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# Educating Child Welfare Workers about Secondary Traumatic Stress

LEARNING TO COPE AND TO HAVE A STRONG SOCIAL SUPPORT SYSTEM IS crucial to managing the effects of the traumatic stress of child welfare work. What complicates coping and social support for child welfare workers is that there is a need to have a professional support system and, at the same time, a separate, but equally important, support system of family and friends. Legal issues and the need to maintain clients' confidentiality prevent child welfare workers from being able to discuss their work with friends and family. Telling family and friends that you had a hard day at work may be all that can be shared. The worker is not able to say, "I interviewed a five-year-old little girl today who had been sexually molested by five different men who were also having sex with the child's mom, but the mom was drunk and passed out, and then I listened to an eight-year-old boy tell me that his stepfather burns him with cigarettes, and then I was called by the hospital because the emergency room had just admitted a baby who had been shaken and had head injuries. The baby will probably die or be a vegetable because the mom lost her temper. That was how my day was—how was yours?"

## A PSYCHOEDUCATIONAL MODEL FOR SECONDARY TRAUMATIC STRESS EDUCATION

Between 1997 and 2004, we conducted workshops with child welfare professionals in five states. Figley's Compassion Fatigue Self-Test was used, along with a demographic questionnaire, to collect information from participants regarding symptoms of secondary traumatic stress and burnout. The data analysis and findings can be found in Appendix A. The key findings were that child welfare professionals are affected by STS, and less so by burnout. Younger workers and workers with less experience in the field were more affected by STS. Individuals who had experienced childhood trauma had high STS scores. The 666 child welfare professionals we studied reported being affected by STS, and many had ten symptoms of secondary traumatic stress, as described by Figley. More than 50 percent of participants in all states reported feeling trapped and hopeless about their work with clients, being in danger while working with clients, avoiding thoughts and feelings about their clients, and having experienced trauma in their own lives as adults.

We used a psychoeducational model as the basis for developing our educational materials (Simon, 1997; Simon, McNeil, Franklin, & Cooperman, 1991). This approach incorporates emotional issues as part of the educational process. One of the first steps in coping is to develop knowledge and understanding of STS and how it is different from burnout. The second is to develop an understanding of how people normally respond to trauma and how it changes their worldview or psychological frame of reference. Third, a thorough understanding of the relationship between a worker and a traumatized client or clients must be achieved. Once this knowledge is acquired and participants have a conceptual framework for understanding how they may be traumatized by the work, then it is time to concentrate the educational process on coping and social support in both personal and professional arenas.

## STAYING COGNITIVE DURING STS EDUCATION: THINKING ABOUT FEELING

One of the most important things we have learned about introducing the concept of STS to child welfare workers, supervisors, and administrators is that workshop participants need to stay at a cognitive level and not let their emotions and memories of past experiences overwhelm them. In every child welfare workshop we conducted there was an abundance of work-related traumatic experience among the participants. We learned early on that if participants allow emotions to overwhelm them, it then becomes difficult to stay focused on learning. This is particularly important if the worker or the organization has recently experienced a traumatic event.

For example, in one workshop, a foster care worker had recently been chased by a psychotic adolescent wielding a butcher knife. The participant began emotionally breaking down when her feelings were aroused by memories of that event during a practical exercise using a fictional case example. One of the presenters took her aside and helped her regain her composure. She decided that the trauma was too fresh in her mind and that she could not continue in the workshop that day.

The way in which we help participants stay at a cognitive level is to encourage them to think about feelings rather than allow themselves to focus on their emotions during the workshop. It is important for participants to stay cognitive and in a learning mode. Staying cognitive also helps to prevent the workshop from disintegrating into a gripe session. Visual reminders are posted in the classroom to help keep the participants thinking and learning.

## GENDER ISSUES

We have also learned the importance of having two educators, preferably one male and one female, deliver the workshop. First, one of the educators may need to leave to assist someone who has become emotionally affected and in need of support. Second, if there are ongoing tensions in the workplace and participants are angry, two presenters can better diffuse the negativity that can detract from education. Third, because of the overwhelming number of women in the field, it helps the few males present to address any gender issues that may affect their traumatic stress ex-

periences in child welfare. Evidence suggests that men and women react differently to traumatic stress (Meyers & Cornille, 2002; Peirce, Newton, Buckley, & Keane, 2002; Tolin & Foa, 2002). It is important that all reactions and individual differences be acknowledged and respected.

## DIFFERENTIATING STS FROM BURNOUT

Many workers and supervisors intuitively understand that they are affected by their work, but most often they use the term "burnout" to describe what is actually STS. Developing a distinction between the words "trauma" and "burnout," and the experiences they represent, is one of the first participatory activities in the STS educational experience. STS workshop participants are asked to develop a list of descriptive words that they associate with trauma/traumatic stress—words that reflect their experiences with the work they do. Participants work in groups to generate lists of terms. Participants are presented with this statement: "When I hear the word 'trauma,' I automatically think ______________." They are instructed to fill in the blank with as many terms as they think of. The lists in table 1 were developed in seven workshops recently attended by child welfare workers, supervisors, and administrators.

**Table 1. Terms Generated by Workshop Participants to Describe Trauma/Traumatic Stress**

| | |
|---|---|
| Group 1 | danger, blood, emergency, pain, injury, emotional upset, anger, betrayal, death, destruction, fear, anxiety, 911, traumatized, harm, hurt, helplessness, hopelessness, sudden, panic, chaos, reactive, uncertainty |
| Group 2 | disaster, severe accident, turmoil, tear, emergency room, pain, victim, death, hurt, abuse, sick, rape, unhealthy, helpless, hopeless, isolated, blood, cuts |
| Group 3 | physical injury, emotional upset, violence, crisis, death, helplessness, hopelessness, loss, pain, blood, burn, broken bones, bruises, emergency room, sickness |
| Group 4 | life threatening, change, mass destruction, emergency room, fear, powerlessness, terror, paralysis, loss of control, shock, helplessness, hopelessness, low self-esteem, death, injury, accident, loss of family, loss, rape, abuse, violence |
| Group 5 | emergency, disaster, harmful, serious injury, despair, grief, life altering, devastation, blood, graphic images, stress, violence, pain, major event, chaos, hopeless, helpless, victim, scarring emotions, loss of control, death, emergency room, super-intense, impact |
| Group 6 | bad, pain, danger, frighten, shock, sudden, crisis, harm, stress, hurt, anger, scared, anxious, helplessness, hopelessness, blood, cut, depression, emergency room |
| Group 7 | pain, injury, suffering, fear, disruption, loss, stress, death, disability, loss of control, assault, anxiety, helpless, hopeless |

Once this list has been discussed, the participants are then asked to list terms they associate with the word "burnout." The participants are instructed to complete the statement "A burned-out colleague is ______________." The lists are shown in table 2.

**Table 2. Terms Generated by Workshop Participants to Describe Burnout**

| | |
|---|---|
| Group 1 | tired, underpaid, angry, frustrated, abused, immobile, unwilling, unfocused, unappreciated, ineffective, invisible, absent, physical, overwhelmed |
| Group 2 | irritable, tired, don't care, messy desk, irrational, angry, late, apathetic, tardy, resistant, frustrated, uninvolved, unmotivated |
| Group 3 | lethargic, passive-aggressive, apathetic, overwhelmed, dangerous, dumped on, stressed, not appreciated, low evaluation, angry, irritable, sarcastic, cusses, hopeless, not productive, frustrated, postal, depressed, withdrawal, absent, insecure, paranoid |
| Group 4 | tired, irritable, frustrated, pregnant, stressed, don't perform, passive-aggressive, procrastinate, uncaring, absent, hostile, uncooperative, impatient, insubordinate |
| Group 5 | depressed, stressed, blaming, job paralysis, no control, no way out, overwhelmed, dreading to work, rigid, combative, ready to quit, no empathy, no creativity, absent, tired, snappy, can't make a decision |
| Group 6 | tired, detached, ineffective, emotionally blunt, overwhelmed, noncompassionate, angry, unproductive, don't care, procrastination, hopeless, resentful, agitated, absent, mentally stressed, unfulfilled, irritable, frustrated, postal, nervous, blaming, confrontational |
| Group 7 | tired, hopeless, unmotivated, uncooperative, late, passive-aggressive, nonchalant, irritable, bipolar, apathetic, immobile, rationalize behavior, defensive, insensitive, negative, nonproductive, absent, isolated, paralyzed, self-destructive, postal, witch, cancer sore, self-medicating |

When the participants compare the two sets of terms, there are a few similarities, but there are many more differences between the lists. For example, "death," "pain," "injury," and "emergency room" don't appear on the list of terms related to burnout, nor do "blood," "burns," "broken bones," and "bruises." Traumatic stress is a different phenomenon from burnout, and as we found in our study, STS is more pervasive than burnout. The sources of the phenomena are different. Traumatic stress comes from the helper's relationship with a traumatized client or clients. Burnout occurs in organizations typified by high demands and low personal rewards. Workshop participants will say that they knew something was wrong and they didn't think they were burned out, but they didn't have a term for what they were experiencing. The bad news is that there is not much that can be done about burnout other than changing the organizational culture or changing where one works. In contrast, there are effective interventions for STS, and that is the good news.

## HOW HUMAN BEINGS RESPOND TO TRAUMA

The next issue addressed is how people respond to trauma. Continuing to work in their groups, participants were asked to identify the ways people respond to trauma

on an emotional, cognitive (intrusive and perceptual), physiological, behavioral (acting), and interpersonal (interacting) level. The groups' responses (shown in table 3) are consistent with what theory predicts and research demonstrates (Figley, 1995; Morrissette, 2004) and what is found in the diagnostic criteria for 309.81 Posttraumatic Stress Disorder.

**Table 3. Terms Generated by Workshop Participants to Describe Responses to Trauma**

| | |
|---|---|
| Emotional | Feeling stressed, anxious, overwhelmed, fearful, fatigued, guilt, numb, tearful, depressed, angry, sad, enraged, a loss of control, worried, shameful, lonely, shocked, frustrated, edgy, guilt, helpless, hopeless |
| Intrusive Cognitions | Having thoughts of the event when you are trying to not think about it, dreams, nightmares, flashbacks, ruminations |
| Perceptual Cognitions | Experiencing an altered outlook, memory loss, a decreased interest in favorite activities, dissociation, a loss of innocence, detachment, impaired cognition (inability to think straight), paranoia, a decline in intellectual functioning, poor concentration, thoughts of harming others, a lack of focus, an altered worldview, jaded thoughts |
| Physiological | Developing clinical depression, ulcers, headaches, migraines, immune system malfunctions, hypertension, hypotension, anxiety disorders, irritable bowel syndrome, crying spells for unknown reasons, memory loss, fatigue, chronic fatigue syndrome, sweating, hyperarousal, substance abuse problems and addictions, overeating, illnesses, sweaty palms, panic attacks, trembling, gastrointestinal problems, chest pain, adrenaline rushes, sleep disruptions, changes in appetite, an increased startle response |
| Behavioral | Being tearful, overreactive, numb, forgetful, sleepy, unable to concentrate, nervous, an excessive substance user, socially withdrawn from others, oversensitive, blameful, easily irritated, paranoid, less spiritual, detached, aggressive, impatient, nervous, overprotective of children, hateful, inappropriate with laughter, untrusting, hurtful to self or others, negative, a thrill seeker, unsympathetic, judgmental |
| Interpersonal | Experiencing codependency, isolation from others, loss of trust, withdrawal, loss of interest in sex, loss of intimacy, withdrawal of support for others, blaming others, family problems, problems with coworkers, problems with children, damaged relationships, divorce, inappropriate relationships, loss of friends |

Child welfare workers, supervisors, and administrators are fairly consistent in their thoughts about emotional reactions to trauma. Many report numbing and distancing in order to be able to intervene in a traumatic situation. They also share that it is sometimes difficult to get in touch with their feelings because so much of the

work is painful. They agree that this makes maintaining interpersonal relationships a challenge. Participants in the STS workshops clearly want to leave the work at the workplace when they go home, but the nature of trauma makes that difficult. They indicate that it is difficult to stop thinking and worrying about the children and families with whom they work at the end of the day. It is not uncommon for these professionals to experience intrusive thoughts or to ruminate about a difficult case, especially if they have become hypervigilant about a client or more than one client. Several workers reported that they had been at the movies on the weekend and suddenly became anxious about a client or case, rendering them unable to concentrate on the movie. Others reported being in church and finding themselves thinking about a child or a family. These professionals experience a fair amount of work-related intrusion into their personal time that often prevents them from staying present for family, friends, or themselves.

Child welfare workers are very much aware that they are changed by the work they do. They know what they do is not "normal," and that others do not understand what they do. They experience a loss of innocence as a price of protecting children and helping families who live in some of the worst conditions. They experience an altered worldview because of what they encounter daily. Many state that it is hard not to look at a perfectly innocent interaction between a child and an adult and wonder if something bad is going on. They also say it is hard to maintain knowledge and awareness that there are stable and healthy families who care for their children and protect them from harm.

Trauma takes a toll on physiology and brain functioning (Scaer, 2001; Van der Kolk, 1996). Dienstbier (1989) demonstrated that levels of catecholamine and cortisol in the brains of workers in high-strain jobs with chronic stress and little control can become elevated and not return to normal levels. It is thought that chronic stress alters one's physiology and contributes to both physical and mental health problems. Child welfare workers know this all too well and are quick to tell of periods of illness they experienced during difficult cases or following difficult cases. Posttraumatic stress affects both physical and mental health in a variety of ways (Friedman & Schnurr, 1995; Schnurr, 1996; Wagner, Wolfe, Rotnitsky, Proctor, & Erickson, 2000). Posttraumatic stress increases vulnerability to heart disease and hypertension and may produce abnormalities in hormones and their ability to function normally. It produces changes in the immune system that lead to opportunistic infections, and it may produce alterations in the body's ability to identify and manage pain (Scaer, 2001). Posttraumatic stress also produces changes in brain chemistry that may lead to depression and poor coping skills. It can also lead to increased anger and hostility, which can contribute to troubled interpersonal relationships. Individuals suffering from posttraumatic stress may increase their use of substances such as alcohol, tobacco, or other drugs in an attempt to moderate the negative effects produced by such stress. In a recent study of 30,800 female veterans, Frayne and her colleagues (2004) found that women with a diagnosis of PTSD had poorer health than those without the diagnosis. Child welfare workers may be at risk for poor health because of the impact that

STS, a form of posttraumatic stress, has on their neurochemistry and physiology. Indeed, it is possible that child welfare work has the potential to make workers sick.

Trauma work also affects behavior. Child welfare workers, supervisors, and administrators have no difficulty identifying ways in which trauma alters their behavior. Participants in all the groups we have worked with have become overprotective of their own children and grandchildren. It is not uncommon for them to interrogate their children when they want to stay overnight at a friend's house. One grandmother, a child welfare supervisor, shared that before her nine-year-old granddaughter is allowed to stay overnight with a friend, the grandmother goes over how to say "no" and "good touch, bad touch." The grandmother, who related that she doesn't sleep well, asked if such anxiety is normal. Because of the nature of the work and her observations of the terrible things that are done to children, her anxiety is to be expected.

Workers often observe how their behavior is affected by work when they go to the grocery store at the end of the workday. In the store, a toddler starts crying and a mother's or father's voice gets tense and then angry as she or he responds to the child. The worker, who merely wants to get his or her groceries and go home, becomes anxious and concerned for the child and may move his or her grocery basket in the direction of the sounds just to be sure everything is all right. Other people in the store may be thinking, "That baby is tired and needs a nap," or "I'm glad I left my child at home with his dad." Because of the work they do, workers know that the tension between the parent and child may escalate and lead to verbal or physical harm. Informed by the child welfare environment, the worker's worldview is different from those of the other people in the store. Other people do not know the terrible things that children experience.

The final area the child welfare professionals frequently address is what happens in their interpersonal relationships with colleagues and significant others. Many participants share that what can be most harmful to them is the impact the work has on their personal and family life. Workers and supervisors who are regularly involved in cases of sexual abuse of children and adolescents relate that at times they have lost interest in sex and intimacy, and that has taken a toll on their personal relationships. Similarly, because others do not understand their work, they feel socially isolated and avoid revealing to others what they do. The reaction of people not involved in child welfare is normally, "How can you do that?" or "Let me tell you about a situation I know of." One worker shared that she tells people that she is a hairdresser and changes the subject. Another common response is that the work causes a lack of trust and loss of compassion. A common phrase that comes up is, "It's like nothing matters anymore." A seasoned worker shared that she does background checks on potential dates just to be sure they don't have a criminal record. What these child welfare professionals are saying is that their worldview has been changed. They are not the same people they were before they began working in child welfare. They will tell you that they work in a world where people do evil things to babies, children, and adolescents.

## UNDERSTANDING HOW TRAUMA CHANGES THE PSYCHOLOGICAL FRAME OF REFERENCE OR WORLDVIEW

The next step to understanding STS is to understand how experience in child welfare changes the worker's psychological frame of reference or worldview. This is best explained by McCann and Pearlman's (1990) use of constructivist self-development theory. They explain that the concept of self is central to each person's worldview. Self is who we think we are, and it is through the self that we experience and interpret the world and how we define the meanings we discover in life. From the time we are born, we develop our self, and that self continues to develop across our life span. Central to self are cognitive schemata that define psychological needs related to how the self is constructed and develops. The cognitive schemata are safety, trust/dependency, independence, power, esteem, intimacy, and control (McCann & Pearlman, 1990, p. 59).

McCann and Pearlman argue that safety is a major theme throughout life. Safety is a need for all humans, and as Janoff-Bullman (1989) pointed out, the reality of the world is that it is not safe, and we engage in illusions of safety as a means to function in an unsafe world. From the time we are born, we hope to be protected from harm. If we are protected from harm in our early years, then we will most likely develop positive safety schemata. While we know that bad things happen in the world, we have not experienced them to the degree that we feel unsafe.

Similarly, we have a need for trust and dependency. As McCann and Pearlman demonstrate, we need to be able to count on others and receive support from others, and that includes self-trust. If children are cared for and their needs are met, they are likely to develop a positive trust schema, believing that they can count on being cared for. This schema will continue to develop positively through adolescence and into adulthood, provided the majority of their experiences with trust are positive.

McCann and Pearlman (1990) describe independence as "the need to control one's own rewards or punishments or to be in control of one's behavior and destiny" (p. 71). Independence schemata have to do with being in charge of, and in control of, one's self. This schema allows individuals to believe that they can make things happen through their own actions and choices.

McCann and Pearlman argue that, in contrast to independence, power is related to having control over the environment in which one lives. The degree to which a child exerts control in his or her environment contributes to the development of a positive power schema. If environmental control continues throughout adolescence and into adulthood, the power schema will be such that the individual believes that he or she exerts some control over the environment and can make things happen in that environment.

Esteem is another cognitive schema related to self. McCann and Pearlman (1990) define esteem as the "belief in one's value," which is "rooted in the need for recognition or validation" (p. 73). When we have positive self-esteem, we tend to feel positive about others and their value as humans. Like other cognitive schemata,

esteem develops in childhood and grows throughout adolescence to adulthood. If life experiences, particularly interactions with family and friends, reinforce positive esteem, then an individual will develop a positive cognitive schema of self-esteem and have esteem for others.

The last cognitive schema related to psychological needs presented in McCann and Pearlman's theory is intimacy. Without connection to others and oneself, individuals become isolated. Intimacy is a combination of belonging and feeling safe in the presence of other people, as well as feelings of being connected to others. Intimacy is considered by McCann and Pearlman to be fragile and easily damaged. Like the other schemata, intimacy is developed across the life span, and with positive experiences, the developed schema will be positive.

Cognitive schemata are highly individualized and reflect the cumulative experiences of each individual across the life span. Traumatic stress changes cognitive schemata, and the traumatic experiences become integrated into the cognitive schemata. In the first chapter we used the example of the car accident to illustrate how cognitive schemata were changed by a traumatic experience. Changes in cognitive schemata contribute to changes in each individual's worldview or psychological frame of reference. Child welfare practitioners are vulnerable to changes in their cognitive schemata because of the work they do and the conditions under which they work. The consequence of these changes is an alteration in individual worldview and psychological frame of reference, which may result in the development of symptoms of posttraumatic stress, such as feeling isolated from others or having intrusive thoughts or persistent numbing. As noted in the first chapter, a practitioner may start to see the world through the lens of the client's experiences, especially those of children who have been badly hurt or killed. The practitioner may become cynical and distrustful as he or she sees the effects of trauma on children and adolescents over and over again. In addition, the work itself is dangerous, and workers may experience threats or physical harm to their bodies or to their property (Curl, 1998; Meyers & Cornille, 2002; Stanley & Goddard, 2002). Tragically, practitioners may lose their connection to their spiritual selves and feel that life has no meaning (Rogers, 2002).

Child welfare practitioners can manage the effects of posttraumatic stress. They can learn to protect their worldview. The metaphor we have used from the beginning in delivering STS education is "learning to dump your bucket." We refer to it as a pain bucket model. It was developed by one of the authors, who worked for a time with Vietnam veterans with well-developed PTSD. Getting veterans to express their feelings was often difficult, and the metaphor seemed to work. It has also worked well over the years for other helping professionals, including child welfare professionals.

## DUMPING YOUR BUCKET

In the workshop, this metaphor is presented by an instructor, who sketches a bucket on a flip chart that all can see. Pleasant and unpleasant life experiences

collect across the individual's life span and slowly fill the bucket. The premise is that the capacity of one's bucket is finite. The child welfare worker brings to the work his or her bucket of life experiences, certainly including personal trauma history. Child welfare practitioners use empathic engagement to facilitate relationship development with clients and to gather the information they need to provide effective help. They collect information about the traumatic experiences of their clients. Those experiences accumulate over time and add to the contents of the worker's bucket. Some of the clients' experiences may be particularly horrific.

The bucket slowly fills and ultimately spills over, interfering with the work and the practitioner's personal and professional life. The spilled contents of the bucket are contagious, as others—friends, family, colleagues—are stepping in the mess, getting it on themselves, and tracking it about. The workplace and home are all affected adversely, and relationships predictably suffer. The quality of personal and professional relationships deteriorates.

## PERSONAL TRAUMA HISTORY

If the practitioner has a personal trauma history, he or she may be more vulnerable to the effects of STS, especially when a client's traumatic experience is similar to his or her own (Cunningham, 2003; Nelson-Gardell & Harris, 2003; Pearlman & Mac Ian, 1995). If the practitioner's own traumatic experience is unresolved, its effects may become exacerbated. Child welfare professionals can be taught methods of coping effectively with traumatic stress. These methods include both individual and social support strategies. These strategies allow the worker to dump his or her bucket, keeping the experiences away from the top of the bucket so that they do not spill over and contaminate the helping relationship as well as the practitioner's personal life.

## COPING WITH SECONDARY TRAUMATIC STRESS AND USING SOCIAL SUPPORT

The goal of coping is to protect the child welfare practitioner's worldview and psychological frame of reference in order to reduce the impact of STS on his or her work and life. There are several intermediate objectives in learning to cope effectively: (1) to understand and accept one's vulnerability to STS; (2) to learn to balance the needs of the client, the agency, and oneself; (3) to understand the role of supervision in mitigating emotional stress; (4) to recognize when one's self-care system is not working; and (5) to recognize negative and positive coping behaviors.

## SELF-ASSESSMENT

Understanding and accepting one's vulnerability to STS requires the practitioner to undertake a self-assessment. Child welfare practitioners bring a variety of ego resources, self-capacities, and personal characteristics to their work. These include both strengths and vulnerabilities. We know that many people are drawn to this work because of their own life experiences, and those experiences may include

a personal trauma history. It is important to understand how a personal trauma history increases one's vulnerability to STS. Undertaking a self-assessment involves examining the way in which our personal factors influence our coping skills. There are five areas to examine: (1) physical self-care, (2) social self-care, (3) emotional self-care, (4) personal trauma history, and (5) disbelief and dismissal trauma.

## PHYSICAL SELF-CARE

Physical self-care is under the control of the child welfare practitioner. Practitioners report that there are several activities that contribute to their physical well-being: sleep, rest, exercise, good nutrition, reliable transportation, massages, hot tubs, and sex are frequently mentioned. While each of these is important to physical self-care, exercise is crucial. The stress, especially traumatic stress, of child welfare work takes a toll on the body. Skovholt (2001) refers to this as living in an "ocean of stress emotions" (p. 87). Physical exercise protects the human body from heart disease, stroke, high blood pressure, obesity, back pain, osteoporosis, diabetes, and myriad other health risks. Regular exercise also contributes to a healthy immune system, promotes bone density and healthy blood sugar levels, and increases levels of HDL (good) cholesterol. Physical exercise also releases endorphins, which make us feel good. There is increasing evidence that moderate exercise, such as a brisk thirty-minute walk daily, can be beneficial. Exercise has also been shown to reduce the risk of depression and to improve mood. Duke University conducted a study of exercise and depression and found that depressed individuals who exercised for thirty minutes three times a week resolved their depression in a few months, without antidepressants (Blumenthal, Babyak, Moore, Craighead, Herman, Khatri, et al., 1999). Similar results have been found in other studies (Craft, 2005). Additional benefits of exercise include improved sleep, less anxiety, and improved sexual performance and sexual pleasure (Krucoff & Krucoff, 2000; Staten & Yeager, 2003).

Child welfare practitioners find innovative ways to exercise at work, such as taking the stairs or a brisk thirty-minute walk at lunch. Some park their cars at a distance from their office buildings to increase the distance they walk. One group obtained permission to use a large room for a thirty-minute aerobics session at the end of the workday. Many join health clubs and make exercise appointments on their calendars to ensure that they go. Others say that doing exercise in a group helps them to sustain the practice.

It is important that the practitioner have a good relationship with his or her family physician. If the family physician is aware of the traumatic stress of the work, then he or she will be in a good position to help the practitioner monitor health concerns and ensure that he or she is treated accordingly. The physician can also assess when brain chemistry has been altered and can help the worker decide on the most effective intervention. There are times when exercise is beneficial but additional interventions are needed. When exercise helps, but the practitioner still finds him- or herself depressed, the family physician may find it necessary to prescribe antidepressants.

## SOCIAL SELF-CARE

Social support is a complex phenomenon, and individuals may both seek and provide it. Payne and Jones (1987) identified 192 ways to measure social support. Our interest is to discuss personal social support and what it does for the child welfare practitioner. Social support helps the practitioner maintain a balance in his or her worldview and positive cognitive schemata. Vaux (1988) maintains that social support is a transactional process subject to personal and contextual influences. Personal social support needs are defined by the practitioner as what suits him or her best. One practitioner may find having interactions and activities with friends meets his or her needs best. Another may find that quiet time with a confidant brings greater renewal than being in a crowd. Each practitioner must learn what his or her support needs are and how to best meet them.

Cohen (2002) argued that having “diverse sources of support (e.g., a spouse, children, friends, workmates, and fellow social and religious members) is associated with greater resistance to infectious agents” (p. 113). He wrote that it is possible that this diverse network of social relationships contributes to individual choices such as exercising and alcohol use. Additional benefits are the promotion of positive psychological states and the reduction of negative states. This contributes to being motivated to take care of oneself and to having multiple sources of information, which may influence well-being.

Social self-care has two aspects: intrapersonal and interpersonal. Each practitioner needs to assess how the work affects him or her personally. Once practitioners acknowledge the ways they are affected by the work, they are then in a position to enjoy the positive aspects and address the negative effects. This is individualized work and requires reflection on the part of the practitioner.

One issue that frequently comes up in discussion is making the transition from work to home or how to leave the work at the workplace. What some child welfare workers share is that they have developed rituals for making this transition. Some change clothes before they leave their office and put on exercise clothing, or what one individual called “play clothes.” One worker developed a ritual with her family so that when she arrived home, she put on her walking shoes and walked a couple of miles before interacting with her family. Many say a hot shower or bath works for them. Rituals help make the transition from work to home easier. They also help the practitioner give her- or himself permission to leave work behind.

Interpersonal social self-care is having a life outside of work that involves doing what the practitioner enjoys and spending fun time with family and friends. There are a variety of ways workers make this happen. Having a supportive family and supportive friends who understand the difficulty of the practitioner’s work but also appreciate the importance of confidentiality is essential.

## SPIRITUALITY

Maintaining a spiritual life has been found by many workshop participants to be another essential practice. Many say that their spirituality is challenged by the

evil they encounter and that staying in a relationship with God and staying in the fight are important to staying with the work. As Rogers (2002) pointed out, "A person's spiritual nature produces qualities such as compassion, forgiveness, love, faith, hope, trust, generosity, and kindness. These characteristics are affected by evil, which produces suffering, leading to the stifling or destruction of some aspect of spirit" (p. 31).

Spirituality has also been shown to lower traumatic stress (Lee & Waters, 2003). These researchers found that age and spirituality were strongly correlated with decline in trauma symptoms. They found that as spirituality increased, trauma symptoms decreased. Lee and Waters concluded that spirituality is a protective buffer for cumulative traumatic experiences. Maintaining a spiritual life helps practitioners keep their worldview balanced and their belief system intact in a world of good and evil and helps them remember that there are happy, stable, healthy people and children who are cared for and who care for each other.

## EMOTIONAL SELF-CARE

Emotional self-care also involves self-reflection and has intrapersonal and interpersonal aspects as well. Each practitioner can assess how the work is affecting him or her emotionally. Periodically taking the Compassion Fatigue Self-Test is one way to monitor the ways in which one may be affected. In the times that are most difficult, practitioners benefit from having someone to talk with, whether that is a colleague or supervisor. It may also be necessary to seek professional counseling when intrusive thoughts, rumination, and an inability to leave the work at the workplace become the rule rather than the exception. Practitioners can support each other in seeking help when they recognize intrusive thoughts and rumination in each other.

Interpersonal aspects of emotional self-care involve being able to be intimately connected to significant others and friends (Tedeschi & Calhoun, 1995). This involves having an emotional life outside of work and not allowing the work to intrude into personal time. Staying present with family and friends and being close to others is pertinent to maintaining a balanced worldview, as are having hobbies and engaging in activities that bring renewal of spirit and soul.

## MANAGING DISBELIEF AND DISMISSAL TRAUMA

In chapter 2, we argued that disbelief and dismissal trauma occurs when the practitioner's beliefs are violated. We also argued that this violation is what causes many workers to give up the work and leave the field. Belief violations are particularly difficult when other professionals refuse to believe that a child is being harmed when the evidence is overwhelming.

One practitioner was told by a judge to return a child to her home in spite of the evidence, which meant that she would be sexually abused by her father. She was told that she would be held in contempt of court if she refused. The worker left the courtroom then returned and, facing the judge squarely, told the judge that if it was his

opinion that regardless of the evidence the child should be returned home, then he could put her in jail, and he could return the child to her home and take responsibility for what was going to happen. The judge changed his opinion.

Another example of disbelief and dismissal trauma was shared in one of the workshops provided to one state's county directors from the Department of Human Resources. After we differentiated between STS and burnout and explained the difference between direct and indirect trauma, one of the participants asked if one could be traumatized by threats from one's superiors. He went on to share that the year before, the head of the department had said that the reason children were dying was because the directors weren't doing their jobs. This resulted in a number of the directors leaving their positions to work for a different agency. We contend that the directors' knowledge, experience, and strongly held values and beliefs were violated by the head of the department.

Child welfare practitioners have to protect their beliefs in the face of frequent disbelief of the horrors of child abuse. It is important to anticipate that there will be times when they will be unable to convince other professionals of what they know to be true. Practitioners often say that it is because of this disbelief and dismissal that their spiritual practices are necessary to their work.

Trauma permeates the work of child welfare. In Meyers and Cornille's 2002 study of 203 child welfare practitioners, 82 percent had traumatic experience before they became child welfare workers. Seventy-seven percent indicated they had experienced physical assault or been threatened by a client. Having a history of trauma contributes to vulnerability of STS and to the number of symptoms experienced (Meyers & Cornille, 2002; Nelson-Gardell & Harris, 2003; Pearlman & Saakvitne, 1995). It is natural for a practitioner who is a trauma survivor to overidentify with traumatized clients, especially when there are similarities between their experiences. Managing disbelief and dismissal of abuse may be particularly difficult for a trauma survivor. The worker must respect that boundaries need to be maintained so the client receives the assistance he or she needs. It is important for the practitioner to be able to seek assistance when this issue arises, either through supervision or through professional counseling.

## PROFESSIONAL COPING FACTORS

Professional factors that help child welfare professionals cope with STS in the workplace must be addressed. First and foremost, STS must be acknowledged as an occupational hazard in child welfare work that can result in an occupational stress injury. Second, certain activities can help the practitioner maintain a balanced worldview (Figley, 2002; Saakvitne & Pearlman, 1996).

One helpful activity is to start the day with a list of work to be achieved, prioritize it, and then try to organize it so that emotionally draining tasks are not piled together. Saakvitne and Pearlman (1996) suggest several activities that are essential to professional self-care. Get up and move around. You may be thinking about your work, but moving your body is important. Plan breaks in your workday that make

you move around. When you find that you are at your desk all the time, your self-care system is failing. Leaving the work for a lunch break is frequently mentioned as a refreshing activity that is all too often ignored in child welfare. Another technique to reduce stress while working at a computer is to have free weights at the work station to relieve tension in neck and back muscles. Lifting and stretching reduce the tension that builds up when you do not move around. Another communication technique helpful to workers is for the worker to answer, when asked to take on a task not essential to the completion of his or her own work, "Let me think about that." This allows the worker time to evaluate whether or not this additional task needs to be taken on at all.

Colleagues are an important part of self-care (Saakvitne & Pearlman, 1996; Skovholt, 2001). They understand the work, and they are essential to professional social support. They are also the individuals to whom child welfare workers can talk about their clients (within reasonable bounds of confidentiality) and how they are affected by the work and what they are doing about it. It can be helpful for seasoned workers to validate the experiences of novice workers, especially around their natural apprehension and anxiety. Expertise and practice wisdom should be shared (Skovholt & Ronnestad, 1995). Cohesion among colleagues can help in the worst of times and can buffer the sometimes grinding ambiguity of the work. Colleagues can help us to recognize our successes with clients and to appreciate what we have done. Colleagues can also help each other to maximize the use of problem-solving coping—thinking the problem through and acting on the conclusion—rather than the use of avoidance to cope. Colleagues also understand each others' sense of humor and the need to debrief and talk about the frustrations of the work (Moran, 2002; Tedeschi & Calhoun, 1995).

## THE USE OF HUMOR AS A COPING SKILL

Moran (2002) stated that "In extreme environments, especially those involving traumatic stressors, the role of humor can be covertly acknowledged while being overtly ignored" (p. 139). This is certainly the case in child welfare. Child welfare workers often use humor to cope with the horrific situations they witness or hear about from the children and families they serve. Moran (2002) discussed the theories of humor and revealed that humor can provide tension release or allow for a "reinterpretation of a given situation or event" (p. 141). He stated that a component of humor may be aggression, and this may allow the expression of feelings that a person may not be able to deal with otherwise. This type of humor, Moran claimed, can be healthy or harmful.

Moran also reported that some researchers have shown that humor, especially laughter, may be health enhancing, since humor and laughter sometimes have a relaxation effect and may have an effect on a person's immune system. Moran (2002) said, "Because humor can result in a reduction of tension and a reinterpretation of events, it can be neatly accommodated into many stress management or therapy programs with these objectives" (p. 143). He discussed how coping humor can

filter out negative information and may lead a person to pay more attention to humor in the environment.

Persons outside the public child welfare agency may hear child welfare workers talk about terrible situations involving children and observe that there is a type of gallows humor that exists in child welfare. The actual situation with the child may not be the source of humor, but the worker will interject something humorous that occurred in the midst of the situation. Moran (2002) stated that in "extreme circumstances humor may be used to provide distance from events" (p. 144). This may be useful when the event is beyond human understanding. "In both humorous and non-humorous reframing, individuals may appear insensitive to outsiders, but workers within the field will frequently recognize the function such reframing serves" (Moran, 2002, p. 145).

Workers must, however, exercise caution in using humor to cope. The overuse of humor may be a form of denial or a cover-up of what is really going on with the child welfare worker. Excessive humor may be an avoidance technique (Moran, 2002). It is also a red flag if a person loses his or her sense of humor. "In the literature on traumatic stress, loss of humor may be listed as part of the symptomology" (Moran, 2002, p. 149). Moran also discussed research that claims humor may have an adverse effect on anxious individuals.

Humor is often used by child welfare workers to cope with the situations they encounter. The communication among child welfare workers often includes jargon that only they know has a humorous side. The research reveals that this is a way to cope with terrible situations. Supervisors and child welfare workers need to be aware that it can be used by the individual to work through a horrific event or to avoid dealing with such an event. Humor is a complex phenomenon, and its use as a coping mechanism in child welfare warrants further research.

## PROFESSIONAL DEVELOPMENT

Professional development success and activism are crucial to child welfare workers' professional health. Professional development consists of two focused tasks (Skovholt, 2001). The first task is getting quality feedback on individual performance, reflecting on it, and gauging individual practice and professional growth. The second task is using continuing education. For example, a person can pursue formal education, attend seminars, collaborate with colleagues, and/or create a customized professional development plan.

Activism is helpful. Getting involved in some aspect of child welfare that is not the individual's own work gives the practitioner an opportunity to proactively address the challenges of the work from a different perspective. Activism may involve collaborating with colleagues to organize a self-help group to address STS in the workplace. It may involve volunteering with one of the community programs that address children from a perspective different from that of one's own agency. As Herman (1992) pointed out, "Social action can take many forms, from concrete engagement with particular individuals to abstract intellectual pursuits" (p. 208).

What these activities do for practitioners is to allow them to address child abuse from a different perspective, preferably one that allows them greater control.

## ANTICIPATORY COPING

The last area that we address in our educational workshop is personal cognition, or engaging in anticipatory coping. Child welfare work takes a physical and psychological toll on the practitioner. Knowing this, the professional is in a position to make contingency plans for the traumatic events and chronic environmental strains that may occur. Building resilience through mental preparation is the goal. Skovholt (2001) identified and discussed twenty hazards of practice that we believe to be applicable to child welfare. We will discuss each and provide examples.

Clients may have a seemingly unsolvable problem that must be solved (Skovholt, 2001, p. 77). Many child welfare clients share this characteristic because there are no immediate and/or good solutions to the problem they present. An example of this would be grandparents who are old and frail and who want to parent their grandchild or grandchildren and cannot realistically undertake the responsibility. The documentary film *Big Mama* (Seretean, 2000) realistically portrays this problem.

Clients may not be "honors students" (Skovholt, 2001, p. 77). Child welfare clients often get into the system because something has gone wrong, usually between the parent and the child. In some cases, the clients' personal problems are so enormous and extensive that they simply cannot care for their children. There are also clients who are not motivated to make needed changes to turn their situation in a positive direction. It can be taxing to work with these clients.

Skovholt discussed clients who have motivational conflicts. One situation Skovholt described was a client who had four children, and the oldest child was severely disabled and had low intelligence. The client received disability payments for the child that helped the whole family survive. When the disabled child started acting out sexually, the worker encouraged the mother to put the child in a group home. In some ways, this would make caring for the other children easier, but the mother did not want to lose the disability payments and found reasons why she could not allow the child to go into the home.

Skovholt asserted that there is a frequent readiness gap between the worker and his or her clients. This is explained as person-in-environment fit. Developmentally, the client may not be ready to change or to work on solving his or her problems, even when that means having children removed from the home. Sometimes this can be a byproduct of other presenting problems. For example, a mother who is seriously depressed and finds it hard to get out of bed will have to have her depression corrected before she can care for her babies. Meanwhile, the babies have to be safe and nourished. The worker may be ready to solve the problem when the client is not.

Child welfare workers know all too well the hazard of clients projecting negative feelings onto them (Skovholt, 2001, p. 81). They know that clients often see them as a continuation of their oppression and the many negative people and social

interactions they have experienced before interacting with the worker. Transference is a common occurrence. In fact, not only do workers experience the projection of negative feelings, but they also experience threats of violence and in some cases assaults. Workers will tell you that if you are going to do this work well, you have to acquire some toughness.

The sixth hazard Skovholt (2001) identified is that "sometimes we cannot help because we are not good enough" (p. 82). We refer to this as practitioner-client fit. There are instances when the practitioner is a poor match for the client and his or her problems. This can bring feelings of shame as it becomes clear that the practitioner will be limited and will not be able to help the client to the extent that he or she needs. This presents a difficulty for the practitioner, who wants to help. The worker may be well prepared to work with children but does not understand their war-veteran father's problems and interprets his behavior negatively. Workers cannot be all things to all people, regardless of how much they care about them.

Clients can have needs that are too great for the social service, educational, or health systems to meet (Skovholt, 2001, p. 82). There will never be enough resources to do the work the way practitioners want, and social services are usually at the bottom of legislators' funding concerns. There will always be clients whose needs exceed what workers can provide even if they had all the resources they wanted. There will be clients whom workers can help with what they have to offer, and these clients will be their successes.

Child welfare practitioners and social workers have difficulty saying, "No, I can't do that," leading to what Skovholt (2001) labeled "the treadmill effect" (p. 83). Saying, "No, I can't do that now," or "Let me think about that" does not mean that the worker is uncaring, but that the worker is realistic about what he or she can or cannot do. The alternative is that the worker ends up with more tasks than he or she can successfully complete and may grow resentful.

The ninth hazard, "living in an ocean of stress emotions" (Skovholt, 2001, p. 86), typifies child welfare work. Clients are most often children who have been hurt, some badly. Emotional distress is embedded in the work and cannot be avoided. Practitioners often minimize their own psychological distress when it should be expressed in a constructive way, which is important to keeping the bucket dumped.

Skovholt (2001) argued that practitioners will experience ambiguous professional loss and referred to this as "ending before the ending" (p. 88). There are times when concrete results are present, and the practitioner knows the impact they have had on a child and his or her family. But there are other times when the outcome remains unknown, and the investment of time and energy in the client is questioned. Practitioners can develop and maintain an inner belief that each investment matters regardless of the outcome. Many workers say their spiritual beliefs help them cope with this lack of closure.

Another hazard that is highly characteristic of child welfare is the covert nature of the work (Skovholt, 2001, p. 90). The covert nature and need for confidentiality means that what the practitioner does cannot be shared, and that can lead to feel-

ings of isolation. This is why professional social support is essential and needs to be established in the workplace. Colleagues can talk with each other about cases and their feelings about their work and the satisfaction they take from it.

The constant use of empathy, interpersonal sensitivity, and one-way caring presents another hazard (Skovholt, 2001, p. 91). A hallmark feature of child welfare work is building relationships with children and adolescents and their families, and that is largely done by connecting to these clients in a meaningful way. Empathy, interpersonal sensitivity, and caring are crucial to making the needed relationship happen. While empathy is a strength, it also makes the worker vulnerable to STS. Interpersonal sensitivity helps with communication, transference, countertransference, and timing, but it can also strain workers, especially when they work with resistant, involuntary, and difficult clients. One-way caring can be a drain on the worker's energy. For these reasons, self-management and renewal are critical in child welfare work.

Elusive measures of success present yet another hazard to the work (Skovholt, 2001, p. 92). Some successes in child welfare are easily measured, and the outcomes are known. There are gray areas where the best evidenced-based practice is not as easily identified, nor are the clients' outcomes. There is always the question: Was it the intervention that made the difference, was it the relationship, or was it something else we don't know about that influenced the outcome? Who defines success, the practitioner or the client?

A related hazard is normative failure. Skovholt argued that it is important to differentiate normative failure from excessive failure. Failures do happen, and sometimes they can be analyzed to discover why they happened. There will be failures in child welfare practice along with successes. Skovholt (2001) pointed out that "practitioners must realize that they are like doctors whose patients die" (p. 95). It happens, and normative failure or the lack of success will be a part of child welfare practice. Seasoned and competent practitioners learn to become realistic about their expectations, at the same time losing some of their idealism.

Another hallmark feature of child welfare practice is the "regulation oversight and control by external, often unknowing others" (Skovholt, 2001, p. 97). Child welfare practice is heavily regulated. Often with good intentions, administrators, lawyers, and state personnel direct what the practitioner can and cannot do. State officials whom practitioners never see make decisions about their work, and often these officials draw conclusions prematurely and without full knowledge or information about the work. This causes workers tension and distress since they are constantly being asked to do more with less.

Many of the hazards described by Skovholt may be more applicable to the novice child welfare worker. The seasoned practitioner, on the other hand, faces challenges such as "cognitive deprivation and boredom" (Skovholt, 2001, p. 98). When one has been a practitioner for a good length of time, it is possible to start thinking that one has seen it all and to begin finding the work less stimulating. When this happens, the practitioner may become less attentive to his or her work and take less satisfaction from it because he or she is bored. Practitioners can

avoid this if they constantly work to increase competence and continue to master skills.

The nature of child welfare practice and the environments in which it takes place can create "cynical, critical, negative colleagues and managers" (Skovholt, 2001, p. 99). Negativity can be highly contagious and spread quickly among practitioners. Cynicism in the work means there is a failure to value the successes that occur every day, which contributes to failures with clients. It leads to a belief that clients cannot grow and change. It also stifles hope, which is essential to believing in the work. Child welfare is hard enough to do even in a positive workplace. Practitioners need positive and motivated colleagues who are aware that collectively they must protect the professional environment in which they work.

Another hallmark feature of child welfare work is "legal and ethical fears" (Skovholt, 2001, p. 100). Child welfare practitioners and their supervisors are always alert to legal issues related to practice with clients. They are also concerned about ethical issues where competing values are present, and choices must be made. They are very much aware that they may be held legally liable if the outcome of a case is negative. Practitioners also know that regardless of the positive work that they do, they may not be supported by the very people asking them to do this work.

The nineteenth hazard that Skovholt (2001) identified is "practitioner emotional trauma" (p. 101), which is what this book is largely about. We know that empathic engagement and listening to the traumatic experiences of others make the practitioner vulnerable to STS, which is especially likely to occur to persons working with children who are vulnerable to the harmful acts of adults. The images of broken bones, bruised bodies, and tortured souls and the feelings that accompany these images do not recede easily. This is a reality of the work and is best acknowledged and accepted. Having done so, the practitioner can realistically assess if the successes are worth the distress of doing the work. Many workers indicate that it is worth the distress; some do not.

The final hazard identified by Skovholt (2001) is "physical trauma" (p. 102). Child welfare practitioners are well aware that the work is dangerous. Clients may be mentally unstable, angry, or under the influence of drugs or other substances. They may make threats and in some cases carry out physical attacks on workers. If the worker is affected by STS and/or burnout, he or she may not be able to assess a potentially violent situation in time to recognize what to do.

We add yet another hazard of child welfare practice—the horrific abuse and death of children. Because of the values practitioners have regarding children and the commitment they have to children's safety, abuse and death are hard to endure. Child welfare practitioners do the work because of the children and because of the changes they bring to families. Success is very powerful. Experiencing child abuse and death will change the practitioner. It is hard to acknowledge and accept that in the process of helping others recover from their wounds and heal, workers also become wounded and have to heal.

It is important to think realistically about these processes and think critically about how the practitioner can prepare to respond to them with the understand-

ing that they are very unlikely to happen all at once. By engaging in anticipatory coping, practitioners are protecting both their personal and professional lives. This can also be a collective experience with colleagues because the phenomenon is a shared one.

In this chapter we addressed how we educate child welfare professionals on how STS differs from burnout, how it arises, and intervention options. The interventions presented here have come from the literature and from our experience with child welfare practitioners. You have to figure out what works best for you in managing the effects of the work and practice it. While there is much that individuals can do to manage STS, supervisors and administrators have important roles and responsibilities in its management also. We will address these roles and responsibilities in the next chapter.