

Child Welfare Work and Secondary Traumatic Stress

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Researchers have identified some special issues of concern to professionals, such as child welfare workers, who work directly with traumatized children and families. Sometimes the vivid recounting of trauma by a trauma survivor causes trauma reactions in the helping person. The professional is, in essence, exposed indirectly to trauma through hearing about the firsthand trauma experiences of others. This is referred to as secondary traumatic stress (STS) which is sometimes also called “compassion fatigue,” or “vicarious trauma,” or “indirect trauma.”

STS can be thought of as a form of occupational stress. It can be a cumulative response to working with many trauma survivors over an extended period of time, or it may result from reactions to a particular client’s traumatic experience.

Common sources of secondary trauma in social services include:

1. Facing the death of a child or adult family member on the worker’s caseload
2. Investigating a vicious abuse/neglect report
3. Frequent/chronic exposure to emotional and detailed accounts by children of traumatic events
4. Photographic images of horrific injuries or scenes of a recent serious injury or death
5. Continuing work with families in which serious maltreatment, domestic violence, or sexual abuse is occurring
6. Helping support grieving family members following a child abuse death, including siblings of a deceased child.

In addition to the secondary traumatic stress that may arise from helping children, many child welfare workers are exposed to traumatic or life threatening events of their own. These events may arise while removing a child from his or her home when emotional intensity is great. Child welfare professionals sometimes confront intense verbal or physical assault by clients or community members (Friedman, 2002). They are sometimes exposed to violent family members, car accidents, and neighborhood violence. Occasionally child protective workers are stabbed or shot. Like other people, most child welfare workers will have short-lived reactions to these threats. With support from their colleagues and families, most workers will recover without formal assistance.

STS may be exacerbated by feelings of professional isolation, frequent contact with traumatized people and visits to trauma environments or locations, such as accident sites. It may be aggravated by the severity of the traumatic material to which the helper is exposed, such as direct contact with victims, or exposure to graphic accounts, stories, photos, and things associated with extremely stressful events. Some researchers believe that dealing with the pain of children is especially provocative for people and makes them more vulnerable to secondary traumatic stress than working with adult trauma survivors (Figley, 1995).

Only a small percentage of individuals will develop STS. However, traumatic events can bring about various posttraumatic reactions in some child welfare workers.

What Are Signs of STS?

Symptoms of secondary traumatic stress can include some of the same symptoms experienced by the direct victims of trauma—including increased fatigue or illness, social withdrawal, reduced productivity, feelings of hopelessness, despair, nightmares, feelings of re-experiencing of the event, having unwanted thoughts or images of traumatic events, anxiety, excess vigilance, avoidance of people or activities, or persistent anger and sadness (ISTSS, 2005).

The effects of secondary traumatic stress may also include changes in how the individual experiences him or herself and others, such as changes in feelings of safety, increased cynicism, and disconnection from coworkers and/or loved ones. Exposure to terrible knowledge about inhumane treatment of children often forces staff to re-examine their assumptions about religion, God, families and life itself (Friedman, 2002). In the workplace, STS has been associated with higher rates of physical illness, great absenteeism, higher turnover, lower morale, and lower productivity.

People may also experience difficulties in their personal or professional relationships, in managing boundaries, and in dealing with their emotions. They may have difficulties sleeping, overeat, or use too much alcohol, have anxiety for their own children and irritability toward their colleagues and family.

STS is different from burnout, although STS and burnout have some risk factors in common—high caseload demands, a personal history of trauma, limited access to supervision, lack of a supportive work environment, and/or a supportive social network. Burnout is often due to long-term involvement in a nonsupportive work environment, large caseloads, and onerous paperwork. With burnout, increased workload and institutional stress are the precipitating factors, rather than exposure to clients' trauma.

Are Child Welfare Workers Especially Vulnerable to STS?

A few studies have been done on STS in child welfare workers and social workers generally. These suggest the incidence of the disorder in this population is relatively high. Some research shows that social workers in the child welfare system have a higher number of STS symptoms than other child welfare workers (Stoesen, 2007).

Reasons for this are not exactly clear. Some researchers say that social workers are taught to be empathetic, and they hypothesize that a worker's ability to empathize with clients may itself be a risk factor for STS (Nelson-Gardell & Harris, 2003). They may also come into the field with their own histories of trauma. A worker's personal history of trauma may put him or her at increased risk of developing STS. Having been abused or neglected as a child increases a person's risk of STS (Nelson-Gardell & Harris, 2003). It is not always clear when a worker with a trauma history suffers posttraumatic symptoms whether their own trauma is actually being re-triggered or whether they are suffering STS. Research shows us that trauma can create biological and psychological vulnerabilities in some people and that the effects of trauma can be cumulative. So individuals with personal trauma or abuse histories may generally be more vulnerable or have fewer resources to confront later stressors and traumatic events.

Exposure to traumatic events is also higher in subpopulations to whom social workers are likely to provide services than it is in the general population (Bride, 2007). Some studies suggest that the more trauma survivors a helping professional has in her caseload, the more symptoms of STS she is likely to have herself (Schauben & Frazier, 1995).

Bride (2007) did a study of master's level social workers licensed in a southern state. The study found that 70.2% of workers experienced at least one symptom of STS in the previous week, 55% met the criteria for at least one of the core symptom clusters, and 15.2% met the core criteria for a diagnosis of PTSD. The intrusion criterion was endorsed by nearly half of the respondents. The most often reported symptoms were intrusive thoughts, avoidance of reminders of clients, and numbing responses.

Bride says that the experience of STS is believed to be one reason why many human services professionals leave the field prematurely. Nationally, vacancy rates for public child welfare workers are significantly higher than those of other state and local government workers (North Carolina Division of Social Services and The Family and Children's Resource Program, 2007).

Ways that Child Welfare Workers Can Prevent STS

Saakvitne and Pearlman (1996; Pearlman & Saakvitne, 1995) identified four areas they say are important to the prevention of STS in mental health providers:

1. Professional strategies (balanced caseloads, accessible supervision, planned assignment rotation)
2. Agency strategies (sufficient release time, safe physical space, access to employee assistance program)
3. Personal strategies (respecting your limits, taking time for self-care)
4. General coping strategies (self-nurturing, seeking connection)

It is important for child welfare workers to be aware of STS symptoms. Get enough sleep and exercise. Eat well. Get social support and ask for help. Workers should have a life outside of their day job, and beware of volunteering for the same type of work they do for pay.

It is especially important for workers to maintain a balance, and to practice stress management, to exercise, to spend time with family and friends, and to take vacation and personal time.

Workers also need to understand their own personal trauma history, and to find an outlet where they can give voice to their feelings. Having a solid connection with other colleagues and supervisors who can help is important. Good supervision is critical to helping workers maintain perspective and balance. Supervision in some social work practice settings has become more bureaucratic and has moved away from support. Preventing and managing traumatic stress must be shared by the agency and workers—neither can do it alone.

Child welfare work is motivated and sustained by hope, compassion, and knowledge. It is important for workers to find relief from everyday tasks by engaging in activities or relationships that restore hope and serve as reminders of the benevolent side of humanity.

What Can Child Welfare Agencies Do to Prevent STS?

Unresolved trauma reactions can hurt workers' physical and mental health. This impacts turnover, morale, and general agency function, which in turn affect an agency's ability to help clients achieve positive outcomes (North Carolina Division of Social Services and The Family and Children's Resource Program, 2005).

Child welfare agencies should factor in STS and PTSD when thinking about developing and retaining staff. Child welfare work, by its nature, will expose workers to events that are extremely stressful for children and parents including placement and traumatic grief from parents following removal of a child. A considerable amount of behavioral and emotional issues displayed by foster children could be associated with loss and/or trauma. It is important for child welfare organizations to establish training and policies that are consistent with current knowledge of risk and prevention of secondary traumatization.

Agencies can destigmatize secondary trauma through organizational recognition and acknowledgement. At the very least, being open to talking about trauma can send the message that the agency cares about employee well-being. Agencies must also cultivate a work culture that promotes getting timely mental health diagnosis and treatment. Support resources, including peer support, are useful, as are professional consultation, training, and counseling (Stamm, Varra, Pearlman, & Giller, 2002). Safety training may be another way for agencies to reduce workers' risk of developing PTSD.

Agencies should also ensure that EAPs or employee health plans cover mental health services. Supervisors should help workers establish boundaries between themselves and their clients, give them a chance to talk about how they've been affected by trauma, and help them recognize the need to find balance in their work and personal lives. Workers should know and use stress management techniques (North Carolina Division of Social Services and The Family and Children's Resource Program, 2005).

The commitment of the agency's senior leadership is very important. They need to be champions of resilience and hope in the organization. They may need to create a trauma support position within the organization to coordinate trauma education and support services.

Professional isolation is believed to be a major risk factor for the development of secondary trauma or burnout. Traumatic stress can make some staff ashamed about their strong reactions and uncomfortable about burdening colleagues or loved ones at home with their pain. At the unit level, trauma support is crucial. In most child welfare agencies, staff identity is based on the unit and the closest relationship workers have are with co-workers on their units (Friedman, 2002).

Isolation can also result from geography, climate, population density and social barriers such as race. Many helping professionals in rural areas are isolated from other providers, peer support, continuing education and access to new information.

One study indicated that rural mental health workers are more likely to report clinically significant secondary traumatic symptoms than their metropolitan counterparts (Larsen, Hudnall-Stamm, & Davis, 2002). A telehealth network may be an important source of support for those who work in helping professions in rural areas (Larsen, et al., 2002).

Summary

It is now clear that no matter how skilled or experienced workers are, when they work in close proximity to major trauma, they will be impacted by it. Child welfare workers cannot inoculate themselves from traumatic stress. Rather they need to develop individual and group supports that help them learn from their experience and reconnect with the sense of hope and empowerment with which they first entered the field.

Work with trauma survivors can be immensely rewarding. Professionals who are vigilant about taking care of themselves and who receive consistent support from their supervisors and others often find that working with trauma victims enables them to grow personally and professionally (Zimering, Munroe, & Bird Gulliver, 2003).

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