a clear link between the field of child-welfare social work and STS.

The Role of Empathy

The literature reveals that there is a relationship between the use of empathy and the emotional well-being of professionals. The role of empathy, described by Figley (1995) as the “cost to caring” (p. 1), is an important consideration when understanding STS. Figley (2002) believed that being compassionate and empathetic “extracts a cost” (p. 1434) on helpers. Nelson-Gardell and Harris (2003) believed that using empathy could lead to negative psychological consequences and that empathy is the “conduit” (p. 6) for STS in work with children who have experienced trauma. Empathy is considered one of the core values of social-work practice (Clark, 2000), yet the regular use of empathy by social workers places them at risk for STS (Nelson-Gardell & Harris, 2003).

According to Paivio and Laurent (2001), empathy is also employed in therapeutic settings by counsellors and therapists as a tool to help individuals learn about their

emotions, develop trusting relationships, and learn appropriate boundaries. Relating to clients this way in a therapeutic setting is similar to the social worker's interaction with children who have experienced child abuse (Ministry of Children and Family Development, 2004). Accordingly, the use of empathy can have similar results for child-protection social workers as it does for therapists.

Vulnerable Client Group

Debate exists in the literature related to the relationship between service to children and increased risk of STS. For example, Bride (2004) argued that existing literature does not support this claim. Other researchers, however, described child abuse as one of the most difficult areas for helpers (Caringi, 2008; Figley, 1995; McCann & Pearlman, 1990; Nelson-Gardell & Harris, 2003), and many claimed possible inherent risks of STS specifically in child-protection social work (Anderson, 2000; Caringi, 2008; Nelson-Gardell & Harris, 2003; Regehr et al., 2004). These researchers believed that the regular use of empathy and the vulnerable client population, namely abused children who are often traumatized when involved in the child-welfare system, are the likely cause of STS in child-protection workers.

Paivio and Laurent (2001) established that there are similarities between the roles of child-protection workers and trauma counsellors who work with child-abuse victims. Paivio and Laurent believed that empathetic responses impact trauma therapists negatively when exposed to traumatic material. Given the similarities between the empathetic relationships in these two professions, it would appear that child-protection social workers and trauma therapists are equally at risk of STS. The above research (Anderson, 2000; Caringi, 2008; Nelson-Gardell & Harris, 2003; Regehr et al., 2004)

suggests that the regular use of empathy in combination with a vulnerable client group heightens the risk of STS for child-protection social workers.

Chapter Two

Related Concepts

When researching the topic of STS, terms such as burnout, VT, compassion fatigue (CF), and countertransference are often found grouped together as related concepts in library databases (Bride, 2007; Figley, 1995; Howe & McDonald, 2001; McCann & Pearlman, 1990; Nelson-Gardell & Harris, 2003). Although these concepts may be related in subject terms, they are distinct conditions, each with unique factors that impact helpers in different ways. This section of the paper explores the differences between these concepts to clarify the properties of STS.

Burnout

Definition. Burnout is a well recognized workplace experience, and it is a pervasive topic in the child-welfare literature (Bennett, Plint & Clifford, 2005; Drake & Yadama, 1996; Jenaro, Flores & Arias, 2007; Mann-Feder & Savicki, 2003; Meltsner, 1989; Savicki & Cooley, 1994; Stevens & Higgins, 2002). Burnout was described by Figley (1995) as a gradual process toward emotional exhaustion. The term burnout is associated with physical, emotional, behavioural, and interpersonal problems that are characteristically chronic, acute, and complex (Figley, 1995). Figley explained that these symptoms were typical of employees who worked in large human-service organizations, and were often exacerbated by feelings of disempowerment. Dunkley and Whelan (2006) explained burnout as psychological strain that was combined with fatigue and apathy. Burnout was also associated with high demands and expectations that exceeded an individual's ability to replenish energy necessary to meet demands (Meltsner, 1989). Jenaro et al. (2007) described burnout as emotional exhaustion, depersonalization, and reduced feelings of accomplishment.

These characteristics of burnout referred to issues like workload, personnel, and working in a bureaucratic setting, which may have helped explain why burnout was an accepted workplace hazard in many places of employment, particularly in child welfare, a field with these types of expected pressures (Adams, Boscarino, & Figley, 2006; Bennett et al., 2005; Dunkley & Whelan, 2006; Figley, 2002; Jones, 1993). Since child protection was usually performed in bureaucratic settings where burnout was said to be common (Figley, 1995; Jenaro et al., 2007; Jones, 1993; Regehr et al., 2004), the experiences of protection social workers may have been labeled as burnout (Anderson, 2000; Bennett et al., 2005; Hall, 2005; Jenaro et al., 2007).

Jones (1993) and Nelson-Gardell and Harris (2003) investigated role conflict as a factor related to burnout in the field of child protection. Jones described role conflict as the perception held by social workers that child protection has inherently polarized roles - one of helper and one of enforcer of mandated services. Nelson-Gardell and Harris, however, described role conflict in terms of social-worker perceptions of the general public's view that social workers possess immense power, versus the powerlessness that workers actually feel due to the bureaucratic and legal demands in the protection system. These researchers provided examples of different types of role conflict experienced by protection social workers that can lead to burnout.

Another aspect of burnout reported in child-protection work that places high demands on social workers is the legal aspect of the job. The legal system is considered by many social workers to be one of the most highly stressful aspects of the work, where social workers feel inadequate, and a clash of ethics and values often occurs between professionals (Vandervort, Gonzalez, & Faller, 2008). In addition to the challenging legal

system, frontline social workers also face added stress due to the possibility of legal liability related to their jobs (Anderson, 2000). These studies demonstrate how the legal responsibilities in child welfare likely contribute to social-worker burnout due to job demands.

Burnout misunderstood. Researchers continue to report the negative effects of work-related stress and burnout in child protection (Bennett et al., 2005; Drake & Yadama, 1996; Mann-Feder & Savicki, 2003; Savicki & Cooley, 1994; Stevens & Higgins, 2002). However, there is growing recognition that burnout may not fully describe the experiences of frontline child-protection social workers (Arvay, 2002; Bride, Robinson, Yegidis & Figley, 2004; Dunkley & Whelan, 2006; Figley, 1995; Jenkins & Baird, 2002; Kassam-Adams, 1995; Pearlman & MacIan, 1995; Regehr et al., 2004). Burnout does accurately describe one type of reaction to chronic stressors in the field of child welfare; however, protection social workers simultaneously experience exposure to the trauma incidents of their clients. It is the social worker's responses to the traumatic material that can impact the well-being of protection social workers on a deeper psychological level (Regehr et al., 2004). The impact of this response is arguably more significant from the perspective of the helper than the workload, personnel, and fatigue issues that characterize burnout (Nelson-Gardell & Harris, 2003).

Nelson-Gardell and Harris (2003) explained the current misunderstanding of STS in child welfare by stating that the negative psychological effects of child-protection work continue to be understood within a context of stress and burnout rather than recognized as STS. This creates problems for child-protection social workers because their experiences could be misunderstood and improperly managed. Stress and burnout

are relatively milder, more preventable conditions (Meltsner, 1989) than STS. Although social workers do sometimes experience these milder conditions, STS occurs because of their role as helpers to trauma survivors. As a result, they are at risk of experiencing both burnout and STS. If employers fail to admit the existence of STS in child welfare, the impact on the profession may be grave. If STS is fully recognized in the profession of child protection, steps can be taken to mitigate the traumatic effects experienced by these professionals.

Compassion Fatigue

Figley (1995, 2002) is a major contributor to trauma-related research and is credited for developing the concept of compassion fatigue (CF), otherwise called “the cost of caring” (Figley, 1995, p. 1). Figley used the terms CF and STS interchangeably. Other researchers (Dunkley & Whelan, 2006; Jenkins & Baird, 2002) disagreed with the meaning of the term compassion fatigue. Dunkley and Whelan stated that CF is too broad a concept to describe it as STS. Specifically, CF refers to the detrimental emotional consequence of caring on helpers (Figley, 1995), but it does not differentiate the type of client material that extracts a cost on the helper, which is a defining characteristic of STS. According to Dunkley and Whelan, CF is a general concept and not specifically related to the client-helper interaction.

However, Figley (1995) defended the term compassion fatigue because he believed that the impact of trauma exposure is a normal human response to caring for others. Calling the condition STS links it to the diagnosis of PTSD, which pathologizes rather than normalizes the act of caring (Figley, 1995). Recent research defines the impact of trauma exposure with more specific consequences than CF describes,

particularly when applied to child-welfare protection workers (Anderson, 2000; Bennett et al., 2005; Caringi, 2008; Hall, 2005; Howe & McDonald, 2001; Ko et al., 2008; Nelson-Gardell & Harris, 2003; Regehr et al., 2004). CF seems to be too general a concept when applied to a topic like trauma exposure that has specific characteristics.

Vicarious Trauma

McCann and Pearlman (1990) are credited with developing the term vicarious trauma. These researchers defined VT as the therapist's long-term exposure to the images and suffering of their trauma client survivors (McCann & Pearlman, 1990). Their seminal research focused on the incidents of therapists experiencing trauma symptoms despite having no direct trauma histories. VT refers to the unique psychological experiences of trauma therapists, distinguished from other forms of workplace hazards such as CF, burnout, countertransference or STS. Dunkley and Whelan (2006) concurred with this conceptualization, describing VT as a transformation in the helper; an occurrence due to "empathic engagement with the trauma client" (p. 108). VT specifically refers to the cognitive changes that occur as a result of cognitive adaptations made by the helper (Dunkley & Whelan, 2006; Steed & Downing, 1998). Specifically, these adaptations include the therapist's cognitive schemas and beliefs about themselves and others (McCann & Pearlman, 1990). The difference between VT and STS is the focus on cognitive changes in the former condition and symptomology in the latter. VT is not defined by symptoms and is therefore not associated with the diagnosis of PTSD (APA, 2000).

VT is mostly perceived as negative by individuals who work with trauma survivors, although it is sometimes known to have positive outcomes for trauma

survivors and therapists alike (Saakvitne, Tennen & Affleck, 1998; Steed & Downing, 1998). These positive changes are generated from alterations in one's worldview and increased self-awareness (Steed & Downing, 1998). For helpers in the field, the positive findings are important aspects of VT, and, according to Steed and Downing, are lacking in much of the research. Thus, additional research is warranted to include positive growth in the conceptual framework of VT.

Countertransference

Some researchers propose that little distinction has been made between STS and countertransference (Pearlman & Saakvitne, 1995). Although countertransference and STS can interact together, the literature suggests that they are quite different in several ways. Countertransference refers to the ways that therapists respond to the information a client presents during sessions (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995). It is described as unresolved therapist issues that are raised when clients share related experiences (McCann & Pearlman, 1990). One of the distinguishing characteristics of countertransference, as compared to STS, is that it pertains to existing personal characteristics of the therapist. It is typically viewed as internal to that individual and related to their historical issues. Countertransference issues can occur regardless of the type of client material presented, so is considered a separate construct from both STS and VT (Pearlman and Saakvitne, 1995).

Other differences noted by McCann and Pearlman (1990) between STS and countertransference were the duration of the reaction. Countertransference is considered to be a short-term reaction to working with a particular client, whereas STS refers to longer term disruptions that occur because of changes in cognitive schemas and beliefs

about the self and the world (McCann & Pearlman, 1990). Furthermore, Pearlman and Saakvitne (1995) claimed that STS is cumulative, although countertransference need not be. In contrast to this claim by Pearlman and Saakvitne, Figley (1995) explained that STS is more likely to occur suddenly than have cumulative effects. This difference of opinion may be due to confusion in the literature between the definitions of STS and VT.

Summary of Related Terms

The above review of the terms associated with STS reveals the many ways that helpers can be affected by their work. The number and variations of the concepts mentioned above confounds the work-related problems for child-protection social workers because their experiences can be mislabeled. The distinctions between VT, CF, and STS are important in a field that recognizes burnout as the primary issue (Anderson, 2000; Bennett et al., 2005; Hall, 2005; Jenaro et al., 2007). In addition, some of these constructs are used interchangeably in the literature despite their unique characteristics (Arvay, 2002). This lack of clear concept definition in child protection suggests a need for better terminology that encapsulates the meaning and effects of trauma work on these helping professionals.

The present project aims to rectify some of the confusion by proposing to dispense with the distinction between symptomatic and cognitive changes experienced by helpers in the case of traumatic stress, because both types of change relate directly to the client's traumatic material. The conceptual separation of VT and STS is not required to educate helpers about the effects of trauma work. What is necessary is an increased understanding about exposure to client trauma-material, particularly in child-protection social work. The status-quo conceptualization of this phenomenon, which is to separate

the condition depending on whether the helper experiences cognitive or symptomatic changes, dilutes the research related to the overall impact of trauma work on helping professionals.

Some researchers continue to consider STS and VT as separate concepts (Jenkins & Baird, 2002), perpetuating a lack of clarity and heightening confusion (Dunkley & Whelan, 2006) pertaining to the overall impact of trauma work on helpers. A growing body of research suggests that the terms STS and VT can be used interchangeably to describe the overall effects of trauma work on professionals (Arvay, 2002).

To advance understanding further and to promote an increased recognition of the impact that trauma work has on professionals, this project proposes the term STS be used to describe the trauma-response because this term links the effects of the client's primary traumatic experience and the helper's re-experience of the traumatic event. Using this term when referring to traumatic stress exposure in child protection will accurately explain the protection worker's experience that it is directly related to the client's trauma, and unrelated to workload, role conflict, legal stresses, or other work demands. Benefits of a new definition may lead to better ways to assess the scope of the problem and ultimately gain a more complete understanding of the impact of trauma work on helping professionals.

Beyond Current Concepts: STS and Theory

This paper has established that the traumatic material shared in the worker-client interaction is the distinguishing characteristic of STS and related concepts such as VT. Within this interaction, a unique client-helper relationship develops, where individual helpers respond to the traumatic material of clients in many different ways (Saakvitne et

al., 1998). McCann and Pearlman (1990) provided a theoretical framework that describes how vicarious trauma changes individuals (Saakvitne & Pearlman, 1996), and explained reasons why helper responses to traumatic material can be so varied. This theoretical foundation, called constructivist self-development theory (CSDT), outlines the uniqueness of trauma work by illustrating the process involved when workers are exposed to a client's traumatic material. The following section reviews CSDT.

Constructivist Self-Development Theory

CSDT was developed by McCann and Pearlman (1990) in the context of therapeutic relationships because these researchers believed that trauma therapists were experiencing something distinctly different than typical countertransference issues. STS pertains to the interaction of the individual, the traumatic material, and the helper's construction of new meaning associated with the material presented by the client (McCann & Pearlman, 1990). CSDT defines the ways that the traumatic material affects the helper's cognitive schema and future experience (McCann & Pearlman, 1990). CSDT explains the impact of trauma on the developing self (Saakvitne et al., 1998) by integrating trauma, psychoanalytic, and social-learning theories within a developmental perspective.

CSDT is based on a theoretical assumption called constructivism, a belief that individuals construct their own realities (Wong-Wylie, n.d.). According to this theory, reality is constructed from increasingly complex cognitive structures, or schemas that are developed as individuals interact with their environments (Gergen, 1985). Constructivism is important in the context of STS because the traumatic material is given meaning based on the subjective experience of the helper. The helper's subjective experience is

embedded in his or her individual socio-cultural contexts (Saakvitne et al., 1998). As a result, according to CSDT, individuals experience the effects of trauma differently, depending on the person, the context, and the traumatic event (Dunkley & Whelan, 2006). Saakvitne et al. stated that CSDT is “an integrative personality theory that describes the impact of a traumatic event (or a traumatic context) on the development of self” (1998, p. 282). Exposure to traumatic material has implications for helpers, and can result in permanent changes in core beliefs and values.

One of the characteristics of CSDT is that traumatic events will affect cognitive schemas and the memory system (McCann & Pearlman, 1990). Previous assumptions about the self and the world can be challenged when exposed to traumatic material. Changes in thoughts and emotions can occur in basic need areas of life, including trust, safety, power, control, independence, esteem, and intimacy (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995; Saakvitne & Pearlman, 1996). Disrupted imagery can be a symptom of the helper internalizing client material, in addition to altered memories due to the intrusions caused by involvement in the client’s trauma (McCann & Pearlman, 1990). According to these authors, these intrusions can manifest as flashbacks, dreams, and imagery related to experiencing the client’s trauma. CSDT explains how a helper’s existing thoughts, beliefs, and memories can be altered by exposure to traumatic events.

In addition, the helper’s frame of reference, which is related to one’s understanding of causality, can be affected. If the helper’s frame of reference is altered through exposure to traumatic material, they may develop distorted views about why the trauma occurred. This can lead to a more generalized disorientation related to the helper’s frame of reference. According to Saakvitne et al. (1998), many areas are affected by

exposure to traumatic material, especially self-capacities, ego resources, and central psychological needs. When children are exposed to trauma, these disruptions can be more permanent because a child's sense of self is less secure, whereas adults are more likely to be temporarily affected by disrupted beliefs caused by trauma (Saakvitne et al., 1998). Therefore, being a child survivor has potentially negative implications for adult helpers who are also survivors.

Although CSDT is considered a valuable tool to explain how trauma changes helpers, some researchers are critical of the theory because it does not account for the positive changes that helpers can experience when working with trauma survivors (Dunkley & Whelan, 2006; Steed & Downing, 1998). In their discussion of thriving and crisis-related growth, Saakvitne et al. (1998) acknowledged the transformative potential of CSDT. These positive consequences, in contrast to the frequently reported negative effects of trauma work, are important factors in need of further investigation related to the well-being of helpers.

In summary, as the helper constructs new realities based on exposure to the client's trauma, their beliefs about themselves and their world changes. Although Steed and Downing (1998) stated that it is possible to transform the new constructions of reality in positive ways, the literature reports more negative consequences of STS, particularly in child welfare (Caringi, 2008). Such negative reports may be due to a lack of understanding of how to manage STS in the field of child welfare. The emotional well-being of child-protection social workers continues to be at risk (Caringi, 2008). This status influences attrition rates, and can lead to systemic instability in the field (Bride, 2007). Ultimately, these negative consequences may affect the outcomes of the children

that the child-welfare system tries to protect (K. U. Behrenz, personal communication, August 23, 2007).

Chapter Three

Contributing Factors of Secondary Traumatic Stress

As mentioned in the previous section, the helper's past experiences influence the client-helper interaction (Gergen, 1985), which in turn could impact the helper's STS levels. A helper's past experience is an example of an Individual factor contributing to the potential for STS. Apart from Individual factors, there are also Organizational and Incident factors that all contribute to an increased risk of STS. These three categories are discussed next.

Individual Factors

History. A helper's individual characteristics influence STS levels in various ways. One characteristic that has been identified as significant across different helper occupations is previous trauma history. In the field of child welfare, two studies found that previous trauma history increases social worker distress levels (Caringi, 2008; Nelson-Gardell & Harris, 2003). Among therapists, similar results were found in studies by Kassam-Adams (1995), Schauben and Frazier (1995), and Pearlman and MacIan (1995). These findings support the claim that previous trauma history increases the likelihood of STS.

In contrast, Stevens and Higgins (2002) found no relationship between childhood maltreatment trauma and an increased risk of STS in adult social workers. Stevens and Higgins concluded that despite no relationship, there were "high levels of depersonalization, emotional exhaustion, and trauma symptoms...reported by those [adult survivors] working with abused and neglected children" (p. 328). One major difference between this study and Pearlman and MacIan's (1995) research mentioned previously is

the subject participants' profession. Stevens and Higgins reported on child-welfare workers and Pearlman and MacIan studied counsellors. This occupational difference limits the generalizability of the findings related to distress levels among trauma workers. There are additional sample issues within these studies that constrained the findings, including reliance on self-selection, which may have resulted in an increased response rate by survivor therapists compared to non-survivors (Pearlman & MacIan, 1995). Low participant response rates, small, self-selected sample sizes, and use of retrospective recall regarding childhood maltreatment events also may have limited the meaningfulness of these studies (Steven & Higgins, 2002). The limitations listed previously must be acknowledged despite the usefulness of the research in terms of understanding whether a helper's trauma history is relevant to STS. Stevens and Higgins's research is particularly meaningful in the context of child welfare because it substantiates the experiences of child-protection social workers as STS. This research also supports survivors as professional helpers.

Gender. Gender is another Individual factor related to STS. This factor was studied by Bride (2004) in a meta-analysis to determine the impact of providing psychosocial services to trauma clients. Bride identified two studies that claim gender is a factor in STS. One study, by Kassam-Adams (1995), found that female therapists had increased symptoms of trauma compared to their male counterparts. The other study by Cornille and Meyers (1999) discovered differences in distress between male and female child-protection workers. Cornille and Meyers reported greater global distress as well as physical and obsessive-compulsive issues in female workers, whereas men's distress tended to be in the areas of interpersonal issues, phobia, paranoia, and psychosis. Gender

is an interesting factor related to STS and child welfare because there is greater male representation in protection work compared to social work in general, which tends to be a traditionally female-oriented profession (Regehr, Leslie, Howe & Chau, 2000). The above research suggested that men and women experience STS differently, and that gender may influence distress levels.

Coping styles. Many researchers identified coping style as an important Individual factor related to STS (Anderson, 2000; Caringi, 2008; Howe & McDonald, 2001; Regehr et al., 2004). In a cross-sectional study investigating coping mechanisms in veteran child-protection workers, Anderson divided coping styles into Individual and Organizational categories. Veteran workers were defined by Anderson as those who had worked for two or more years in the field. The term veteran seems inconsistent with a two-year time frame, although it is not surprising given the high attrition rates of social workers in the field of child protection (Bennett et al., 2005; Caringi, 2008; Howe & McDonald, 2001; Regehr et al., 2004). Two different coping styles associated with social workers include engaged (active) and disengaged (avoidant) strategies. Within these two categories, social workers who use engaged strategies are more likely to feel a sense of personal accomplishment and less depersonalization than those who use disengaged strategies. According to Anderson, neither coping style prevented workers from emotional exhaustion. Parry (as cited in Anderson, 2000) explained that social support, including collegial relationships, is strongly associated with maintaining well-being and continued employment in the field. Unfortunately, social support is reportedly used less often than problem-solving and cognitive restructuring (Anderson, 2000). These latter two coping mechanisms are more typically used by social workers despite being less beneficial

(Anderson, 2000). This may mean that workers rely more on themselves when dealing with STS than reaching out to others for assistance. However detrimental to individual workers, it appears that to succeed in the protection profession, particularly in the absence of trauma-informed systems (Ko et al., 2008), Individual factors such as self-reliance and resiliency are essential when facing STS.

Organizational Factors

In addition to the Individual factors of trauma history, gender, and coping styles mentioned above, there are also Organizational factors that influence how helpers experience STS. The following section identifies and reviews some of the organizational issues relevant to STS, which include: worker turnover, job category, work unit, workload, lack of agency acknowledgement of the problem, and finally, inadequate supervision.

Turnover. Worker turnover is identified as an important consideration in the field of child welfare. According to Ryan, Garnier, Zyphur, and Zhai (2006), caseworker turnover is a significant issue that reflects a relationship between the social worker and the organization. Studies suggest that children who experience a greater number of workers tend to have more negative outcomes (K. U. Behrenz, personal communication, August 23, 2007; Ryan et al., 2006). Social worker turnover appears to be related to psychological morbidity including STS (Bennett et al., 2005; Caringi, 2008). Although the Ryan et al. study conceptualized turnover in a context of burnout, which, as this paper argues, may represent a weakness in terms of accurately assessing social-worker experience, the study remains useful because it established a link between negative

outcomes for children and caseworker turnover. Additional research is required to isolate the reasons for social-worker departure from the field.

Systemic changes. One study did investigate the reasons for high departure rates in child-protection services in Canadian hospitals (Bennett et al., 2005). STS (described as psychological morbidity) was included in the study, which concluded that there is a potential crisis in the field (Bennett et al., 2005). The authors identified a need for systemic changes to avert massive losses in trained personnel within this specialized field. Bennett et al. suggested increased numbers of staff, better compensation, specialist training, and additional employee-assistance programs to mitigate the problem.

There are other systemic problems identified in the field of child welfare identified by Berg and Kelly (2000) that relate to perceptions of a damaged child-welfare system in the state of Michigan, USA. An evaluation of Michigan child-welfare organizations found systemic reasons for the problems, such as a culture of negativity (Berg & Kelly, 2000). Although an exhaustive review was conducted, these researchers limited their focus to the practices and policies within the system and did not mention STS as a deleterious factor. The effects of helping child-trauma survivors were seemingly not understood or not considered relevant to the discussion of the systemic problems in that region. Despite this omission, Berg and Kelly's review led to an overhaul of services in that region. The result, a renewed strengths-based approach to child welfare, changed the philosophy and the delivery of Michigan's child protective services.

Berg and Kelly's (2000) findings contributed to establishing new ways of working in child protection, and this likely laid the foundation for ongoing commitment toward better service provision in that area. However, the omission of STS as a potential

contributing factor to the systemic problems in child welfare may be illustrative of missed links between the perceived crisis in the profession and the emotional health of social workers who perform the job. There are a number of studies that suggested correlations between STS and child welfare work (Anderson, 2000; Bennett et al., 2005; Caringi, 2008; Ko et al., 2008; Regehr et al., 2004; Stevens & Higgins, 2002), yet Berg and Kelly's research demonstrated a lack of recognition of this issue. This oversight provides one example of how the perceived crisis in the system and the emotional experiences of the social workers providing the vital services to traumatized children remain under-investigated and misunderstood.

In contrast, more recent research conducted by Ko et al. (2008) recognized the need for an understanding of the impact of trauma on helping professionals. Systemic changes in the areas of child welfare, education, emergency services, health care and juvenile justice programs are essential, according to Ko et al., who call for "trauma-informed systems...to enhance the quality of care for...children" (p. 396). Ko et al. identified problems within existing child-serving systems that do not routinely account for or screen for trauma indicators, even though research suggests that trauma is a major factor affecting children and families today. Ko et al. believed that in child welfare, as well as other systems, protection services for children need to incorporate screening tools for trauma. If recognized in the field, such an acknowledgement would lead to better services for children facing traumatic events and increased understanding of STS experienced by the social workers who protect these vulnerable survivors.

Job category. Job category is another important factor related to job departure in protection services. Bennett et al. (2005) investigated whether job category was related to

departure rates in hospital-based child-protection units. In a cross-sectional study measuring burnout, psychological morbidity, and stress, Bennett et al. discovered that psychologists and protection social workers experienced the highest rates of burnout (including psychological morbidity). Physicians had higher levels of professional efficacy relative to the two other professions. Unfortunately, the concepts of psychological morbidity and burnout were not operationally well-defined in the Bennett et al. study. Although it is likely that those in the job categories with higher rates of morbidity were experiencing STS, the lack of conceptual definition makes it difficult to draw conclusions about the findings. For this reason, additional research to determine the extent of STS versus burnout in this specialized field is an important future direction.

Work unit. The findings in the Bennett et al. (2005) study related to job category in hospital-based child-protection units can be compared to Caringi's (2008) research that investigated work units in child-welfare protection agencies. Frontline child-protection workers experienced the greatest levels of STS, whereas other social-work functions such as foster care, adoption, and prevention had lower distress levels. Similarly, Bennett et al. concluded that frontline hospital social workers also experienced the highest morbidity.

Workload. Type of caseload is another issue related to STS. Kassam-Adams (1995) and Schauben and Frazier (1995) reported that therapists with high percentages of trauma clients on their caseload had heightened symptoms of PTSD. Those counsellors without cases involving trauma had fewer symptoms of STS (Arvay, 2002). Similar findings exist in the field of child welfare because protection caseloads have high percentages of trauma survivors (Caringi, 2008). These studies established that workloads consisting of high numbers of trauma survivors can increase risk of STS.

Lack of acknowledgement. Caringi (2008) identified lack of agency awareness as a major factor in STS. Although Caringi's study was limited to a sample of New York State child-protection workers, other studies also pointed to a lack of recognition (McCann & Pearlman, 1990) of STS in the field. Unfortunately, those agencies that do recognize the impact of trauma on protection social workers seem to be exceptions in the profession (Howe & McDonald, 2001).

There are indications, however, that workplace wellness programs are beginning to recognize the impact of trauma on child-protection social workers (D. Yip, personal communication, July 25, 2008). For example, the Vancouver Coastal region of the Ministry of Children and Family Development in British Columbia offered a one-day workplace wellness program that listed trauma-work as a factor related to workplace wellness (D. Yip, personal communication, July 25, 2008). For child-protection workers, this recognition is likely a welcome acknowledgement.

Adequate supervision. Anderson (2000) reported that inadequate supervision was a significant problem identified by protection workers. According to Anderson, adequate supervision and social support are the most helpful coping strategies for workers; however, these kinds of organizational strategies have been utilized less often than individualized coping methods. When agencies defer coping responsibility onto individual workers, stress-related problems can be misunderstood as personal problems rather than addressed as a systemic issue. In many child-welfare organizations, supervision is performed by former experienced frontline protection workers who may not have adequate training to support trauma exposure (Caringi, 2008). The lack of organizational response to the special needs of protection workers, such as ensuring

adequate clinical supervision, reveals either a potential lack of organizational understanding or priority of the issue of protection-worker trauma exposure.

Some professionals, such as family-violence counsellors, link specialized supervision to the well-being of trauma workers (McBride, 2008). McBride advised counsellor supervisors to be proactive in areas of prevention and protection to transform the negative effects of trauma exposure into more meaningful experiences for counsellors. This kind of specialized supervision is a positive organizational strategy and could be utilized in the field of child welfare to benefit protection workers.

Incident Factors

Incident factors, which refer to the number, frequency, and amount of time since the traumatic incident, influence levels of distress in helpers (Regehr et al., 2004). Dunkley and Whelan (2006) pointed out that trauma affects individuals in unique ways and that certain incidents impact helpers more than others. Child sexual abuse is one type of trauma that seems to increase distress responses in helpers (Dunkley & Whelan, 2006). Protection social workers deal with child sexual abuse regularly. In addition, frontline social workers experience critical incidents including deaths, assaults, and threats (Regehr et al., 2000). Regehr et al. found that Children's Aid intake social workers reported the highest Impact of Event Scale (IES) scores compared to other stressful occupations including firefighters and ambulance workers. Based on this study, incident factors inherent to protection work placed social workers at greater risk of STS when compared to other high-risk professions.

According to Cornille and Meyers (1999), more severe STS symptoms were reported by social workers who had worked longer in child protection. This finding is in

contrast to research by Anderson (2000), who found heightened distress in new social workers, whereas veteran workers had discovered coping strategies that help them feel better about their jobs. The Anderson findings make intuitive sense; those social workers who could not cope left the profession within the first few years of employment. Both of these studies suggest that duration of employment is an incident factor affecting the risk of STS.

The Individual, Organizational and Incident factors discussed above outline the various influences on STS. These factors can sometimes interact together, compounding the complexity of the helpers' experience of STS. Understanding the prevalence of the problem requires accurate assessment tools to measure the helper's experience. The following section examines the issue of formal measurement and STS, exposing further complexities related to the condition.

Chapter Four

Measurement

The preceding research (e.g., Anderson, 2000; Caringi, 2008; Figley, 1995; McCann & Pearlmann, 1990) suggested that there is a relationship between helping professionals engaged in trauma work and psychological morbidity. Due to the aforementioned ill-defined concepts related to STS, there are difficulties in interpreting data and making inferences from existing measurement tools. For example, Bride (2004) reviewed a study that measured STS using the Impact of Event Scale (IES), Traumatic Stress Institute Belief Scale (TSIBS) and the Spiritual Well-Being Scale. According to Bride's review, analysis of these measures indicated that therapists with high numbers of child sexual-abuse survivors on their caseloads did not have higher levels of trauma symptoms or disruptions in cognitions. Bride interpreted these results by concluding that high numbers of child trauma survivors on caseloads do not increase the likelihood of STS. This interpretation counters Figley's (1995) assertion that childhood trauma work increases vulnerability to STS. There are other comparative studies using similar measurement tools that confirm Figley's research (e.g., Ko et al., 2008; McCann & Pearlman, 1990; Stevens & Higgins, 2002). It is therefore difficult to draw conclusions from one study about specific risk factors for STS, such as whether higher numbers of survivors on caseloads increases the risks of STS.

One of the issues related to measurement and STS is that some scales used to assess STS were developed for other problems (Payne, 2004). The SCL-90-R is one example of a tool that was created to measure general psychiatric symptoms. These symptoms relate to nine factors that are associated with typical psychiatric cases

(Derogatis & Savitz, 1999). While the SCL-90-R may detect STS symptoms in individuals, elevated scores may be due to other psychiatric issues that are not specifically related to STS. For this reason, the validity of a test score attempting to measure STS exclusively is questionable and typically inappropriate.

Researchers have attempted to address these conceptual inconsistencies related to measurement and STS (Adams et al., 2006; Arvay, 2002; Bride, 2004; Bride et al., 2004; Dunkley & Whelan, 2006; Figley, 2002; Jenkins & Baird, 2002; Nelson-Gardell & Harris, 2003; Sabin-Farrell & Turpin, 2003). The goal of more recent research is to further define the characteristics of the concepts and increase validity and reliability (Jenkins & Baird, 2002). Some of the measurement tools that are used to assess trauma work and STS specifically are the Traumatic Stress Institute Belief Scale (TSI), which is commonly used to measure VT, and the Impact of Event Scale (IES), which measures VT, STS and burnout (Jenkins & Baird, 2002). The Compassion Fatigue Self-Test for Practitioners (CFST) is designed to measure STS/CF (Figley, 1995). There are also variations of the CFST scale such as the Compassion Satisfaction and Fatigue (CFS) test, which has been revised and renamed the Professional Quality of Life Scale (ProQOL) by Hudnall Stamm (2005). The Maslach Burnout Inventory (MBI) purportedly measures burnout (Sabin-Farell & Turpin, 2003).

Many of the above tools have been used interchangeably by researchers to measure different concepts related to workplace stress and the effects of trauma work on helping professionals (Sabin-Farrell & Turpin, 2003). This has led to considerable variation in terms of interpretation of findings and accurate measurement (Sabin-Farrell & Turpin, 2003). In the absence of a consistent definition of STS, accurate measurement

poses difficulties for researchers (Jenkins & Baird, 2002; Sabin-Farrell & Turpin, 2003; Schauben & Frazier, 1995). This has led to problems of validity, exacerbating the issue of construct confusion related to STS and other concepts. As a result, the true nature and impact of trauma work on helping professionals is not clearly understood. Clearer definitions of STS and related concepts would lessen the uncertainty regarding accuracy of measurement (Sabin-Farrell & Turpin, 2003).

Attempts to Determine Validity in Secondary Traumatic Stress

Jenkins and Baird (2002) conducted comparison studies using the CFST, TSI-BSL, MBI and Symptom Checklist (SCL-90-R) to determine the concurrent, discriminant, and construct validity between the STS, VT, burnout, and general distress, respectively. Jenkins and Baird found that the measurement scales of VT and STS resulted in good concurrent validity despite their conceptual differences. Jenkins and Baird found enough empirical and conceptual differences between STS and VT to define them as unique conditions. The researchers confirmed that VT relates to cognitive restructuring and that STS is symptom-focused. Thus, Jenkins and Baird recommended separate assessment tools to measure these unique constructs. Specifically, the researchers suggested using the TSI-BSL and the CFST-CF together to assess helpers' experiences of trauma work. Although these findings do not support the reconceptualization of STS to include VT as suggested in this paper, Jenkins and Baird contributed further understanding toward measurement tools and trauma work in various professions.

However, the recommendations made by Jenkins and Baird (2002) to use two tools when measuring STS may not be practicable in the field of child welfare. Given the

previous lack of recognition in the field, it is unlikely that protection agencies would have the resources or expertise to provide two tools to assess STS in protection workers. It is vital that child-protection workers become informed about the deleterious effects of trauma exposure, particularly because many workers view their challenges as symptoms of burnout (Nelson-Gardell & Harris, 2003). At this time in the devolution of knowledge related to STS in child welfare, the primary goal is to link trauma exposure and the emotional well-being of protection workers. Requiring two tools to assess the discrete constructs of STS and VT, as recommended by Jenkins and Baird, may confound the existing unawareness and confuse the problem further. In addition to potential prohibitive costs if two tools were needed, interpretation of results also becomes an issue. In this writer's opinion, it is more important to raise awareness about the deleterious effects of trauma exposure by providing a general definition of the effects of trauma exposure and a simple assessment tool than it is to focus on whether the emotional consequences are symptomatic or cognitive. For this reason, one tool should be utilized. Understanding the effects of trauma in general terms is a first step, hopefully leading toward trauma-informed systems in child-welfare services (Ko et al., 2008).

Other measurement problems relative to the CFST scale specifically were reported by Hudnall Stamm (2005) and Jenkins and Baird (2002), who identified problems with the psychometric properties of the scale. These researchers criticized the conceptual structure of the CFST because the scale purportedly measures burnout and CF (Jenkins & Baird, 2002). Due to these perceived difficulties separating constructs with this particular scale, Hudnall Stamm developed a revised version of the CFST, called the Professional Quality of Life (ProQOL) scale, which allegedly corrects these content-

validity issues. The reinvention of the scale, according to Hudnall Stamm, was intended to serve the dual purpose of correcting the psychometric issues of the CFST as well as stimulating positive organizational change (Hudnall Stamm, 2005). To this end, it was shortened to less than half the length of the earlier version, and only the questions with the strongest psychometric properties were kept, resulting in a more robust measurement tool (Hudnall Stamm, 2005).

In terms of applicability in the field of child welfare, the most suitable measurement tool to assess protection social-worker experiences of STS may be the ProQOL. This scale is useful because it isolates burnout from STS, an important distinction in this field due to previously mentioned misconceptions of protection social workers having experienced burnout rather than trauma effects. Accurately isolating the type of stress experienced by protection workers is integral to helping them define their experience, and to designing methods for individuals to transform their experiences to achieve positive growth. In addition to these useful qualities of the scale, the ProQOL provides a Compassion Satisfaction subscale, offering social workers increased understanding of positive aspects of their job. A sample of the ProQOL, and a score-handout are included in Appendices B and C respectively. This tool is included in this project as a sample assessment measure for the future development of a desk manual to help social workers understand and assess their experiences of STS.

Another validation study by Adams et al. (2006), to investigate the properties of the Compassion Fatigue Scale – Revised (CFS), which was previously developed by Figley (1995), surveyed a random sample of social workers. Adams et al. assessed the psychometric properties of the CFS and examined whether it is a predictive measure of

STS. The study successfully measured symptoms of STS, including intrusion, avoidance, and arousal, which had only previously been associated with PTSD. This research strengthens the association between the primary diagnosis of PTSD and secondary diagnosis of STS (Adams et al., 2006) by confirming that the symptomatology between diagnoses are consistent. This study is important because it contributes to consistency related to terminology. By describing STS to include CF, the study simplifies the constructs and contributes to the goal of this paper -- to redefine the many constructs related to trauma work as STS in the field of child welfare.

Despite the usefulness of the Adams et al. (2006) study, there are also limitations to the research. First, the scale did not successfully control for related issues such as depression, which means that factors other than what is being measured may contribute to the answers given by the subjects in the survey. As well, the random sampling used resulted in a homogeneous group of respondents. Therefore, the study cannot make claims related to the profession as a whole, nor can it be considered to be culturally sensitive (Offet-Gartner, 2005). It did, however, distinguish intrusion and avoidance as separate and unique symptoms of STS. For child-welfare social workers and other helpers working with traumatic events, this scale may be a useful tool for assessing risk and early prevention.

Another measurement tool, the Secondary Traumatic Stress Scale (STSS), also developed by Figley (1995), was validated by Bride et al. (2004) in a correlational study that sampled a large number of licensed Master's level social workers. The goal was to measure the frequency of STS, defined as intrusion, avoidance, and arousal symptoms (Bride et al., 2004). The study concluded that the STSS is a reliable and valid tool to

measure STS in social workers engaged in practice with traumatized clients. There were sample limitations, however, because the study excluded undergraduate and unlicensed social workers who may also have experienced symptoms of STS. Unfortunately, and perhaps due to a desire for a large enough sample size, the study did not control for type of social work performed. Although it is likely that at least some of the research participants worked with traumatized children in child protection, it is difficult to draw conclusions about the generalizability of the results to this specialized population of social workers. In addition to this methodological issue, the Bride et al. research may in fact have revealed a contradiction in a different study by Bride (2004) that claimed no greater risk of STS for those working with traumatized children. Despite its large size, the limited scope of the sample group, and lack of clarity regarding participant characteristics within the Bride et al. research, it claimed to provide a reliable and valid measure (*"Nature of Theory,"* n.d.) of STS.

Further methodological issues in the area of STS were reported by Sabin-Farrell and Turpin (2003), who explained that low response rates, selective sampling, type and duration of trauma exposure, and unsystematic designs are all problems associated with measurement. Part of the inconclusiveness alluded to by these researchers may be due to the complexities of the individuals who work with traumatized clients. For example, the research revealed that some professionals have trauma histories and this exposure inevitably alters their responses when compared to professionals without historical trauma exposure. Schauben and Frazier (1995) investigated the relationship between the number of trauma survivors on caseloads and helpers' symptoms of trauma, disrupted beliefs, and negative affect. Schauben and Frazier found a positive correlation between

the percentage of survivors on caseloads and increased disruptions in beliefs, symptoms of PTSD, and VT. Although the relationship between counsellor trauma history and increased emotional distress was investigated, the study found no increased risk of trauma symptoms in counsellors with trauma histories. This finding contradicts another study by Pearlman and MacIain (1995) who found increased TSI belief-scale scores in counsellors who had previous trauma histories. Such inconsistencies lead to questions about construct validity and reliability of test scores (Sabin-Farrell & Turpin, 2003). These contradictory findings in the literature reveal an ongoing need for continued research in the area of measurement and STS.

Chapter Five

Ethical Issues

As research becomes available regarding negative outcomes related to helpers engaged in trauma work with clients, the issue of professional ethics arises. Ethical practice concerns every professional engaged in helping relationships. As outlined by Sinclair and Pettifor (2001), one of the principles of ethical practice for psychologists is responsible caring. Within this standard, competence and self-knowledge are addressed. Included in this standard is the need for self-care, to ensure that a helper's own issues do not interfere with their ability to provide benefits to clients. The social workers' Code of Ethics has similar references to competence (British Columbia Association of Social Workers, 2002). Ethical considerations become an issue of particular importance when researchers (e.g., Arvay, 2002) investigated the traumatic exposure of therapists treating clients with PTSD, and found that the strongest mitigating factors against STS are education and training. This finding draws attention to the need for professional bodies and educational institutions to offer helping professionals advanced training in trauma work, and particularly STS.

Ethical practice standards are also a consideration for professionals who regularly use empathy with their clients (Figley, 1995). Nelson-Gardell and Harris (2003) argued that educators have not given social-work students sufficient information regarding the impact that empathy can have on their personal well-being. Adams and Riggs (2008) studied therapist trainees and found that a lack of training places students at increased risk of STS. These researchers believe that educational requirements should include intensive, semester-long trauma-specific training instead of in-class discussions or half-

day workshops that are the current practice in many settings (Adams & Riggs, 2008). It is encouraging to see that some educational institutions, such as the Faculty of Social Work at the University of Toronto, for example, link the effects of trauma with child-welfare practice (Lambert & Regehr, n.d.). Hopefully this trend will catch on with other schools in the future.

A review of the literature related to ethical considerations and STS leads to questions about the roles and responsibilities of individuals and professional organizations regarding the topic. These questions pertain to reasonable expectations of personal accountability on the part of individual practitioners and the ethical obligations of professional bodies and educational institutions to disseminate information and provide training. At the very least, it raises the question whether professional organizations can be confident in their members' abilities to manage their STS experiences. The area of STS is rife with ethical dilemmas that future research will undoubtedly continue to uncover.

Chapter Six

Transformative Models

Despite the myriad of ethical issues described in the previous section, positive steps toward increased understanding of the dilemmas facing helpers are beginning to take hold. One example is acknowledgement in the literature that the impact of STS is debilitating for helpers unless there is a process to transform the experience (McCann & Pearlman, 1990). McCann and Pearlman were at the forefront in the field of STS as seminal researchers who drew attention to the importance of transforming the helper's trauma from negative experiences toward achieving psychological well-being. McCann and Pearlman believed that emotional well-being is integral for the continued ability of the social worker to help survivors of trauma. Several different transformation strategies exist for helpers to transform their negative experiences.

Personal Strategies

Traumatic material transferred to helpers from trauma clients is a unique experience that can lead to significant alterations in the helper's worldview as well as disruptions in their functioning (Saakvitne & Pearlman, 1996). Personal strategies are available to helpers who experience disrupted schemas. These can pertain to various basic needs such as safety, trust, esteem, intimacy, and control (Pearlman & Saakvitne, 1995). Depending on the helper's personal history, certain trauma images may have a greater negative impact than others, as well as long-term consequences. Pearlman and Saakvitne recommended that the helper gain self-awareness by identifying and understanding which need the traumatic imagery is triggering. By isolating the need that

the helper defines as troubling, the individual gains insight and is more likely to find ways to cope and to manage the trauma exposure.

Personal strategies that can help manage trauma exposure and even counteract the effects of STS include regular routines of journaling and mindfulness practice to heighten awareness (Newsome, Chambers, Dahlen & Christopher, 2006). Individual counselling is also recommended to assist the helper in understanding the ways that he or she is affected by the trauma exposure (Pearlman & Saakvitne, 1995).

Organizational Strategies

Traumatic material requires processing within trauma-informed systems (Ko et al., 2008). According to Pearlman and Saakvitne (1995), it is integral for therapists to obtain clinical supervisory support to engage in such a process of awareness. For similar reasons, it can be argued that child-welfare workers must have access to trauma-informed, quality clinical supervision. However, these supports are often not available to child-welfare workers (Caringi, 2008).

One of the dilemmas facing many workers in the field is the risk of sharing personally traumatic experiences with other workers and supervisors, potentially increasing their stress. McCann and Pearlman (1990) cautioned helpers to maintain boundaries in this area and encourage open discussion about the need to declare limits to personal resources. This concern is mitigated by an encouraging aspect of Clemens's (2004) research, that STS is considered a preventable condition for social workers and other helpers in the field of trauma work.

A balance is needed between the ability of workers to verbalize the traumatic imagery while recognizing the added stress this support brings to colleagues (McCann &

Pearlman, 1990). Organizational support is integral to reaching this goal. If organizations view social workers' trauma reactions as normal, internalized responses to children's trauma, more appropriate organizational responses can be achieved. For example, agencies can help workers manage STS by ensuring that regular peer and supervisory debriefing occurs. In addition, agencies can offer in-service training in areas that address STS, such as mindfulness-based self-care (Newsome et al., 2006), for example.

Saakvitne and Pearlman (1996) developed a workbook to assist professionals who are engaged with trauma clients. Workbooks could be easily integrated into many workplace settings and readily used by many different professionals. Desire on the part of the organization is required, however, for workers to utilize such resources to transform trauma experiences. According to McCann and Pearlman (1990), the helper must be able to work through the traumatic experiences in a supportive environment. If this is not possible, helpers risk developing symptoms of stress disorders like STS, such as intrusive thoughts and emotional reactions (McCann & Pearlman, 1990).

Group work. Another organizational strategy that can transform negative STS experiences includes lessening feelings of isolation (McCann & Pearlman, 1990). Encouraging workers to engage in group work is one way to guard against isolation and move toward positive transformation (Clemens, 2004; McCann & Pearlman, 1990). The focus of group work can include normalizing the helper experience to assist workers in various fields, including child welfare (Clemens, 2004). One of the guiding principles of group work in this area states "although [STS] can have negative effects on both worker and client, with a responsive agency, worker self-awareness and practiced self-care, it can be prevented and corrected" (Clemens, 2004, p. 56). Successful support groups exist in

various forms, including one- and two-day models, facilitated by experienced professionals, who help to normalize the debilitating effects of STS.

Groups can also be used for group-setting analysis, specifically related to disrupted beliefs in individual's core need areas (Pearlman & Saakvitne, 1995). Examining one's core needs helps trauma workers determine which issues cause reactions (McCann & Pearlman, 1990). Clemens (2004) believed that STS can exist in any field where victims of trauma are helped, particularly those who work with individuals affected by violence, including child-protection workers. This group-work model is a useful way for trauma workers to cope as well as a method of prevention of STS. McCann and Pearlman suggested that one area in particular that tends to deplete the personal resources of helpers is exposure to serious violence against children. For helpers in the child-protection field, such findings provide evidence that STS exists. McCann and Pearlman's research is a welcome acknowledgement that exposure to this type of traumatic material is particularly challenging for child-welfare workers. Group-work strategies are an ideal format for child-protection workers who commonly work in specialized team environments (Caringi, 2008).

Knight (2006) is another proponent of group work for individuals engaged in trauma work. Support groups can be organized through professional bodies, particularly with the advent of technological resources such as telehealth and teleconferencing, making access to professional multi-disciplinary support achievable. These kinds of professional relationships require a proactive agency, a prerequisite identified by many researchers (Clemens, 2004; Knight, 2006; McCann & Pearlman, 1990; Pearlman &

Saakvitne, 1995) who discussed the impact of STS on workers and the value in promoting collegial relationships to transform the negative outcomes of trauma work.

Technological Solutions

Telehealth. When workers are geographically isolated, one strategy to combat the feelings of isolation that can accompany STS was discussed by Larsen, Hudnall Stamm, and Davis (2002), and relates to the use of technological solutions. Larsen et al. described both emotional and geographical isolation. There are many reasons why isolation occurs in helping professions, specifically, lack of resources, particularly in rural communities; global disaster zones, which can be geographically difficult to access; challenges with climate; socio-economic issues such as race, class, and poverty, among other reasons. Often added to these barriers is a lack of understanding on an organizational level regarding the impact of STS on helpers (Larsen et al., 2002). Some of these isolating scenarios can apply to child-welfare agencies.

According to Larsen et al. (2002), the use of telehealth systems helps to guard against personal and professional isolation. Telehealth utilizes telecommunications technology to provide various services from medicine to support programs (Larsen et al., 2002; Stamm, 2000). Through the use of such systems, multidisciplinary support models can be utilized, which expand professional knowledge and collegial relationships. For example, child-protection social workers and hospital personnel may have similar STS experiences. Telehealth enables communication between professions while building on working relationships. In addition, this kind of a system draws from a larger pool of clinical support. Each profession stands to gain from these kinds of professional connections. By linking child-welfare workers with other professions also known to

experience STS, increased understanding of the challenges facing protection social workers is more likely.

National websites. The National Child Traumatic Stress Network (NCTSN) is a website that is supported by researchers who call for trauma-informed systems in established child-serving agencies (Ko et al., 2008). The research grew out of a greater understanding of the negative impact of traumatic stress on children and families. The network is a national, collaborative effort between academic and community organizations. Their mission is to raise awareness and increase care standards for traumatized children (NCTSN, n.d.). Part of the network's goal is to provide trauma training for child-welfare social workers in a train-the-trainer format (NCTSN, 2008). The acknowledgement of the impact of trauma on children by a national network that is supported by research helps to address the primary needs of the children and by association, the secondary needs of the protection social workers and other professionals who work in the field and experience STS.

Training

Child-welfare agencies expend considerable resources preparing employees through extensive specialized training (Ministry of Children and Family Development, 2004), but the current focus of worker preparation is on understanding the effects of abuse and neglect as well as identifying and investigating child abuse. While in many child-welfare organizations there is increased acknowledgement of the negative impact that the work has on employees (Howe & McDonald, 2001), stress and burnout continue to be viewed as central causes of these negative effects instead of a much-needed broader understanding of the psychological risks of trauma work (Nelson-Gardell & Harris,

2003). New tools such as trauma training tool kits specifically designed for child-welfare agencies are becoming available (NCTSN, 2008), although agencies seem to be slow to provide this greatly needed training. Although the link between child protection and heightened risk of STS has been made in the literature, it has yet to be widely acknowledged in the child-welfare field (Caringi, 2008). Due to this lack of awareness, social workers are in need of tools to assist them in the identification and assessment of STS in their workplaces.

Peer Support

There are a few notable exceptions to the lack of recognition between child welfare and STS. Howe and McDonald (2001) linked the emotional health of social workers and organizational success in their study investigating staff retention problems in an agency in metropolitan Toronto. Howe and McDonald studied terminated employees to gain insight into reasons for high staff turnover. This qualitative study supported Howe and McDonald's hypothesis that STS is linked to attrition rates and general instability in the agency. These findings resulted in a philosophical shift in the agency toward reflection about what doesn't work (Howe & McDonald, 2001). Howe and McDonald drew on Figley's (1995) research related to STS to propose their ideas about peer-support teams in child welfare. The research was instrumental in substantiating a need for peer-support teams in the organization. The result of the research initiative linking STS and employee retention was the implementation of peer-support teams in the agency, which is now considered to be a leading approach in the field of child-welfare peer support.

Stevens and Higgins (2002), one of the few research teams writing specifically about child welfare and the effects of trauma, suggested finding support strategies for

workers who have increased levels of trauma symptoms. Peer support seems to be one positive method of transforming the effects of traumatic experiences. Berg and Kelly (2000) state:

Almost all of the workers report that they learn from the informal peer network they have developed on the job; thus, when they have doubts about a case, or encounter a shocking situation, they turn to each other for support, validating their perception. (p. 207)

According to Clemens (2004), in any agency that serves traumatized clients, support groups are necessary, either facilitated by specialists or led by peer-support teams.

Positive Growth

According to some researchers, PTSD and STS are considered normal human responses to trauma exposure (Figley, 1995; McCann & Pearlman, 1990). Given this perspective, some recommended that helpers be viewed in non-pathological terms. Instead of pathologizing helpers, researchers suggested awareness of CSDT, and recommended that helpers focus on their basic need areas to process the traumatic material. Such understanding of the condition is integral to transforming the experience from debilitation toward increased insight and emotional well-being (McCann & Pearlman, 1990).

There is growing research related to the positive outcomes of trauma exposure in helpers (Steed & Downing, 1998). This includes increased insight and well-being, which are sometimes described as the positive result of trauma or transformative growth (Regehr et al., 2004). For predictive purposes, Regehr et al. tested a hypothetical model to determine the impact of trauma on child-welfare workers. Post-traumatic growth,

defined as the capacity to perceive positive outcomes from traumatic experiences (Tedeschi and Calhoun, 2004) was also measured in the Regehr et al. study, and included factors such as self-reliance and feeling closer to others. This study found that heightened levels of distress are related to the degree of post-traumatic growth. Those who reported high levels of stress also experienced positive changes as a result, which, Regehr et al. suggested, is indicative of the insightfulness and resilience of social-work professionals. Research on post-traumatic growth is a promising field of study that will undoubtedly benefit some protection social workers in the longer term. However, prior to realizing such longer-term benefits, a first step is to inform protection workers about the deleterious effects of trauma work, including STS.

Chapter Seven

Solutions for Professionals Who Want to Prevent STS

Recent research is beginning to acknowledge the effects of trauma on helping professionals, particularly in public services (Caringi, 2008; Ko et al., 2008). This is evidenced by an emerging concept referred to as trauma-informed systems (Ko et al., 2008). Ko et al. studied the different systems involved in service provision to children and recommended the creation of trauma-informed systems to improve care. This study is part of a movement in the United States toward an increased understanding of the impact that trauma has on children. The national website NCTSN is the result of cooperation between academic and community-based organizations that understand the negative effects of trauma in society.

The relatively recent research of Caringi (2008) and Ko et al. (2008) identified above contributes to a better understanding of the impact of trauma on helping professionals. Other resources worth noting that also raise awareness related to the effects of trauma are journals such as *Traumatology*, edited by Charles Figley, who is an expert in the field of trauma. These resources place emphasis on trauma effects on helping professionals regardless of whether the conceptualization is related to VT, CF, or STS. This approach to understanding trauma is particularly relevant in the field of child welfare because it applies to the child survivors and the helpers who experience secondary trauma. As research confirms the deleterious effects of trauma on children and protection social workers, renewed understanding of trauma is an important aspect of improving outcomes (Caringi, 2008; Ko et al., 2008; Regehr et al., 2000; Regehr et al., 2004).

Future Directions for the Project

The literature reviewed in this project suggests that STS is a major issue facing professionals engaged with trauma survivors. Child-protection social workers are among those professionals at substantial risk of STS (Caringi, 2008). It appears, however, that employers and professional training programs are neither dealing with the problem nor preparing social workers for the eventuality of STS.

One way to raise awareness about STS in the field of child welfare is to provide social workers with a practical tool such as a manual that includes: (a) a description of the condition of STS, (b) a method to assess their individual status, and (c) recommendations for useful coping strategies so that they can recognize and deal with their experiences. A sample Table of Contents outline of such a manual is provided in Appendix A.

Ultimately, this type of tool is a necessary component of the process of information dissemination, transformation, and positive growth. Such a manual could be used as part of core training for new workers and also provided to those social workers currently working in the field.

To achieve the goals of this project and to raise awareness about the effects of trauma work in the field of child welfare, information about STS must be disseminated to professionals engaged in the work. To serve this purpose, a Table of Contents outline and sample assessment measure is included in the Appendices of this project, which may lead to the future development of a desk manual designed for frontline social workers. Such a manual should include a definition of STS to ensure that workers understand that it is a separate construct from burnout. The manual should also equate STS with the primary diagnosis of PTSD, so that social workers will become more informed about the

symptoms of intrusion, avoidance, and arousal. As well as explaining symptoms, the manual should also include information about cognitive changes experienced by those affected by trauma work. In this way, social workers will learn that STS is a combination of symptoms and changes to their inner cognitive experiences. The ProQOL scale (Hudnall Stamm, 2005) is recommended for inclusion in the manual (see Appendix B) so that social workers can assess their status and determine whether they are more affected by STS or burnout or both. A scale handout (see Appendix C) can also be provided for workers to understand the meaning of their scores relative to others. In addition, the manual should include information and tips to help social workers transform their experience of STS. Child-protection social workers need to know that one of the major aspects of transforming their trauma experiences is adequate supervision from supervisors who have specialized trauma training and are able to offer workers a safe environment to process their experiences (McBride, 2008). The manual should also incorporate useful references such as Saakvitne and Pearlman's (1996) workbook on transformation strategies, in addition to other resources such as relevant articles and websites for workers to gain more information about the meaning of their exposure to trauma. Social workers require information that teaches them about this particular workplace risk.

Summary and Conclusion

The field of child welfare requires a unified approach to understanding the impact of trauma in order to truly grasp the problem and provide responsive workplaces for child-protection social workers. Future directions in protective services require a more accurate understanding of the impact of trauma exposure rather than continued debate

about constructs and methodology. The review of the STS literature in this project reveals an added layer of complexity due to the continued lack of clarity related to concept definition. This complexity includes divisions within the constructs of STS and VT, although researchers such as Arvay (2002) are drawing attention to the need to relate the concepts. Maintaining the distinctions seems to be limiting professional understanding of the impact that trauma work has on protection workers in a way that hinders the field. Child-welfare organizations need to be part of the expanding study of trauma work and trauma-informed systems (Ko et al., 2008). This includes resources such as trauma-infused services (Ko et al., 2008), national website resources, and trauma training toolkits (NCTSN, 2008) applied to the field of child protection. The recent proliferation of trauma research should increase awareness of the effects of trauma on child-welfare workers and draw attention to the need for professional bodies to adhere to their ethical obligations to provide the necessary training and support.

The goals of this project, to link STS and problems in child-welfare work and to transform protection workers' experience of trauma exposure, are supported by research that confirms STS in protection social-worker experience (Anderson, 2000; Bennett et al., 2005; Bride, 2007; Bride et al., 2004; Caringi, 2008; Clemens, 2004; Hall, 2005; Howe & McDonald, 2001; Ko et al., 2008; Nelson-Gardell & Harris, 2003; Regehr et al., 2004; Regehr et al., 2000). Several of these researchers drew particular attention to the need for agencies to provide support on an organizational level as well as to encourage the development of individual coping strategies for social workers to manage STS (Anderson, 2000; Bennett et al., 2005; Bride, 2007; Caringi, 2008; Clemens, 2004; Howe & McDonald, 2001; Ko et al., 2008; Nelson-Gardell & Harris, 2003; Regehr et al., 2000).

As the risks associated with STS and frontline child-welfare work gain attention, further studies will be needed that address how systemic problems are related to social-worker emotional health. With additional studies, the effects of trauma on the emotional health of social workers, and its role in what has been called a crisis in child protection (Bennett et al., 2005), can be further addressed. This understanding can improve the education of social workers and their workplaces by helping identify the impact of trauma and providing a means to transform the negative experiences.

In addition to further research on the topic of STS in child welfare, one of the goals of this project is to inform readers about the effects of exposure to traumatic material. Rather than continue to perpetuate a divergence of the constructs VT and STS, by unifying the concepts under the rubric of STS, the focus becomes raising awareness, specifically for child-protection social workers. Raising awareness requires practical information and a method for social workers to determine the degree to which they are affected by the trauma work they perform. It is hoped that the above review combined with the future development of a desk manual based on the principles discussed in this project will assist in accomplishing this goal.

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Appendix A

A Proposed Table of Contents for a Child-Welfare Desk Manual on STS

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Appendix B

ProQOL R-IV

PROFESSIONAL QUALITY OF LIFE SCALE

Compassion Satisfaction and Fatigue Subscales—Revision IV

[Helping] people puts you in direct contact with their lives. As you probably have experienced, your compassion for those you *[help]* has both positive and negative aspects. We would like to ask you questions about your experiences, both positive and negative, as a *[helper]*. Consider each of the following questions about you and your current situation. Select the number that honestly reflects how frequently you experienced these characteristics in the *last 30 days*.

0=Never 1=Rarely 2=A Few Times 3=Somewhat Often 4=Often 5=Very Often

- _____ 1. I am happy.
- _____ 2. I am preoccupied with more than one person I *[help]*.
- _____ 3. I get satisfaction from being able to *[help]* people.
- _____ 4. I feel connected to others.
- _____ 5. I jump or am startled by unexpected sounds.
- _____ 6. I feel invigorated after working with those I *[help]*.
- _____ 7. I find it difficult to separate my personal life from my life as a *[helper]*.
- _____ 8. I am losing sleep over traumatic experiences of a person I *[help]*.
- _____ 9. I think that I might have been “infected” by the traumatic stress of those I *[help]*.
- _____ 10. I feel trapped by my work as a *[helper]*.
- _____ 11. Because of my *[helping]*, I have felt “on edge” about various things.
- _____ 12. I like my work as a *[helper]*.
- _____ 13. I feel depressed as a result of my work as a *[helper]*.
- _____ 14. I feel as though I am experiencing the trauma of someone I have *[helped]*.
- _____ 15. I have beliefs that sustain me.
- _____ 16. I am pleased with how I am able to keep up with *[helping]* techniques and protocols.

- _____ 17. I am the person I always wanted to be.
- _____ 18. My work makes me feel satisfied.
- _____ 19. Because of my work as a [*helper*], I feel exhausted.
- _____ 20. I have happy thoughts and feelings about those I [*help*] and how I could help them.
- _____ 21. I feel overwhelmed by the amount of work or the size of my case[*work*]/load I have
- _____ 22. I believe I can make a difference through my work.
- _____ 23. I avoid certain activities or situations because they remind me of frightening
- _____ 24. I am proud of what I can do to [*help*].
- _____ 25. As a result of my [*helping*], I have intrusive, frightening thoughts.
- _____ 26. I feel “bogged down” by the system.
- _____ 27. I have thoughts that I am a “success” as a [*helper*].
- _____ 28. I can't recall important parts of my work with trauma victims.
- _____ 29. I am a very sensitive person.
- _____ 30. I am happy that I chose to do this work.

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© B. Hudnall Stamm, 1997-2005. *Professional Quality of Life: Compassion Satisfaction and Fatigue Subscales, R-IV (ProQOL)*. <http://www.isu.edu/~bhstamm>. This test may be freely copied as long as (a) author is credited, (b) no changes are made other than those authorized below, and (c) it is not sold. You may substitute the appropriate target group for [*helper*] if that is not the best term. For example, if you are working with teachers, replace [*helper*] with teacher. Word changes may be made to any word in italicized square brackets to make the measure read more smoothly for a particular target group.

Disclaimer

This information is presented for educational purposes only. It is not a substitute for informed medical advice or training. Do not use this information to diagnose or treat a health problem without consulting a qualified health or mental health care provider. If you have concerns, contact your health care provider, mental health professional, or your community health center.

Self-scoring directions, if used as self-test

1. Be certain you respond to all items.
2. On some items the scores need to be reversed. Next to your response write the reverse of that score (i.e. 0=0, 1=5, 2=4, 3=3). Reverse the scores on these 5 items: 1, 4, 15, 17 and 29. Please note that the value 0 is not reversed, as its value is always null.
3. Mark the items for scoring:
 - a. Put an **X** by the 10 items that form the **Compassion Satisfaction Scale**: 3, 6, 12, 16, 18, 20, 22, 24, 27, 30.
 - b. Put a **check** by the 10 items on the **Burnout Scale**: 1, 4, 8, 10, 15, 17, 19, 21, 26, 29.
 - c. **Circle** the 10 items on the **Trauma/Compassion Fatigue Scale**: 2, 5, 7, 9, 11, 13, 14, 23, 25, 28.
4. Add the numbers you wrote next to the items for each set of items and compare with the theoretical scores.

Appendix C

Your Scores On The ProQOL: Professional Quality of Life Screening

For more information on the ProQOL, go to <http://www.isu.edu/~bhstamm>

Based on your responses, your personal scores are below. If you have any concerns, you should discuss them with a physical or mental health care professional.

Compassion Satisfaction _____

Compassion satisfaction is about the pleasure you derive from being able to do your work well. For example, you may feel like it is a pleasure to help others through your work. You may feel positively about your colleagues or your ability to contribute to the work setting or even the greater good of society. Higher scores on this scale represent a greater satisfaction related to your ability to be an effective caregiver in your job.

The average score is 37 (SD 7; alpha scale reliability .87). About 25% of people score higher than 42 and about 25% of people score below 33. If you are in the higher range, you probably derive a good deal of professional satisfaction from your position. If your scores are below 33, you may either find problems with your job, or there may be some other reason—for example, you might derive your satisfaction from activities other than your job.

Burnout _____

Most people have an intuitive idea of what burnout is. From the research perspective, burnout is associated with feelings of hopelessness and difficulties in dealing with work or in doing your job effectively. These negative feelings usually have a gradual onset. They can reflect the feeling that your efforts make no difference, or they can be associated with a very high workload or a non-supportive work environment. Higher scores on this scale mean that you are at higher risk for burnout.

The average score on the burnout scale is 22 (SD 6.0; alpha scale reliability .72). About 25% of people score above 27 and about 25% of people score below 18. If your score is below 18, this probably reflects positive feelings about your ability to be effective in your work. If you score above 27 you may wish to think about what at work makes you feel like you are not effective in your position. Your score may reflect your mood; perhaps you were having a “bad day” or are in need of some time off. If the high score persists or if it is reflective of other worries, it may be a cause for concern.

Compassion Fatigue/Secondary Trauma _____

Compassion fatigue (CF), also called secondary trauma (STS) and related to Vicarious Trauma (VT), is about your work-related, secondary exposure to extremely stressful events. For example, you may repeatedly hear stories about the traumatic things that happen to other people, commonly called VT. If your work puts you directly in the path of danger, such as being a soldier or humanitarian aide worker, this is not secondary exposure; your exposure is primary. However, if you are exposed to others’ traumatic events as a result of your work, such as in an emergency room or working with child protective services, this is secondary exposure. The symptoms of CF/STS are usually rapid in onset and associated with a particular event. They may include being afraid, having difficulty sleeping, having images of the upsetting event pop into your mind, or avoiding things that remind you of the event.

The average score on this scale is 13 (SD 6; alpha scale reliability .80). About 25% of people score below 8 and about 25% of people score above 17. If your score is above 17, you may want to take some time to think about what at work may be frightening to you or if there is some other reason for the elevated score. While higher scores do not mean that you do have a problem, they are an indication that you may want to examine how you feel about your work and your work environment. You may wish to discuss this with your supervisor, a colleague, or a health care professional.