COMPASSION FATIGUE IN PUBLIC CHILD WELFARE

CASEWORK SUPERVISORS

by

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ABSTRACT

The current study explores the phenomena of Compassion Fatigue and its impact on supervisors in public child welfare settings. The study is a secondary analysis of data collected by Pryce, Shackelford, and Pryce during a series of workshops in 1997 on the topic of Secondary Traumatic Stress. During the workshops, 458 child welfare caseworkers and 103 supervisors were administered the Compassion Fatigue and Compassion Satisfaction Self-Test for Helpers providing scores on Burn Out, Compassion Fatigue and Compassion Satisfaction. Demographic data was also collected on the 561 participants. Data analysis was conducted on the supervisors’ responses and then compared to those from caseworkers.

Results of the data analysis revealed that the supervisors experienced Compassion Fatigue but at a lower level than was reported by the caseworkers. Moreover, the impact of the demographic variables on the level of Compassion Fatigue was contrary to that seen with the caseworkers and as was predicted in the literature. The variables of age and years of experience, for example, held an inverse relation with Compassion Fatigue levels for caseworkers but not for supervisors. The variable of gender did not impact levels of Compassion Fatigue for either caseworkers or supervisors, in contrast with the literature’s indications. Of particular interest was the relation between formal education and Compassion Fatigue level. Those respondents who held a bachelor’s degree in Social Work (BSW) as their highest degree experienced the greatest level of Compassion Fatigue. This outcome was in contrast to expectations and prompted discussion on what aspects of Social Work education may be facilitating experiencing Compassion Fatigue.
DEDICATION

This dissertation is dedicated to my late father, John D. Weiss, who is by my side every day.
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Loa Tzu, the Chinese Taoist philosopher, is credited with saying “The journey of a thousand miles begins with one step.” My first step towards completion of this journey began with my late maternal grandmother, an Italian immigrant, who challenged me over fifty years ago to study, learn, and make something of myself. Through the various stages of my life her words slowly faded to my ears but echoed loudly in my heart and mind: study, learn, make something of yourself. I graciously acknowledge Mary DeMatteo for planting the seed of desire to make something of myself when I was but a young child. I thank my family who has been with me every single step of the way. My wife, Reta, who had to endure months of solitude because of my studies and work away from our home, was always patient, supportive, encouraging, and offered her strength when I needed it. I acknowledge the incredible emotional, spiritual and even financial support provided by my mother, Frances D. Weiss, and my beloved sister, Mary Jo Weiss. They took on my challenges as if they were their own. Through their love and prayers this dissertation became a reality.

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CHAPTER I
INTRODUCTION

The Nature of Traumatization

Within the last twenty years the phenomenon of secondary traumatization, a result of involvement with trauma victims, has garnered an increased level of attention by researchers (Abendroth & Flannery, 2006; Arvay, 2001). Researchers have identified and described secondary trauma in a number of ways, including Secondary Traumatic Stress (STS), Vicarious Traumatization (VT), and Compassion Fatigue (CF). Though essentially related, there are subtle differences between the conceptualizations of these phenomena (Gentry, 2002). Vicarious traumatization, for example, refers to the transference of traumatic stress through observation and/or hearing others’ stories of traumatic events and the resultant changes that occur in the caregiver’s perceptual and meaning systems (McCann & Pearlman, 1990). Thus, VT represents cognitive changes in the individual that occur as a result of exposure to other's experiences of traumatization. An alternate or different manifestation of secondary trauma is conceptualized as STS. This phenomenon occurs when one is exposed to the extreme events directly experienced by another, and the individual becomes overwhelmed by this secondary exposure to trauma (Figley & Kleber, 1995). In contrast to VT, STS relates more to the behavioral manifestations of stress such as those seen with Post Traumatic Stress Disorder (PTSD). Further, STS is unlike VT in that it can occur from work with a single client while VT requires repeated exposures to traumatic material across time and clients (Figley, 1995). “The conceptual literature in regard to
compassion fatigue and VT indicate some basic differences. VT is a process that occurs over time (Pearlman & Saakvitne, 1995), whereas compassion fatigue involves a faster onset of the symptoms as well as a faster recovery than experienced in VT (Figley, 1995)” (Salston & Figley, 2003, p.173).

STS is described as a syndrome of symptoms that are identical to those of direct traumatization or PTSD, the characteristics of which are intrusion, avoidance, and arousal. (Figley, 1999; Kinchin, 2005; Simon, Pryce, Roff, & Klemmack, 2005). Moreover, STS is defined as “the negative transformation in the self of the helper that comes about as a result of empathic engagement with survivors’ trauma material and a sense of responsibility or commitment to help” (Saakavitne, et al., 2000, p.48). Figley (1995, p.7) described STS as “the natural consequent behaviors and emotions resulting from one’s knowing about a traumatizing event experienced by a significant other”.

As STS evinces symptomology similar to PTSD it can have a deleterious impact on both the professional and personal functioning of those who may be afflicted (Figley, 1995; Kaniasty & Norris, 2008; McGruder-Johnson, et al., 2000). An individual who suffers from STS may experience difficulty in performing their professional duties, presenting both safety and ethical issues (Catherall, 1990; Munroe, 1999). The NASW code of ethics, for example, is quite explicit about social workers who are impaired:

4.05 Impairment
(a) Social workers should not allow their own personal problems, psychosocial distress, legal problems, substance abuse, or mental health difficulties to interfere with their professional judgment and performance or to jeopardize the best interests of people for whom they have a professional responsibility.
(b) Social workers whose personal problems, psychosocial distress, legal problems, substance abuse, or mental health difficulties interfere with their professional judgment and performance should immediately seek consultation and take appropriate remedial action by seeking professional help, making adjustments in workload, terminating practice, or taking any other steps necessary to protect clients and others.” (NASW, 2006
In summary, those social workers who are experiencing personal problems as a result of some malady, including STS, burnout (BO), and CF, should disengage from therapeutic relationships with clients and seek professional help. Those traumatized helpers who do not receive help, for whatever reason, risk further injury to clients as well as themselves. STS also impacts one’s personal life in terms of the individual’s overall functioning, essentially one’s transactions with their social environment, requiring intervention for the sake of the worker, clients, the organization, and others (Cornille & Myers, 1999). Finally, the consequences of STS are serious and include low morale, high turnover, psycho-social-emotional problems, and even spiritual crisis resulting in significant concern for service providers (Brady, et. al, 1999; Friedman, 2002).

**Compassion Fatigue**

Beyond VT and STS, a third conceptualization of secondary traumatization may be viewed as the phenomena of compassion fatigue (CF). Originally conceptualized as being “identical to secondary traumatic stress disorder (STSD) and is the equivalent of PTSD” (Figley, 1995, p. xv), the term CF was used interchangeably with STS. CF has since evolved into a more encompassing conceptualization than STS and includes burnout (BO) as well (Adams, Boscarino, & Figley, 2006; Figley, 1995; Newell, 2008). In terms of association within CF, BO is viewed as a phenomenon related to, albeit distinct from, STS. Despite the fact that the effects of secondary trauma inflicted on trauma workers have been alluded to for some time, it is only within the last 25 years that empirical studies on STS and CF have commenced. Many of the earlier studies of traumatic stress were exploratory in nature as researchers attempted to conceptualize STS and distinguish it from other phenomena such as burnout or emotional contagion (Hyman, 2004; Lerias & Byrne, 2003; McGruder-Johnson, et al. 2000; Neumann &
Gamble, 1995). Recently, studies have tended to be more descriptive in that they examined the relationship between demographic characteristics and STS in an effort to predict the likelihood of secondary traumatization leading to CF (Abendroth & Flannery, 2006; Adams, Bocarino & Figley, 2006; Allen & Lauterbach, 2007).

Several authors promoted research in STS but found difficult barriers to robust and compelling research. A number of researchers discussed the confusion that existed in the field of secondary traumatization because the terminology used for VT, STS, CF, and burnout were so similar (Dunkley & Whelan, 2006). Further, Lerias and Byrne (2003) demonstrated a need for a uniform and consistent definition of the terms as, they revealed, researchers were assessing different phenomenon when STS, VT, CF, and/or burnout were studied. Savin-Farell and Turpin (2003) state that research evidence for STS is meager and inconsistent, making it difficult to conceptualize the phenomenon of STS, VT, and emotional contagion. (According to Barsade (2002, p.644) emotional contagion is "a process in which a person or group influences the emotions or behavior of another person or group through the conscious or unconscious induction of emotion states and behavioral attitudes.") Moreover, there was much overlap and confusion defining the scope of burnout, STS, and VT and how these phenomenon may relate to each other. Sabo (2006) asserted that research sources for CF, STS, and VT are both few and limited, particularly if one excludes the topic of burnout. Moreover, Sabo states that to date there is no good measure of the phenomenon of STS. Thus, the confusion about what exactly was being studied, and possibly measured, inhibited empirical research in this important area. Prior to the works of Figley (2002, 1995), Pearlman and Maclan (1995), and McCann and Pearlman (1990), STS characteristics were generally conceptualized as being a part or variant of burnout. Soederfeldt, Soderfeldt, and Warg (1995), for example, envisioned STS as having a similar
beginning as burnout while some authors, e.g., Hafkensheid (2005), questioned the very existence of STS. At best, STS seemed to be considered a part, possibly a phase, of burnout. Indeed, some of the symptomology that we now attribute to STS was originally conceived as characteristic of burnout. Most researchers now recognize that burnout and STS, though sharing characteristics, are distinctly different phenomena. While the research on burnout is quite rich in both quality and quantity, research on STS has been relatively scant. This dichotomy of related phenomena research may be partially the result of the depth of the research. That is to say, that burnout, in comparison to STS, has been studied for a longer period of time, and the depth of the research on it has been greater, thus stimulating even more research on burnout. With the current emphasis on CF in the literature, however, the relationship between STS and burnout is put into perspective and the research on these two phenomena can complement each other.

**Burnout and CF**

Integral to studying CF is the knowledge that the phenomena of burnout, along with STS, comprise CF (Figley, 1995). Maslach (1982) proposed a multidimensional conceptualization of burnout consisting of emotional exhaustion, depersonalization, and reduced personal accomplishment. Further, burnout is the loss of enthusiasm, excitement, and sense of mission in one’s work as the result of "chronic emotional and interpersonal stressors on the job" (Maslach, Schaufeli, & Leiter, 2001, p. 397). Cherniss (1980) notes that burnout is a process in which previously committed professionals disengage from their work in response to stress and strain on the job. Moreover, Pines and Aronson (1988) describe burnout as a state of physical, emotional, mental, and spiritual exhaustion resulting from chronic exposure or involvement in human service work. Burnout occurs because of excessive and prolonged levels of job stress and is a result of emotional exhaustion (Figley, 1995). Thus, burnout is considered to have a lengthy
“incubation period”, i.e., burnout appears to occur cumulatively over time (Jackson, Schwab, & Schuler, 1986). This is in contrast to STS, which may develop even after one exposure to traumatic stress and is often the result of therapeutic transference rather than organizational factors (Figley, 1995). Unlike burnout, the STS victim experiences “a sense of helplessness and confusion, and a sense of isolation from supporters; the symptoms are often disconnected from real causes, and yet, there is a faster recovery rate” through patient education, pharmacotherapy, and psychotherapy (Figley, p.12). A further distinction between STS and burnout is the social context of the stressors. In burnout, the stressors are conceptualized as being organizational in nature (Maslach, 1982). In contrast, STS is more intimate in nature, i.e., the transfer of trauma is from one to another (Figley).

Several factors may contribute to the likelihood than an individual experiences burnout. These variables may include high caseloads, lack of clinical experience, poor job training, low peer and supervisory support, and bureaucratic constraints (Cyphers, 2001; Lloyd, King, & Chenoweth, 2002; Thorton, 1992; MorBarak, Nissly, & Levin, 2001). Symptoms of burnout include chronic absenteeism, chronic tardiness, fatigue, poor client care, and low completion rates of clinical and administrative duties (Cyphers, 2001; Jayartne & Chess, 1984; Newell, 2008; Thorton, 1992). Burnout is often resolved when those afflicted change job environments or employment fields (Maslach & Jackson, 1984; Cherniss, 1980).

Paradoxically, our understanding of STS and CF has been both limited and enhanced because of its association with burnout, not only conceptually as seen above, but empirically as well. As evidenced by several studies, researchers have found that there had been much overlap in the measurement of STS and burnout thereby blurring the conceptual distinction between them. Some authors, e.g., Adams, Matto and Harrington (2001); Regehr, et Al. (2004) have
sought to study the templates of CF (STS and BO) together rather than in isolation. The model presented by the authors allowed researchers to predict traumatic distress in child welfare caseworkers by viewing the complicated interaction of the factors of both burnout and traumatic stress in terms of the individual worker as a whole, and not just the isolated parts as previously studied in many cases.

Some authors, such as Baird and Jenkins (2002) for example, examined both measures of burnout and traumatic stress. The authors found good concurrent validity between burnout and STS on many instrument subscales, again clouding the distinction between burnout and STS. The evidence of an STS-burnout connection (i.e., CF) in the literature can be seen by both the instruments and variables measured in the research on trauma workers. Citing Conrad and Keller-Guenther (2006); Figley and Stamm (1996); Jayaratne and Chess (1986); Regehr, Leslie, Howe and Chau (2000); Sprang, Clark, and Whitt-Woosley (2007), burnout and STS often co-exist, the symptoms of each exacerbating those of the other. Overall, the literature suggests that burnout and STS are intimately connected, both impacting trauma workers in their own way, burnout through an organizational perspective and STS from a more client-centered, individualistic aspect. Thus CF, which may be conceptualized in an oversimplified manner as a combination of STS and burnout, explains the impact of both job stress and secondary trauma on helpers.
**Compassion Satisfaction**

A phenomena related to CF, Compassion Satisfaction (CS) has been explored by Craig and Sprang (2009), Conrad and Kellar-Guenther (2006), Figley (1995), and Figley and Stamm (1996), among others. CS describes the positive benefits that caregivers/trauma workers derive from their therapeutic relationship with traumatized or suffering persons (Stamm, 2002). These “positive benefits” are essentially the sense of well-being and fulfillment from helping others and positive collegial relationships (Stamm, 2002). Conrad and Kellar-Guenther believe that CS may mitigate the adverse effects of burnout and CF, as evidenced by their 2006 study with Colorado Child Protective Service workers. This study measured compassion fatigue/satisfaction and burnout using the Compassion Satisfaction and Compassion Fatigue Self Test designed by Figley and Stamm (1996). Some 363 child protection staff in Colorado participated, providing the general results that 50% of the participants suffered from high or very high levels of CF. In terms of Compassion Satisfaction (CS) however, 70% of participants expressed good or high potential. The authors asserted that CS, while it may seem to be a contradiction when present with CF, actually mitigates the effects of burnout. Thus, this study suggests that CF and burnout are related in at least one respect as measured by the instrument, and further, that both are antithetical to CS.

The mitigation of burnout and CF by CS may also help explain the results of other studies examining child welfare caseworker turnover, e.g., Cherniss (1980), Cyphers (2001), Harrison (1980), and Jayartne and Chess (1980). That is, despite the fact that some child welfare caseworkers may suffer from CF and/or burnout, they remain on the job because their CS levels are so high, i.e., they “love” their job and helping clients so much that the effects of CF and/or
burnout are mitigated or lessened. These authors also note that if CS is low for an individual, the tendency to quit their job is higher.

**Communicability of Trauma**

A prominent characteristic of psychological/emotional trauma is that it is transferable from one individual to others (Bloom, 1999; Gentry, 2002). McCann and Pearlman (1990a, b) assert that those who work with traumatized individuals are likely to become traumatized themselves. Figley (1995) theorizes that, just as the victim of trauma can traumatize others in his or her family by sharing the traumatic experience, it is equally possible for the traumatized client to traumatize the clinician working with him or her. Without intervention, trauma is not isolated to the primary victim, but as Bloom suggests, the phenomena takes on an epidemiological perspective resulting in trauma to those associated with the primary victim. One may envision tossing a pebble into a pond and observing the concentric circles that emanate from the point of impact. The closer to the initial impact (trauma) one is located, the greater the force will be felt. Conversely, those individuals quite removed from the initial impact may still feel a force though possibly less in intensity (Gentry, 2002). In the case of the child welfare worker, one may envision the overlapping ripples caused by many simultaneous impacts over time. This is not unlike the STS experienced as a result of the 2001 terrorist attacks,

The ripple effect of trauma, seen in the aftermath of September 11, create “circles of vulnerability.” The hardest hit are those closest to the epicenter and those who are psychologically closest to the victims, including family members, rescue workers and other helpers. (Gentry, 2002, p.1)

For trauma workers, some of these “impacts” may be from relationships with victims of trauma, while some may be a result of their own traumatic experiences. The accumulations of traumatic stressors can result in the worker’s inability to cope and thereby result in a change to one’s
concept of self. Pryce, Shackelford, and Pryce (2007) cite the example of a bucket that is slowly filled with the accumulated stressors and traumas experienced in life, including those gained via empathic engagement with clients. Overflow will take place unless the bucket is emptied. This “overflow” of emotional trauma not only impacts the ability of the workers to help their clients, but has a significant deleterious effect on every aspect of the worker’s life.

As trauma is seen as being communicable from one person to another, STS can be viewed as the result of one’s close association with traumatized individuals (Bloom, 1999; Figley, 1995). Viewed another way, Atwood and Stolorow (1984) speak of conjunctive counter-transference. In this situation, the client’s experiences resonate with, and are assimilated by, the internal experience of the therapist. While this process facilitates the development of empathy which is necessary for the therapeutic relationship; it may also serve as a basis for STS. In terms of child welfare services, for example, the phenomenon of STS is essentially a result of the stories or the witnessing of violence perpetrated upon child victims which precipitate a sense of stress in child welfare workers. These caseworkers may internalize the trauma experienced by the children with whom they work; this “transfer” of trauma may lead to STS (Conrad & Kellar-Guenther, 2006; Salston & Figley, 2003). Concurrently, the individual may also be experiencing stress from an organizational perspective which would then constitute CF (Cornille & Meyers, 1999; Figley, 1995; Friedman, 2002).

**Compassion Fatigue and Child Welfare in Public Settings**

Symptoms of STS, and therefore possibly CF, may be evident in anyone who bears an emotional connection to the primary victim of trauma, including family members, peers, and the service providers who work with them (Figley, 1995; Pryce, Shackelford, & Pryce, 2007). These providers include, but are not limited to, mental health practitioners, educators, medical staff,
lawyers, law enforcement officers, and social workers (Baird & Jenkins, 2003). Though the professionals in many disciplines work in stressful jobs, it is those positions where an emotionally intense relationship exists between the traumatized consumer and the helper that have the greatest propensity for secondarily traumatizing the helper (Figley, 2002). Recent studies suggest that of the professional disciplines evaluated, social workers have been found to be among those manifesting the highest levels of STS (Arvay, 2001; Baird & Jenkins, 2003; Figley; Pryce, Shackelford & Pryce, 2007; Salston and Figley, 2003). Bride (2007), for example, notes that while 7.8% of the general population experience PTSD over a lifetime, 15 % of the social workers he surveyed met the complete diagnostic criteria, 20% met two of three criteria, and 55% met one of three diagnostic criteria. In such situations, workers who are struggling with their own traumatization are attempting to help other victims of trauma (Bride, 2007). Public child welfare, which provides services to abused and/or neglected children, has been considered one of the most stressful and challenging settings for social workers (Friedman, 2002; Kadushin & Martin, 1988; Kadushin, 1980; Wulczyn et al., 2005). Accordingly, this service climate may be considered as a contributing factor to the development of STS and, in combination with BO, a factor in the development of CF (Regehr et al., 2000). Cunningham (1999) documents that social workers who work with man-made trauma (e.g., physical and sexual abuse, domestic violence) tend to suffer from STS in significantly greater numbers and at higher levels than those who work with natural sources of trauma (e.g., disease, violent weather, etc.), supporting the premise that Child Protective Service (CPS) workers in particular are exposed to significant trauma and consequently may suffer from STS. In one study of CPS workers in the southern U.S., approximately 37% of the caseworker respondents were found to be experiencing clinical levels of emotional distress associated with STS (Cornille & Myers, 1999). A 2007 study by
Caringi produced similar results in New York State. Overall, the literature suggests that the phenomenon of STS has a significantly deleterious impact on trauma workers in general and child welfare workers in particular (Ellet, Ellet, & Rugutt, 2003; Denton, Culver, & Burroughs, 2001; Samantrai, 1992; Yassen, 1995).

Public child welfare presents a fertile environment for the development of not only STS, but, in combination with burnout, CF as well. The research areas of caseworker turnover, job dissatisfaction, and child welfare worker burnout have produced a large number of studies as found in the literature, e.g., Bednar (2003), Drake and Yadma (1996); Glisson and Hemmelgarn (1998), Silver, Poulin and Manning (1997). Overall, child welfare workers face the horrors experienced by their clients on one front and the organizational stressors of non-support, an emphasis on paperwork and form completion, few resources, inadequate training, and high caseloads on the other (Costin, Karger, & Stoesz, 1996; Hagedorn, 1995; Liederman, 1993). Akin to a "perfect storm" situation, the field of child welfare has been, and in many cases continues to be, a very dangerous environment in which to work (Pryce, Shackelford, & Pryce, 2007).

**Compassion Fatigue and Child Welfare Supervisors**

The position of the child welfare supervisor is key to the proper functioning of the agency (Faller et al., 2003). Sometimes supervisors are referred to as being in the “sandwich position” because, from an organizational perspective, they not only represent the agency administration but also must directly attend to the needs of supervisees. The research clearly sites supervision as the only consistent factor in maintaining caseworker retention, indicating that supervisors play a significant role in promoting service provision and the integrity of the agency (Cyphers, 2001; Dickinson & Perry, 2002; Landsman, 2001; Pryce, Shackelford, & Pryce, 2007; Regehr, et al.,
Despite the importance of the supervisor in all aspects of the public child welfare agency, little attention has been given to specific supervisory practice and functions (Collins-Camargo, 2002; Pryce, Shackelford, & Pryce, 2007). Kadushin (1985) viewed three distinct functions of the caseworker supervisor: administrative, educational, and supportive. These functions tend to overlap and get in the way of each other. Administrative aspects of child protection supervision, for example, may impede the effective provision of clinical supervision (Collins-Camargo, 2002). Further, supervisors face role ambiguity and even conflict in the performance of their duties (Harrison, 1980; Newsome & Pillari, 1992). This is significant as both role conflict and role ambiguity have been shown statistically to be significantly correlated with burnout (Acker, 2003). While caseworkers’ stress is derived in particular from role conflict between client advocacy and meeting agency needs, a similar scenario exists for casework supervisors. In the case of supervisors, however, both client and worker advocacy can be pitted against agency needs (Lloyd, King, & Chenoweth, 2002). Moreover, discrepancies in role expectation also impact the ability of the supervisor to function effectively within the agency. Organizational stress results when the realities of one’s job are in conflict with the organizational expectations (Vinokur-Kaplan & Hartman, 1986). Though organizational stress is often related to the phenomenon of burnout, the non-supportive environment of stress can contribute to CF as well (Maslach, 2003; Pryce, Shackelford, & Pryce, 2007).

There are many impacting variables to consider when examining supervisor stress. The job of the supervisor may be complicated when supervisors are required to have a caseload of their own, as seen in small agencies or during times when turnover is high. Further, supervisors are frequently required to represent the agency to community organizations and the court; they must perform administrative functions, “fix” caseworkers’ problems, and keep track of a myriad
of administrative tasks (Kadushin, 1985; 1980). In view of a supervisor’s multifaceted areas of responsibility, the supervisor could be under a large amount of both organizational and traumatic stress. Further, the etiology of supervisor stress may be organizational in nature as well as from pressures external to the agency, with stress deriving in particular from role conflict between client advocacy and meeting agency needs. These factors tend to have a cumulative negative effect on job satisfaction and performance, thereby increasing the likelihood of CF (Anderson, 2000; Norvell, Walden, & Gettelman, 1993; Vinokur-Kaplan & Hartman, 1986). Please refer to Figure 1 in Appendix F; this figure graphically illustrates the difficult position the casework supervisor holds in the child welfare agency. Figure 1 indicates that caseworkers who work with traumatized clients may become traumatized themselves, although not in the magnitude most likely seen in an actual child welfare agency. These traumatized caseworkers then interact closely with their supervisor, suggesting that, because of their interaction with traumatized workers, supervisors themselves are traumatized; therefore the trauma experienced by clients may impact the supervisor via indirect means. Cyphers (2001) states that each child welfare supervisor typically supports seven fulltime CPS workers, though this number may vary widely depending on organizational factors. These caseworkers would likely have mixed caseloads that are comprised of some clients who are trauma victims and some who are not traumatized. Caseworkers may find working with trauma victims a greater challenge than working with non-victims and, therefore, focus on traumatization during supervision. The consequence of this “distillation effect” is that supervisors may have to deal with a preponderance of trauma victims’ circumstances and, in effect, be exposed to a concentrated level of trauma. Circumstances in individual agencies may vary because of staffing patterns, so a supervisor may have many more caseworkers to support plus, possibly, their own caseload of the more challenging clients.
Though supervisors may not be directly exposed to more clients than caseworkers, they may be exposed to a higher ratio of trauma cases. Moreover, the precipitant stress that the supervisor may receive from workers may exhibit a cumulative effect, thereby traumatizing the supervisor. Overall, the stress intrinsic to the child welfare casework (CPS) supervisor is significant; this situation may be a factor in the development of burnout and STS (Allen & Lauterback, 2007; Briere, Kalatman, & Green, 2008; Scarpa et al., 2006).

**The Parallel Process**

A connection between the secondary traumatization of child welfare caseworkers and the possible tertiary traumatization of supervisors may lie in a practice, known as the parallel process that is fostered within child welfare organizations. This process, or specified sequence of events as modeled by supervisors, is intended to be a template for the caseworker-client link, i.e., the caseworker-client relationship should be a model or reflection of the supervisor-caseworker relationship (Cohen, 2003). As the supervisor-caseworker helping relationship can be viewed as progressing through sequential stages, so goes the worker-client relationship. It is important that each stage, and the factors that may affect it, be attended to in order to ensure the effectiveness of the relationship (Williams, 1997). How well supervisors strategically use the stages of their relationships with caseworkers serve as models for caseworkers to use with clients, and therefore bears significantly on the agency’s ability to fulfill its mission. “With the worker, the supervisor evaluates the family’s progress in achieving the child welfare outcomes and communicates the expectation that a parallel process of review is occurring between the worker and family” (Cohen, p.42). If the caseworker-client relationship, therefore, is a reflection of the supervisor-caseworker relationship in terms of process, the two relationships may experience similar problems as well. Given the communicability of trauma, it may be possible that caseworkers,
who are secondarily traumatized, might also serve to traumatize their supervisors. Further, by fostering the parallel process, child welfare agencies may inadvertently be fostering the secondary/tertiary traumatization of child welfare supervisors. The literature has established that trauma is communicable, and that the source of the trauma is not as significant as the personal characteristics of the proposed victim (McCann & Pearlman, 1990). Given this scenario, one can question what impact working with vicariously traumatized caseworkers has on child welfare supervisors. These issues and questions remain unanswered in the current literature, and one purpose of this research was to examine the topic of STS and child welfare supervisors to address this gap.

**Purpose of this Study**

CF is a phenomenon that adversely impacts the ability of trauma workers to do their jobs. In the case of public child welfare, caseworkers are affected by their efforts at helping child victims of trauma and, concurrently, must face organizational stressors. This double exposure to traumatic stress (STS and BO) results in individual dysfunction and high turnover rates for child welfare agencies (Bride, 2007; North Carolina Division of Social Services and the Family and Children’s Resource Program, 2007). The loss of a trained workforce serves to the detriment of all those who are involved with the system of child welfare and society in general. This serious problem is both avoidable and treatable, but continued research and workforce-friendly policy is needed. This research project examined a sample of child welfare workers and supervisors who may have developed CF as a result of working with victims who have been traumatized by abuse or severe neglect. Specifically, the aim of this research was to explore the possibility that caseworker supervisors may experience CF and compare this experience to that of child welfare caseworkers who may also be suffering from CF.
In preparation for this project, an extensive literature review was conducted. Though interest in STS and CF has increased over the last ten years, the number of studies addressing the specific phenomena of child welfare caseworker and supervisors and STS/CF continues to be sparse. Nelson-Gardell & Harris (2003) and Pryce, Shackelford, & Pryce (2007) are two examples of the available research that directly relates to this phenomenon. This constitutes a rather alarming situation because, as indicated by Nelson-Gardell and Harris, studies on STS or CF utilizing various professional participants may not generalize to child welfare personnel participants. Despite the apparent importance of exploring the vicarious traumatization of child welfare personnel, few empirical studies have been conducted to date. The current research project proposed to partially fill this void in the literature. It was also intended to provide policy makers with pertinent information with which to formulate organizational strategies that could assist in both the prevention and treatment of CF in child welfare personnel including supervisors.

Previous studies have explored various components of STS and CF, including contributing personal characteristics, intervention techniques, and various population samples. One area that has escaped a focused effort, however, is the possibility that child welfare supervisors may be secondarily traumatized by working with their supervisees who are, themselves, traumatized from their exposure to victims of trauma. The possibility of this tertiary traumatic stress has been only briefly mentioned in the literature. Figley (1995), for example, suggests that proximity to harm impacts the degree to which one may be vicariously traumatized in either primary, secondary, or tertiary traumatic stress reactions or disorders. Rippon (2008) briefly addressed the topic in a study on aggression and violence towards health care professionals. Courtois (2002), recognizing the lack of professional awareness, discussed the
need to include information on both secondary and tertiary traumatic stress in Social Work curricula. Finally, Sewell (1993) briefly touches on tertiary traumatic stress in a study on the traumatic stress of multiple murder investigations. Incredibly, despite the known communicability of traumatic stress and its apparent importance to both consumers and providers, a void exists in the literature, not only on the topic of CF in terms of child welfare caseworkers, but on the possible tertiary traumatic stress of supervisors as well. Arguably, this “void” may not be due to a lack of interest in the phenomena, but to a historic inability for interested researchers to agree on what the exact nature and scope of the phenomena is. Hafkensheid (2005), for example, asserts that that “vulnerable trauma therapists may too eagerly embrace the event countertransference and vicarious traumatization perspectives as a cover up for their own failures. Thus, these very perspectives may, unintentionally, provide trauma therapists with an unproductive justification to externalize the problems encountered in their work with traumatized patients” (p.166). The worst scenario, states Hafkensheid, is that of the “we are all victims of your trauma” myth, “with a pathetic therapist denying responsibility for ruptures and stagnations in the therapeutic relationship with traumatized patients. The worst possible implication would be that therapists indulge in self-pity or self-victimization” (p.167). Thus, despite perceived progress in identifying, measuring, and therapeutically addressing STS and CF, the controversy of secondary traumatization continues.
CHAPTER 2
LITERATURE REVIEW

Introduction

This chapter begins with a review of the literature on the development of the construct of “compassion fatigue,” including a discussion of the history of traumatization, followed by the introduction of material on PTSD. This done, the chapter then reviews literature related to STS and BO, the components of CF. Finally, CF is discussed and the implications of what is known about this phenomena and what gaps remain in our present knowledge of the study of CF are presented.

Though the study of CF as a specific phenomenon is relatively new, it benefits from a rich heritage of extensive research conducted in the fields of burnout and traumatic stress. Chapter II presents supporting evidence indicating that trauma is communicable whether the trauma is direct or secondary. The literature review herein also reveals that the demographic characteristics of some trauma workers, i.e., professionals who work with traumatized populations, increases the likelihood of their experiencing symptoms of CF. Finally, this chapter discusses the complex role of the public child welfare agency supervisor, with specific regard to the supervisor-caseworker relationship, and how the dynamics of this relationship are conducive to the development of CF.
A Historical Perspective of Traumatization

The literature on traumatic stress includes accounts describing a set of symptoms strongly resembling PTSD that afflicted combat veterans and other trauma victims, and persons associated with them, dating to ancient times (National Center for PTSD, 2008). The Greek historian, Herodotus, for example, spoke of the severe psychological impact that the battle of Marathon in 490 B.C had on Athenian soldiers. Later, in 480 B.C., Herodotus describes how even the well-trained Spartan soldiers suffered emotionally as a result of the battle of Thermopylae Pass (Bentley, 1991). More recently, during the 19th Century, PTSD-like characteristics were described during the American Civil War, with veterans who suffered from “Da Costa’s Syndrome” or “soldier’s heart,” a set of symptoms including sleep disturbances, terrible nightmares, heightened anxiety, elevated pulse, and dissociation (National Center for PTSD, 2008). World War I era researchers and medical staff noted the psycho-social-emotional turmoil that veterans experienced as a result of being engaged in hostilities, and termed the phenomenon “combat fatigue” (Babington, 1997; Binneveld, 1997).

The origin of modern traumatic stress research lies in work documented by the United States Department of Veterans Affairs and others regarding the returning World War II combatants who were described as having "shell shock" or "battle fatigue"(Shalev, Bonne, & Eth, 1996). Despite different nomenclature, the same symptoms were noted in combatants of subsequent wars, e.g., Korea, Viet Nam, the Balkans, and the Middle East (Weisaeth, 2002).

Though the psychological horrors of any war impact civilians as well as combatants, World War II stands out as being particularly heinous, partially because of the well-documented atrocities perpetrated through the Holocaust. Faced with torture, starvation, and the possibility of death on a daily basis, Nazi death camp detainees experienced incredible levels of stress and
were traumatized emotionally, physically, and socially (Witztum & Malkinson, 2009; Sigal, 1998). Those who somehow survived the ordeal carried the psychological and physical marks for the remainder of their lives (Luchterhand, 1967). Further, the psychological scars of the survivors’ mistreatment were also manifested in their family members, trauma being transferred from one generation to another (Bergman & Jucovy, 1982; Fossion, et al., 2003; Prot, 2010; Rakoff, 1966). The transgenerational effects on holocaust survivors’ children have been studied by a number of investigators, revealing a hand-me-down syndrome of PTSD-like symptoms (Danieli, 1985; Jordan, et al., 1992; Wanderman, 1979). Thus, the horrors of the death camp vicariously impacted both the immediate and extended families of the victims through a process of transference (Sigal, 1998). Moreover, given the longitudinal studies of Archibald, Long, Miller, and Tuddenham (1962) and Archibald and Tuddenham (1965) on World War II veterans, the evidence indicates that PTSD is a real phenomenon and that its effects are not isolated to only the primary victims of trauma, but impact those who associate with them, or secondary victims, as well.

Despite the psychological trauma encountered by millions of World War II combatants and non-combatants alike, it was not until the Viet Nam conflict that research into PTSD commenced to a significant degree (Pryce, Shackelford, & Pryce, 2007). It was noted that not only were returning combatants exhibiting signs of traumatic stress, but, as seen with WWII veterans, those associated with the veterans who had never witnessed the horrors of war directly also exhibited traumatic stress symptomology (National Center for PTSD, 2008; Pryce, Shackelford, & Pryce, 2007). Rosenbeck & Nathan (1985), for example, found that the children of Vietnam Veterans with PTSD suffered a type of secondary traumatization reflecting that of their fathers’. This is also supported by Nezu & Carnevale (1987), wherein the interpersonal
problem solving and coping reactions of Vietnam veterans with PTSD were examined. Further, an elevated risk of developing behavior or psychiatric problems was identified for children of traumatized Vietnam Veterans (Davidson, Smith, & Kudler, 1989; Roberts, 1982). Finally, the results of Jordan, et al. (1992) reveal that “Compared with families of male veterans without current PTSD, families of male veterans with current PTSD showed markedly elevated levels of severe and diffuse problems in marital and family adjustment, in parenting skills, and in violent behavior” (p.916). Thus, as Bloom (1999), Figley (1995), and other researchers have suggested, trauma and its effects are communicable.

The increased attention to traumatized veterans, both in terms of research and treatment that began in the 1960’s, facilitated the conceptualization of the phenomenon of “Secondary Traumatic Stress”, or “Compassion Fatigue,” as Figley (1995) later called it. Post-Viet Nam War studies bridged the gap between the military and domestic arenas as research on trauma resulting from rape and domestic violence, including child abuse, commenced (Burgess & Holmstrom, 1974; Gelles & Straus, 1979; Kempe & Kempe, 1978; and Walker, 1979). Studies on PTSD, and later STS, revealed important similarities between the two phenomena, leading some to question if they might actually be variants of the same phenomena (Figley, 1995; Pearlman & McIan, 1995). The fundamental difference between PTSD and STSD (secondary traumatic stress disorder), according to Arvay (2001) however, is simply the position of the stressor. In PTSD, the primary stressor is an action that may directly harm, or threaten to harm, and results in trauma, e.g., a soldier is engaged in hostilities during a battle or a child is severely beaten; both experience emotional trauma as a result of the stressors. In STSD, however, the stressor is the exposure to the trauma experienced by other previously traumatized individuals via observation or listening to their horrific stories, resulting in a secondary traumatization
As traumatization is dependent upon the individual’s demographic factors and characteristics, however, some people may actually be traumatized by an event while others may simply be troubled or concerned by it (Pearlman & MacIan, 1995).

The emerging research trend indicates that not only are those who directly suffer trauma psychologically impacted, but so are the people who only have an association with, or even just an awareness of, the traumatic events. Clear evidence of this was seen during the emotional aftermath of the terrorist attacks on 9/11/01 in New York and Washington, D.C. (Gentry, 2002). Jordan et al. (1992) suggest that individuals closest to a person with a major psychiatric disorder may suffer most, and that the effects of such problems can extend from one generation to the next. Prior research has supported the observation that psychiatric disorders (beyond PTSD) may have a serious negative impact on those around the disturbed individual (Swan & Lavitt, 1988; Watt, Anthony, Wynne, & Rolf, 1984). Thus, the situation exists that those afflicted by CF may be more highly susceptible to mental health problems, while, at the same time, those who have a history of personal trauma resulting in psychological disturbance are more likely to experience CF symptoms (Abendroth & Flannery, 2006; Dane, 2000; Nelson-Gardell & Harris, 2003; Perron & Hiltz, 2006).

In reference to the communicability of trauma, Jordan et al. (1992) report that “in recent years, the effect of PTSD on family relationships, spouses, and children of combat veterans has also been examined. A variety of problems that can negatively affect the family have been found to be associated with combat-related PTSD” (p.917). These problems included: difficulties with family cohesion and expressiveness (Solomon, Mikulincer, Fried, & Wosner, 1987); veteran's problems with intimacy and sociability (Roberts et al., 1982); veteran's problems with self-
disclosure, expressiveness, physical aggression, and relationship adjustment (Carroll, Rueger, Foy, & Donahoe, 1985); and veteran's deficiencies in interpersonal problem-solving skills (Nezu & Carnevale, 1987), as reported in Roberts et al., 1982. Moreover, the evidence obtained through the studies also pointed to four major types of symptoms: re-experiencing, avoidance, numbing, and arousal (National Center for PTSD, 2008). Other empirical studies, e.g., McCann, Sakheim, and Abrahamson (1988), have identified disturbances in five areas of psychological functioning as a result of PTSD and STS: emotional, cognitive, biological, behavioral, and interpersonal response patterns. Chrestman (1995), Courtois (1988), Danieli (1988), Herman (1992), and McCann & Pearlman (1990) all note that “secondary traumatization includes symptoms parallel to those observed in people directly exposed to trauma, such as intrusive imagery related to clients' traumatic disclosures” (Bride, 2007, p.64). Courtois’ work focuses on avoidant responses, while Figley (1995) and McCann and Pearlman (1990) discuss physiological arousal. STS results in a change in how secondary trauma victims, including trauma workers, view their social environment and the method of interaction with that environment, i.e., their essential functioning (behavior) adjusts to accommodate the trauma witnessed in others (Figley, 1995; Hesse, 2002; McCann & Pearlman, 1990). The net impact of this STS is that the worker demonstrates characteristics as if he or she had personally experienced the abuse (Figley; Pearlman, & MacIan, 1995). That is, as Sexton (1999) describes, the symptoms, issues, and conflicts experienced by trauma therapists and organizations parallel those experienced by survivors.

Based on the evidence provided by extensive research with combat veterans and recent studies on civilian trauma victims, it can be stated that people are psychologically traumatized when faced with horrifying, life-altering circumstances. This trauma can be so profound that its
impact is felt far beyond the primary victim, even by those who only witness the events or are associated with the primary trauma victim in some manner.

Recapitulating, there is substantial evidence in the literature indicating that those who work with victims of trauma can become traumatized themselves through a process of transference of trauma from the client (Figley, 1995; Harrison, 1980; McCann & Pearlman, 1990). The conceptualization that the effects of traumatization are capable of being passed from the primary victims to others associated with them is supported via a “disease” model reminiscent of a public health concern (Bloom, 1999; Danieli, 1988; Eth & Pynoos, 1994). Operationally defined as STS, the helping professional “absorbs” the victims’ trauma and experiences some of their emotions, in effect becoming traumatized as well (Figley, 1995; Pryce, Shackelford, & Pryce, 2007). Saakvitne et. al (2000, p. 48), define STS as “the negative transformation in the self of the helper that comes about as a result of empathic engagement with survivors’ trauma material and a sense of responsibility or commitment to help”. Both definitions of STS speak to the fact that certain changes, whether they be psychological, physiological, or a combination of both, occur in the helper as a result of their emotionally intense work with traumatized clients. When burnout is also present, CF develops and the worker is faced with a multi-faceted, possibly life-changing situation (Figley, 1995). The consequences of CF in child welfare workers are quite serious and include low morale, high turnover, difficulties for agencies in recruitment and retention of workers, psycho-social-emotional problems, and even spiritual crisis (Friedman, 2002). Thus the “problem” of CF is both an individual and an organizational issue that affects clients, families, workers, and agencies each in their own way. Similarly, CF impacts the micro, mezzo and macro levels of social work practice.
Factors Influencing the Likelihood of STS and CF

An important point in terms of the PTSD-STS-CF paradigm is that the source of the trauma is not as significant as are the individual characteristics of the victim in determining causation (Briere et al., 2008; Allen & Lauterback, 2007). Like stress, trauma is an individualized reaction to one’s environment, and consequently, what is traumatizing to one person may not be to another (McCann & Pearlman, 1992; Pearlman, 1998; Saakvitne et al., 2000). Thus, in terms of the secondary traumatization of child welfare workers, one worker may be traumatized by a child’s horrific recollection of abuse, while another worker is not (Figley, 1995). As in the case of some combatants developing PTSD because of demographic characteristics, not all those family members or service providers exposed to the trauma will develop secondary traumatic stress. Consequently, the development of STS may be viewed as a complex matter requiring exploration for other impacting variables so that the phenomenon can be understood in its proper context. For the current study, the variables that are included are age, years of child welfare experience, gender, education, and position.

**Demographic influences.** Beyond inherent job stressors, there are several social work educational, organizational, and demographic characteristics that may be considered as contributing to the likelihood of case workers experiencing the phenomenon of STS and, if burnout is present, CF.

One characteristic that has been identified by a number of studies as being related to one’s likelihood of experiencing CF is a previous personal history of traumatization. Generally, results have indicated that trauma workers who had been traumatized themselves were more likely to develop symptoms of STS when working with other trauma victims (Bride, 2007; Caringi, 2007; Nelson-Gardell & Harris, 2003; Salston & Figley, 2003; Scarpa et al., 2006).
Utilizing a different approach, Baird & Kracen (2006) conducted a meta-analysis and found that persuasive evidence existed indicating that personal trauma history was a predictor of STS. These results were not universal, however, as some researchers found the impact of the variable of previous traumatization as being non-significant or negligible (Adams, Matto, & Harrington, 2001; Creamer, 2002; Weaks, 2000).

Several researchers studied the impact that a previous psychological diagnosis as a result of life stressors might have on the likelihood of developing STS. Allen & Lauterback (2007), for example, studied the relationship between personality type and personality disorder. This study found that the experience of childhood trauma is related to the personality traits of adult survivors. Those individuals who had experienced any type of trauma as children reported higher levels of neuroticism and openness to new experiences than the individuals who had not experienced trauma as children (control). This suggests that child trauma victims are more likely to suffer from tension, nervousness, and emotional disturbances than persons not victimized as children. In a similar study, Briere et al. (2008) examined the relationship between accumulated exposure to different types of traumatic events (cumulative trauma) in childhood and the total number of different types of symptomology reported (symptom complexity) in adulthood. Results indicated that a linear relationship existed between the number of trauma types experienced by participants before the age of 18 and symptom complexity. This effect remained even when controlling for specific traumatic events, suggesting a generalized effect of cumulative trauma and that a personal history of trauma contributes to a worker’s disposition towards secondary traumatic stress.

Another personal attribute that may impact the likelihood of experiencing STS is that of a negative “coping style.” Through their meta-analysis, Baird & Kracen (2006) presented
evidence that coping style was an important predictor of STS. Caringi (2007), Courtois (2002), Savin-Farrell & Turpin (2003), and Stamm (1997) all report similar findings in that trauma workers who utilized positive coping mechanisms were less likely to suffer trauma symptomology. Way et al. (2004) studied clinicians who treated sexual abuse survivors and abuse perpetrators. The relative contribution of variables theorized to contribute to two effects, avoidance and intrusion, was tested using the Impact of Events Scale. As a result of this study, the clinicians in the Way sample who treated survivors were found to use more positive personal and professional strategies, and exhibited fewer symptoms of traumatic stress, than did those who worked with perpetrators. Overall, the literature strongly suggests that those trauma workers who utilize positive coping skills rather than negative responses fare much better.

The variable of life experience has been shown to be associated with propensity to experience STS. This construct has been operationalized somewhat differently from one study to another, but generally includes “those life experiences which resulted in the individual experiencing significant stress and possibly traumatization” (Abendroth & Flannery, 2006). These authors studied the variable of life experience with a sample of nurses and found that those participants whose life experiences were most stressful were more likely to experience STS. Supporting these findings was the study by Collins and Long (2003). In their meta-analysis, the concept of compassion satisfaction (CS), as well as life experience, was examined. Findings demonstrated that CS is a protective factor that serves as a buffer to the impact of stressful life experiences, thereby preventing or buffering against compassion fatigue or STS. Moreover, findings have shown that a history of stressful life events in helpers is a potential risk factor. A 1999 study by Cornille and Myers also lent support to the significance of life experience in predicting STS and CF in trauma workers. This study assessed the prevalence and severity of
STS symptoms among a sample of Southern child protective service (CPS) workers. The results indicated that all participants were exposed to traumatic stress as a result of client exposure. In addition to being exposed to the trauma of the children under their care, many had also experienced direct trauma in the line of duty. Seventy-eight percent of the sample (n=143) reported having been assaulted or threatened by a client while on the job. In a study by Weiss et al. (1995), researchers identified predictors of symptomatic distress in emergency services (EMS) personnel exposed to traumatic critical incidents. The analyses showed that levels of symptomatic distress were positively related to the degree of exposure to critical incidents. Level of adjustment was also related to symptomatic distress, suggesting that events in one’s life do influence likelihood of experiencing STS leading to CF. Finally, Bride, Radey, and Figley (2007) examined the relationship between levels of CF in CPS workers and a personal history of trauma, peer and administrative support, intent to remain employed in child welfare, professional experience, and size of caseload. Results revealed that moderate levels of secondary level trauma existed within their sample. Positive significant correlations were lifetime trauma history (.247) and caseload size (.171) in relation to STS total score.

The three variables of age, level of training or education, and degree of exposure appear to work in tandem in predicting STS and CF. Bride (2007), Chrestman (1995), and Cornille and Meyers (1999) make the general point that those trauma workers who are older tend to have more experience with trauma victims and, therefore, a greater degree of exposure. Concurrently, these tend to be the same workers who have more formal education and training with traumatized populations. Younger workers tend to have less training and experience with trauma victims and, consequently, have a greater propensity to experience STS and CF (Bride, 2007). The tendency is to assume that those who have the most work experience and may be older have
the most training and education, but assessing the number of years of experience and level of education may not tell the entire tale, as it is possible that the training and years of experience may have not been with victims of trauma. In a study of front-line supervisors, Costin, Karger, and Stoessel (1996) found that while some had many years of experience, barely one-third held graduate degrees in social work (MSW), the preferred academic/professional degree for a supervisor in the authors’ sample. Thus, not only may the quantity of training or experience impact tendency towards STS, but the issue of the level or sophistication of a worker’s or supervisor’s education and training needs to be addressed as it may be an influential factor as well.

In consideration of further evidence of demographic influences on the likelihood of secondary traumatization, the work of Salston and Figley (2003) must be considered. These authors conducted a substantial meta-analysis study that identified some of the most important mitigating factors in the development of STS and CF. Focusing on the effects of working with survivors of traumatic stress, particularly those who have been victimized by criminals, the authors reviewed the relevant research and treatment literature. The authors were specifically interested in STS and the related phenomena of burnout, CF, VT, and countertransference. As a result of this study, the authors were able to identify several important factors that mitigated development of a trauma reaction in victims. These factors included staff training appropriate and pertinent to trauma work, a personal history of trauma, and the interpersonal resources of the worker. Moreover, the authors were able to identify a differential effect of trauma on diverse populations, e.g. race, region, nationality, disability, and socio-economic status. Finally, the authors concur with Figley (1995) and Valent (1995) who argue that “a desire to help survivors
of traumatic events, exposure to the traumatic material of survivors, and empathy are foundational factors in the development of STS” (Salston & Figley, 2003, p.172).

In a study by K.R.Chrestman (1995) additional supporting evidence of the influence of demographics on propensity towards STS is provided. In this study, the author examines the relationship between therapist variables and the level of trauma-related symptomology that the therapist may experience. Employing a survey methodology, the author tested the hypothesis that distress is mediated by risk and resiliency factors “which include the therapist’s personal characteristics, characteristics of the client and the trauma, therapist’s attempts to cope, and the environment in which the therapy takes place” (p.35). Chrestman suggested that secondary exposure to trauma was associated with increased symptoms of intrusion, avoidance, dissociation, and sleep disturbance. Several variables appeared to mediate between secondary exposure and therapist distress, however. Specifically, increased professional experience, increased income, utilization of additional training, decreased percentages of trauma clients in the caseloads, and higher percentages of time spent in non-trauma related activities such as research, were all associated with decreased trauma symptoms. That is professional experience, income, and post-graduate training had an inverse relationship to distress symptomology. Higher caseloads of trauma clients and increased clinical activities were positively associated with distress. Statistical analysis revealed that those therapists who experienced secondary exposure were more likely to report slight increases in trauma-related symptomology. These therapists also reported increased efforts to protect themselves and their families from harm. Thus, the literature suggests that certain trauma worker attribute “clusters,” or traits working in tandem, may serve to buffer a worker from STS or CF, while other clusters facilitate secondary traumatization.
Generally, the literature suggests that the variables of age, length of time working with trauma victims, and education level are inversely related to incidence of CF (Adams, Matto, & Harrington, 2001). Degree of exposure has been found to have a positive association with STS and CF development, in that a diverse caseload is less conducive to the development of STS than a caseload comprised mainly of victims of trauma (Bride, 2007; Briere, Kaltman, & Green, 2008; Campbell & Wasco, 2005).

In terms of gender, Becker-Blease and Freyd (2005) and Cornille and Meyers (1999) suggest that women tend to be more susceptible to STS and possibly CF. In these studies, and others, it is possible that there were intervening variables that may have influenced the results. Women tended to have experienced a history of personal trauma more frequently than their male counterparts. Further, males tended to be in more administrative or supervisory roles in many of the studies. Thus, they may have been further from the point of direct traumatization of victims. Moreover, as age and education/training are inversely related to acquisition of STS, those in management or supervision, who generally are more highly educated and trained, may again have a buffer.

Studies that examined perceived locus of control as a factor in STS development (e.g. Cunningham, 1999; Fitzgerald et al., 2003; Van der Kolk et al., 1996, and Weiss et al., 1995), suggested that those who had developed a strong sense of internal control tended to be less traumatized than those who adhered to an external locus of control. Locus of control was also viewed in conjunction with coping style. The studies cited revealed that those who maintained self control often did so through positive coping mechanisms rather than negative responses such as avoidance.
The Role of Empathy

McCann and Pearlman (1990) suggest that secondary traumatization is a natural outgrowth of working with traumatized people. In contrast to primary or direct traumatization, STS is a reaction to indirect stress, or the transference of feelings of anxiety, helplessness, and victimization, as experienced by clients and related via their stories to therapeutic providers and other human service workers. Contributing to vulnerability to STS and CF are four factors identified by Figley (1995) as empathy, personal trauma history, unresolved trauma, and children’s trauma. Of these four, empathy is the only factor over which we may have at least some control. Perhaps, in view of social workers in general and child welfare workers in particular, the issue of STS could be addressed more efficiently were we not working with people who are altruistically motivated to help others in distress and who are encouraged to feel along (i.e., empathize) with traumatized clients (Abendroth & Flannery, 2006; Corcoran, 1983; Lugris, 2000). Figley notes, “If we are not empathetic or exposed to the traumatized, there should be little concern for compassion fatigue” (p. 7). Beyond a personal propensity to want to help others in pain or distress, social workers are exposed to a formal education process that emphasizes empathy as a basic practice skill, more so than many other professions (Figley, 1995, 2002). Social workers are taught from the most basic level to “start where the client is,” feel what the client might feel, and put themselves in the client’s position (Kirst-Ashman & Hull, 1993). Findings in the literature suggest that the practice rubric of empathy development, though necessary for client engagement and understanding, might pre-dispose social workers to be more susceptible to CF (Simon, Pryce, Roff, & Klemmack, 2006). Further, the literature suggests that one variable that significantly impacts the ability to transfer trauma from one individual to
another is the phenomenon of empathy (Abendroth & Flanney, 2006; Corcoran, 1983). Figley (1995) warns, “Those who have enormous capacity for feeling and expressing empathy tend to be more at a risk for compassion stress” (p.1). Thus, as trauma workers of some capacity, by definition we cannot help but be exposed to the pain and suffering of others. As transfer occurs and we take on the client’s suffering as our own, we too may become transmitters of trauma impacting those around us.

Although empathy is a necessary condition for a therapeutic relationship, the empathic transfer of trauma may be overwhelming for some individuals. Abendroth and Flannery, for example, who studied nurses in a hospice setting, found that 78% of their sample was at a moderate to high risk of STS, which contributes to CF. The study variables that impacted levels of STS included personal trauma, anxiety, life demands, and excessive empathy. Corcoran (1983) found that empathy correlated negatively with the maintenance of emotional separation, or the ability to maintain one’s distinct response to traumatic events and communicate that distancing from the victim’s response to the victim. Conrad and Kellar-Guenther (2006) note:

Child protection caseworkers, supervisors and other child welfare professionals work daily with children and families who have been traumatized. They listen to their stories and feel their hurt. Empathy is often the most important tool they bring to helping these children. Unfortunately, the more empathic they are the greater their risk for internalizing the trauma of their child clients. The result of this engagement is secondary traumatic stress. (p. 41)

Pearlman and Saakvitne (1995) argue that secondary traumatization is exacerbated by, and perhaps rooted in, the open engagement of empathy, or the connection with the client that is inherent in counseling. The nature of the profession of social work, however, precludes any other known alternative. To be a social worker in the field of child welfare means that one will necessarily expose oneself to the risk of secondary traumatization. Essentially, the worker cannot avoid being exposed. Remen (1996) asserts that the expectation that we can be immersed in
suffering and loss daily and not be touched by it is as unrealistic as expecting to be able to walk through water without getting wet. When one places this actuality in the context of the parallel process (to be discussed shortly) that is promoted by child welfare organizations, the opportunity for developing STS and CF is enhanced. As both preventative methods and treatment interventions are available for trauma workers, however, the judicious use of empathy can enhance workers’ professional lives (Anderson, 2000). Further, proper training and education in the use of empathy and the development self-help/protection skills can serve to insulate the trauma worker from CF. Cunningham (1999), for example, notes that secondary or vicarious traumatization is not a pathological reaction to working with trauma survivors, but rather a result of the clinician’s ability to engage empathically with the client that leaves the clinician at risk for secondary traumatization. Like the trauma survivor, the clinician will develop a new world view in an effort to accommodate the traumatic experiences they have endured.

**Child Welfare and Burnout**

Although previously addressed, albeit briefly, in Chapter I of this study, the importance of the impact of burnout on human service workers cannot be overstated. Burnout has a profound influence on organizational functioning and it, in turn, is a result of organizational factors (Cordes & Doughtery, 1993). Maslach, Schaufeli & Leiter (2001) provide us with an extensive review of the phenomenon of burnout and associated literature notes:

What has emerged from all of this research is a conceptualization of job burnout as a psychological syndrome in response to chronic interpersonal stressors on the job. The three key dimensions of this response are an overwhelming exhaustion, feelings of cynicism and detachment from the job, and a sense of ineffectiveness and lack of accomplishment. (p.399)
Maslach, et al. (2001) explain that the exhaustion component represents the basic individual stress dimension of burnout and it refers to feelings of being overextended and depleted of one’s emotional and physical resources.

The cynicism (or depersonalization) component represents the interpersonal context dimension of burnout. It refers to a negative, callous, or excessively detached response to various aspects of the job. The component of reduced efficacy or accomplishment represents the self-evaluation dimension of burnout. It refers to feelings of incompetence and a lack of achievement and productivity at work. (p.399)

In relation to child welfare, the literature is rich with studies connecting child welfare workers and burnout (e.g., Anderson, 2000; Conrad & Kellar-Guenther, 2006; Drake & Yadama, 1996; Harrison, 1980; Jayaratne & Chess, 1986; MorBarak, Nissley, & Levin, 2001). This body of literature suggests that burnout among child welfare workers is the result of external circumstances such as high caseloads, overwhelming paperwork, arbitrary deadlines, critical comments from the community in general, bureaucratic difficulties, and isolation of caseworkers, i.e., organizational factors (Glisson & Hemmelgarn, 1998; Jimmieson & Griffin, 1998; Johnson & McIntyre, 1998; Karger, 1981). Further, Harrison (1980) attributes child welfare worker feelings of alienation, depersonalization, and other symptoms of burnout to the organizational variables of role strain and ambiguity. Rycraft (1994) points out the significant role the agency performs in a caseworker's decision to continue employment in public child welfare: a caseworker's sense of mission can be enhanced during tenure with an agency; the deployment of staff is within the control of the agency; the provision of supervision is the responsibility of the agency; and staff working conditions, compensation, and benefits are an integral component of administrative practice.

Client difficulty also impacts burnout and its correlates, job satisfaction and turnover. This is to say that clients presenting with chronic dysfunction, or severely challenging acute
difficulties, often require intensive interventions in order to affect a positive change. Because of this challenge, workers may feel unsuccessful and frustrated in their efforts. Acker (1999) discovered that those workers who had a higher percentage of seriously mentally ill clients on their caseload experienced lower job satisfaction and higher rates of burnout and turnover. Acker also reported that as support increased, job satisfaction increased and emotional exhaustion decreased, lending evidence to the assertion that organizational factors, in addition to personal attributes, have a significant impact on burnout.

Bahner and Berkel (2007) write that social support has been identified as a factor that may help workers cope with job stress and, therefore, may help reduce susceptibility to job-related burnout. The authors note that a large body of research has concentrated on burnout among mental health professionals who, along with child protective service workers, tend to experience a significant amount of stress on their jobs. As the amount of job stress increases, the likelihood of experiencing emotional exhaustion and depersonalization also increases. Sources of this stress might include the need to fulfill multiple roles, work overload, and exposure to dangerous clients (Bahner & Berkel, 2007). Human service providers often enter their jobs with ideals that they will be successful in helping their clients and that they will be autonomous and have personal control over their work. Often they believe that their work will be meaningful and stimulating and that clients will be grateful and cooperative. The failure of some jobs in human services to live up to these ideals may contribute to burnout (Daley, 1979). These frustrations could be magnified with those who work with violence in families by a sense of powerlessness over clients’ abusive behavior towards others (Bahner & Berkel, 2007). Further, contributing to workers’ sense of being overwhelmed by caseload demands is the fact that responsibilities may not be clearly defined for them, resulting in role conflict and thereby exacerbating the symptoms
of burnout (Acker, 2003). Jayaratne (1986) provides similar findings in the author’s study on the impact of stress and burnout on female child welfare workers and their husbands. Results of this study indicated that greater feelings of burnout in the workers were associated with depression, anxiety, and irritableness in response to job frustrations. Further, these individuals were also likely to report lower marital satisfaction.

Coping strategy not only impacts CF as mentioned previously, but also the likelihood of BO (Caringi, 2007; Courtois, 2002; Savin-Farrell & Turpin, 2003; and Stamm, 1997). Anderson (2000) identified two types of coping mechanisms: active coping strategies and avoidant coping strategies. Those workers who employ active coping strategies do less depersonalizing of their clients and feel a greater sense of accomplishment at their work. Alternatively, those workers who use avoidant strategies are more likely to experience emotional exhaustion, feelings of depersonalization, and a diminished sense of personal accomplishment.

Burnout is a serious problem that contributes to high turnover rates and lowered child welfare caseworker retention. A study by Salovitz and Keys (1988) reported a turnover rate of 75% per year of child welfare workers in New York City. Nationwide, reports of child welfare caseworker turnover ranged between 46 and 90% (Drake & Yadama, 1996). This loss of trained and experienced workers drains badly needed skills and energy from the system. Further, burnout has been strongly correlated with poor job satisfaction and staff turnover (Bednar, 2003). Acker (1999) notes that social workers who quit their jobs do so mainly because of a lack of organizational or supervisory support. In the manner of a double-edged sword, human service organizations tend to create the problems that cause them the greatest harm, i.e., social work agencies contribute to the development of burnout because they constrain autonomy and promote bureaucratization (Arches, 1991). Bednar expresses the concern that many in the Social Work
profession have concerning the future of child welfare. The author states that providing an organizational climate that promotes job retention by child welfare caseworkers and supervisors should be a national priority as the safety and welfare of our children are at stake.

A meta-analysis by Barak, Nissly, and Levin (2001) identified burnout and job satisfaction as two of the main predictors of both intent to leave and actual turnover. Age and experience were also highly associated with intent to leave. This validates the findings in many other studies on the topic that younger inexperienced workers tend to be less satisfied with their jobs and burnout more quickly. Decreased worker satisfaction and increasing burnout, however, may impair workers long before they decide to leave their positions, resulting in poor service provision by “wounded warriors” (Shapiro, Dorman, Burkey, & Welker, 1999; Silver, Poulin, & Manning, 1997). Despite the volume of the literature concerning burnout and child welfare workers, there is little that describes burnout in child welfare supervisors. Supervisors are identified as being both a part of the burnout problem, and significant contributors to burnout prevention, but not as victims of burnout themselves (Drake & Yadama). In a rare study on the topic however, Erera (1992) studied the burnout experiences of sixty-two supervisors in public welfare organizations. “The results suggest that in contrast to line workers, the supervisors experienced significantly high levels of depersonalization and reduced personal accomplishment, but only a moderate level of emotional exhaustion.” (p.131). Erera argues that the basis for the supervisors' experiences of burnout was due to “ambiguous and incompatible organizational policies”. Moreover, Erera asserts that person-role conflict, perceived overload, and conflicting expectations from superiors also contributed to the supervisors' burnout. As seen with other studies on burnout and its resolution (e.g., Acker, 2003; Cypher, 2001; Lloyd, King, &
Chenoweth, 2002; & MorBarak, Nissly, & Levin, 2001), social support moderated the influence of both role conflict and ambiguity.

**Child Welfare Supervision and the Parallel Process**

The position of caseworker supervisor is considered both a high profile and integral job within the child welfare agency (Rycraft, 1994). The supervisor must assume numerous roles on behalf of both her/his supervisees and the agency administration. The relationship between the supervisor and supervisees, therefore, may be of substantial depth, taking on the form of a teacher–student or mentor–mentee (Kahn, 1979; Rycraft, 1994). Supervisors’ empowering behaviors toward workers significantly affect workers’ belief that they have the capability to shape events in their jobs and their lives, that their actions are effective, and that they have some control over their choices and actions (Cearley, 2004). Thus, the supervisor in the public child welfare agency also serves as a model for her/his supervisees (Dill & Boggo, 2007).

The supervisor in child welfare agencies is perceived as often being able to exert some influence on supervisees, possibly to the point of impacting staff turnover rates (Sharma, et al., 1997). Nissly, MorBarak, and Levin (2005) found that social support received from those at work (supervisors and coworkers) provides a stronger buffer against the effects of organizational stress on intention to leave than does social support from significant others and family/friends. Thus, the peer and supervisorial relationships exert a significant influence on the child welfare caseworker. Anderson (2000) takes a different position, however, and argues that, while the cause of significant turnover rates has been the subject of numerous studies over the years, there is little consensus about turnover precipitants. Anderson cites the following impacting variables as promoting high turnover rates: low pay, lack of community support, dangerous working conditions, a serious lack of resources, poor organizational support, and a lack of quality
supervision. In terms of the variable of supervision, not only does quality supervision in child welfare agencies reduce attrition, it also tends to ameliorate the effects of STS (Cunningham, 1999). In a study of telephone counselors, Dunkley and Whelan (2006) found that quality supervision facilitated trauma workers’ efforts to develop effective coping styles and, thereby, buffer the impact of STS. Thus, there is evidence that the relationship between the worker and the supervisor is of importance for many reasons, including the reduction in the likelihood of turnover due to burnout and a similar reduction in the possibility of STS.

Due to the nature of child welfare, the position of supervisor can be particularly challenging in such an agency (Dill & Boggo, 2007). Faller et al. (2003) note that there are five child welfare best practice concepts that they feel should be considered and balanced in supervision: child protection and safety, family centered practice, permanence for children, culturally competent practice, and outcomes-based practices. The authors identified 14 areas that were considered important but were, essentially, neglected. Some of the areas include: supervising to accomplish tasks in a timely way; counseling workers to help them deal with conflicts within and outside the agency; communicating and coordinating; planning, including determining goals and ways to achieve them; team building; and facilitating appropriate actions through modeling and empowering techniques. The authors assert that child welfare agencies sometimes resist change or learning even when it is in their own best interests.

Having the time to learn depends, in part, on whether the organization wants to learn and makes time for it. It also depends, in part, on the nature of the work the organization does, and how focused it can be in carrying out its functions. Child welfare agencies have trouble with respect to both of these factors, making supervision in these organizations a special challenge. (Faller et al., 2003, p.9).

Gibbs (2001) is particularly critical of how supervision in child welfare agencies is approached. This author suggests that a refocusing of supervision be seen as one possible strategy for lowering high attrition rates among child protection workers. Gibbs argues that the
current model of supervision gives insufficient attention to three important factors: the emotional intrusiveness of the work, building resilience in workers, and the implications of adult learning theory. The supervisor must affirm both the merit and necessity of exploring the impact of feelings and thoughts on action and perception. A key message for supervisors to deliver is the value of individual workers to the organization, leading to increased self-esteem and self-efficacy. Gibbs maintains that currently the overriding priority for supervisors seems to be ensuring that the work is completed and conforms to acceptable standards. While this is a political and organizational imperative, the consequences are immense if the only message received by supervisees is about completing tasks and getting on with the job without complaining. Finally, Gibbs also argues for adult learning via reflective supervision. This change to supervision involves a fundamental shift in organizational priorities and policies, and an acceptance throughout of the impact of anxiety on all those working in this field.

The topic of supervision style has been the subject of research in terms of its possible association with burnout, and it is well represented in the literature. Being social workers as well as supervisors, most supervisors prefer to supervise in a “client-centered” modality but have found this difficult to achieve because of the pressures of the job (Bowers, Esmond, & Canales, 1999). Because of role dichotomy, some supervisors may be quite stressed and find it difficult to serve two masters, i.e., casework and administration, at one time. Despite this possibility, the method of client-centered practice is preferred. This, in turn, requires a client-centered supervisory approach. Bowers, Esmond, and Canales express skepticism that a client-centered approach should be the preferred supervisory method despite its popularity at the time. The authors note that the nature of different practice approaches, the impact of context or environment, the influence of various mediating factors on the decision to employ one approach
over the other, and the consequences of either for case management, are absent from the
literature. Further, the authors warn that until more research is done in this particular area, one
specific supervisory style should not be endorsed, particularly in relation to the phenomena of
burnout and STS. This admonition finds support in the work of Cohen and Rhodes (1977) who
suggest that supervisors should be provided with both training and education on various
supervisory orientations. Further, the authors propose an eclectic or integrated approach that
“emphasizes concern for task, people, and competitive job orientation in the practice of social
work supervision” (p. 281). One such example would be the Discrimination Model proposed by
Bernard and Goodyear (1992). With this model, supervisors pay attention to three prescribed
roles: teacher, consultant, and counselor. The role of supervisor as counselor, in particular, has
important implications in terms of supervision in child welfare. It is through this arena that the
parallel process of supervision is promoted.

In regard to the phenomena of STS and CF, Dunkley and Whelan (2006) noted that the
respondents in their study who perceived themselves as having a strong working alliance with
their supervisor had lower levels of vicarious traumatization. Further, having a strong
supervisory working alliance was associated with lower levels of disruption in beliefs. Trippany,
White-Kress, and Wilcoxon (2004) note that it is important that supervisors and administrators
overseeing counselors working with trauma survivors consider the impact that VT may have on
counselors, and take an active preventative role. The authors assert that supervisors have a
responsibility to use their knowledge about secondary traumatization to prevent counselor VT
and to facilitate counselor mental health through providing a supportive and VT-preventative
environment.
The literature concerning child welfare supervision is dominated by the unidirectional idea that supervisors impact their supervisees who, in turn, impact their clients. Little research has been done to examine the reverse of this perspective, or the fact that supervisors may be impacted by their supervisees in a similar manner that caseworkers might be impacted by their traumatized clients. Norvell, Walden, and Gettleman (1993) examined stress and physical symptoms reported by a sample of child welfare supervisors at a state human-services agency. The results of the study suggest that the child welfare supervisors in this sample tended to suppress feelings of anger that were a result of perceived stress in the work environment and experienced an increase in physical symptoms related to stress and anxiety. Moreover, the conflicting pressures and responsibilities of a supervisory position have been hypothesized to increase perceived stress. An association was made between levels of perceived stress and level of satisfaction with coworkers and supervisees. Norvell, Walden, and Gettleman (1993) maintain that child welfare workers and their supervisors face high levels of occupational stress due to many factors including the inherent dangers, both physical and psychological, of working with the abuse-perpetrating population in their own homes. Concurrently, child welfare workers often face occupational stress from the agencies themselves in the form of a lack of support, inadequate resources, caseloads that are unrealistic and unmanageable, role ambiguity, and inadequate compensation. The population of child welfare worker supervisors was chosen due to its vital role in the function of the agency, administratively as well as clinically (Norvell, Walden & Gettleman, 1993). The authors found that, as a group, the supervisors did not suffer from physical symptomology from stress at a significantly different level than the published norms for the stress measuring instruments. The level of perceived stress by the supervisors was significantly higher, however, which may have to do with issues of empowerment. An important
finding was that the mode of anger expression is an important variable affecting the perception of stress in child welfare supervisors. Child welfare supervisors often have to hold their anger while other groups may have better outlets. The authors note that this finding supports previous research that describes a relationship between method of anger expression, stress, and physical symptoms related to hypertension and chronic pain. Thus, while the supervisors in the study did not evince significant physical symptomology to stress, they did tend to experience psycho-emotional symptoms that were of a serious concern (Norvell, Walden, & Gettleman, 1993).

Though it is certainly the goal of supervisors to be a positive influence on their supervisees, Ganzer and Ornstein (1999) argue that “viewed from a contemporary relationship approach … the supervisor-supervisee relationship in actuality would be characterized as less hierarchical and more one of mutual influence, of give and take, in which the issues of both individuals are at play at one time or another during the supervision” (p. 232). Further, supervisors may suffer from emotional or psychological problems which impact the supervisor-supervisee relationship. Canfield (2005) asserts that in working with traumatized clients, particularly those who have been sexually abused, support from important people in the therapist’s social environment may be difficult to come by. There seems to be a tendency for supervisors to blame the therapist or caseworker for not maintaining appropriate boundaries, enmeshment, or for having ulterior motives for engaging in such work. Moreover, they may be told that their reactions reflect unresolved issues in their personal lives, or that they should not be doing clinical work. Supervisors who are perceived as impaired seem to have a large impact, both professionally and personally, on the workers they supervise. As workers go through their training, they look to their supervisors for guidance and nurturing. Younger workers, still in the process of forming their adult identity, may look to their supervisors for role modeling for both
personal and professional development. Further, junior workers may be quite dependent on their supervisors early on. Lack of supervision resulted in nearly 40% of a study sample reporting developing significant symptoms of anxiety or depression (Igartua, 2000). Samantrai (1992) reports that interviews with human services workers who had left their positions found that lack of a supportive, caring supervisor was one of two primary reasons contributing to the turnover. Thus, the supervisor in a child welfare agency holds great responsibility for both the agency and the caseworkers in its employ.

Facing the demands of the organization, the supervisors are the first line of management. As so, they must attend to the specific operational tasks of the agency. Gibbs (2001) suggests that supervisors need to be more involved with supervising people and less involved as “paperwork police,” as so often occurs. Gibbs offers that a refocusing of supervision could be seen as one possible strategy for lowering high attrition rates among child protection workers. A key message for supervisors to deliver is the value of individual workers to the organization, leading to increased self-esteem and self-efficacy. A common source of stress for supervisors appeared to be their attempts to reconcile the messages emanating from their supervisees with those from higher management. Currently, the overriding priority for supervisors seems to be ensuring that the work is completed and conforms to acceptable standards. The reality of the enforcement of correct and timely report submission should not overshadow the human aspect of supervision. Supervisors themselves must be given an organizational message that they have a critical role to play in responding to the high level of anxiety experienced by front-line workers. The capacity to supervise in a challenging yet caring way must be acknowledged as a highly skilled job that warrants specialized training and support (Gibbs, 2003).
A connection between the secondary traumatization of child welfare caseworkers and the possible tertiary traumatization of supervisors may lie in a practice known as the “parallel process” that is fostered within child welfare organizations. This process, or specified sequence of events as modeled by supervisors, is intended to be a template for the caseworker-client link; the caseworker-client relationship should be a model or reflection of the supervisor-caseworker relationship (Cohen, 2003). Parallel process is defined as an unconscious replication in the supervisory session of therapeutic difficulties that a supervisee has with a client (Williams, 1997). As the supervisor-worker relationship and the worker-client relationship were regarded as simply subsystems of a larger system, Kadushin (1985) called this an isomorphism, the tendency for a pattern to repeat at all levels of a system. Further, the dynamics of the supervisee-client subsystem are reflected as the parallel process (Kadushin). Each subsystem mutually influences the other. “The supervisee, when presenting material for supervision, cannot avoid being influenced by interactions with the client any more than the supervisee can avoid being influenced by the supervisor’s ideas and personality when working with a client (Marohn, 1969). Moreover, Ganzer and Ornstein (1999) assert that transference and countertransference are paramount to facilitating the worker’s learning situation. Thus, through empathizing with the caseworker and vicariously experiencing what the worker experiences with the client, the supervisor can take advantage of a learning moment and direct the worker to appropriate action.

Not all authors believe that the parallel process of supervision evinces best practice techniques. Fosshage (1997) and Hirsch (1997) are critical of the parallel process and question its appropriateness in every encounter, particularly if it does not add to therapeutic engagement. Further, these authors object to the role of the all-knowing and infallible worker and the unknowing client. Berman (1998) proposes an alternate paradigm of supervision in child
welfare. Suggesting that the top-down style of supervision be discarded along with the bottom-up style, Berman suggests a cyclic configuration in which the focus can be on any member of the “supervisory triad” (the supervisor, worker, and client who are involved in a relational matrix). Through this cyclic supervisory process, transference and countertransference involve the “psychic reality” of each member that is constantly activated and molded through the influence of the others (Berman). That is to say, through the actions of transference and countertransference, each member of the therapeutic triad impacts the others in such a manner as to facilitate the formation of a new psychic reality or, in social work terms, a worldview. The parallel process, therefore, goes beyond simply modeling good casework skills to workers. Through the process of transference from one member of the triad to the other, however, the parallel process facilitates the development of cognition, behavior, and attitude.

As the supervisor-caseworker helping relationship can be viewed as progressing through sequential stages, so goes the worker-client relationship. It is important that each stage, and the factors that may affect it, be attended to in order to ensure the effectiveness of the relationship (Williams, 1997). How well supervisors strategically use the stages of their relationships with caseworkers serves as a model for caseworkers to use with clients and, therefore, bears significantly on the agency’s ability to fulfill its mission. “With the worker, the supervisor evaluates the family’s progress in achieving the child welfare outcomes and communicates the expectation that a parallel process of review is occurring between the worker and family” (Cohen, 2003, p. 42). The caseworker-client relationship, therefore, is a reflection of the supervisor-caseworker relationship in terms of process.

Briefly revisiting the topic of empathy, Arlow (1963) and later, Casement (1985) make a connection between it and the parallel process. Arlow states that in the supervisory session the
supervisor helps the supervisee to consciously identify their “transient identification” with the client, i.e., examine the transference between client and worker. Through a similar process, the supervisors places themselves in the role of the supervisees in an effort to experience what is being described by the supervisees (Casement). Caligor (1984) suggests that during the parallel process, “the supervisee brings the therapeutic situation to the supervisory session by playing out the interaction (concerning the client) with the supervisor. The therapist then plays the role of the client. By doing this, the supervisor can experience the therapeutic situation firsthand and respond to it” (Williams, 1997). During this process, given the communicability of trauma, is it possible that caseworkers who are secondarily traumatized might also serve to traumatize their supervisors? Further, by fostering the parallel process, are child welfare agencies inadvertently fostering the secondary/tertiary traumatization of child welfare supervisors? These questions remain unanswered in the current literature; one purpose of this research was to examine the topic of STS and child welfare supervisors and address this gap.

A Conceptual Basis for Secondary Traumatization

There have been several theoretical bases, including learning and behavioral theories, which have been used to attempt to explain secondary traumatization. Constructionist Self Development Theory (CSDT) is one approach that provides us with an understanding of the phenomena from a VT perspective. It was developed as a result of clinical experiences and extensive research with adult trauma survivors by McCann and Pearlman (McCann & Pearlman, 1990). CSDT is described as a theory that integrates psychoanalytic theory with theories of social cognition (Pearlman, 1988). It provides us with a framework for understanding the impact of trauma on the individual, or self. Moreover, CDST describes the effects of traumatic life experiences on the development of the individual (McCann and Pearlman, 1992).
CSDT explains trauma as a result of the process of accommodation and assimilation of non-normative information into one’s cognitive schema (McCann & Pearlman, 1990). Essentially, one has “learned” that non-normative stimuli do not fit one’s present schema and a new schema must be developed albeit at a high psychological cost. That is, when presented with a situation that is non-normative for the individual, a sense of incongruence ensues, leading to a stress/anxiety reaction. The individual must accommodate his or her cognitive schema to the new stimulus, and then assimilate it into a new schema. The “new” cognitive schema is then internalized as the template for further interactions with the social environment (McCann & Pearlman, 1990). (Please refer to Figure 2 in Appendix F.) “A basic tenet of (CSDT), drawn largely from developmental social cognition theories, is that complex cognitive representations of self and others underlie much of an individual’s interpersonal behavior” (McCann & Pearlman, 1990, p. 57). Thus one’s adapted cognitive self prompts the exhibition of new behavioral characteristics which permit less friction while interfacing with one’s social environment. Further, Kelly (1955) asserts that there are certain structuring tendencies inherent to human nature by which people attempt to make sense of their experiences, both within themselves and within their environment. In the case of trauma workers, one is trying to understand the horrors that victims have experienced. As its name implies, a premise of CSDT is that the individual is active in developing, or constructing, their own reality (McCann & Pearlman, 1990). Reality construction is influenced by one’s interactions with the social environment that may be stressful. CSDT maintains that as stress is individually perceived, the nature of trauma is also individualized in that one constructs the meaning that a particular trauma has for them (Pearlman, 1998). Further, a major assumption of CSDT is that the self, that is the
seat of the individual’s identity and inner life, develops over the life span through internalization, assimilation, and accommodation (Hayes & Oppenheim, 1997).

CSDT posits that there are five areas of the self that are affected by traumatic events:

1. Frame of reference: one’s usual way of understanding self and world, including spirituality;
2. Self capacities: the capacity to recognize, tolerate, and integrate affect and maintain a benevolent inner connection with (the) self and others;
3. Ego resources: necessary to meet psychological needs in mature ways, specifically abilities to be self-observing, and to use cognitive and social skills to maintain relationships and protect oneself;
4. Central psychological needs: reflected in disrupted cognitive schemas in the five areas of safety, trust, control, esteem, and intimacy; and
5. Perceptual and memory system: including biological (neuro-chemical) adaptations and sensory experience.” (Saakvitne et al., 2000, p. 6)

McCann and Pearlman (1992), the authors of the theory, suggest that CSDT provides a framework for the systematic assessment and practical treatment of three aspects of the self that are affected by trauma: “These include self-capacities, or the ability to tolerate strong affect and regulate self-esteem; cognitive schemas, or beliefs and expectations about self and others in the areas of frame of reference (or identity and world view), safety, trust, esteem, intimacy, power, and independence; and intrusive trauma memories and related distressing affect” (McCann & Pearlman, p. 191). This construction is based on the individual’s unique history that shapes the person’s experience of traumatic events and defines the adaptation to trauma (McCann & Pearlman,). This experience of traumatic events can be “re-lived” repeatedly through traumatic
memories that are in response to stimuli received from one’s social environment (McCann & Pearlman, 1990). Herein lies one of the greatest challenges of traumatization. Trauma that is relived may be as devastating as the original trauma, as memories of the event(s) are encoded within the imagery portion of the memory that is associated with strong emotions (Paivio, 1986). Possibly this phenomenon is the key to STS as it is in the “reliving” of traumatic images and emotions with caseworkers, in lieu of the perpetrator, that results in STS. Both the client’s and the worker’s cognitive schemas are altered and adaptation must take place in response to the trauma. In effect, the individuals have constructed a new “reality” for themselves. The adaptation is functional for the individual but may lead to further conflict with the social environment, e.g., difficulties with relationships, and psychological and physiological dysfunction. Thus, the model reveals that CSDT “centers on the interaction between the survivor’s subjective response to trauma and its objective content, with particular focus on disruption to the developing self” (McCann & Pearlman, 1990, p. 1). The concept of trauma disrupting the self is important, as the individual’s entire frame of reference is changed because of external events. This, in turn, precipitates an alteration of the way one conducts transactions with their social environment (McCann & Pearlman).

A related, albeit distinctly different, theory used to explain STS is that of social cognitive theory. Social Cognitive Theory explains how people acquire and maintain behavioral patterns and it provides a framework for understanding, predicting, and changing human behavior (Bandura, 1977). Social cognitive theory addresses the topic of human behavior and, as such, has its basis in behaviorism. SCT provides the theoretical framework for interactive learning used to develop constructivism and cooperative learning (Beck, 1976). As such, this theory
represents a combination of behaviorist, social learning theory, and cognitive theory. It could be termed cognitive-behavioral in nature (Boeree, 2006).

Bandura (1986) felt that the individual’s interaction with the social environment involves beliefs and cognitive competencies that are developed and then modified by social influences and structures within the environment. The environment also has an effect on the individual’s behavior in that a person’s behavior determines the aspects of their environment and, conversely, that the individual’s behavior is modified by the social and physical environment, i.e., “reciprocal determinism” (Bandura, 1993; Jones, 1989). Rotter (1954) takes a slightly stronger position, asserting that “personality represents an interaction of the individual with his or her environment. One cannot speak of a personality, internal to the individual, that is independent of the environment. Neither can one focus on behavior as being an automatic response to an objective set of environmental stimuli. Rather, to understand behavior, one must take both the individual (i.e., his or her life history of learning and experiences) and the environment (i.e., those stimuli that the person is aware of and responding to) into account” (Mearns, 2009, p. 1538).

Overall, SCT depends on the premise that behavior is based on three separate but interacting regulatory systems (Bandura, 1986, 1977): (1) external stimulus events, (2) external reinforcement, and (3) cognitive mediational processes (MacCormick-Brown, 1999). Social cognitive theorists maintain that behavior is essentially dependent upon environmental, both physical and social, and situational factors (Mower, 1960; Parraga, 1990). “Situational factors” refers to the cognitive representations of the environment that may affect a person’s behavior, e.g., the situation is a person’s perception of place, time, physical features, and activity (Glanz, et al., 2002). The three components of situational (personal) factors, environmental factors, and
behavior are engaged in a dynamic, reciprocal process wherein environment affects behavior that impacts the situation and so on (Bandura, 1989a). This process was formally named “contextualism” in the 1970s (Lerner, 1986). Rotter (1954) saw “personality, and therefore behavior, as always changeable. Change the way the person thinks, or change the environment the person is responding to, and behavior will change” (in Mearns, 2009, p.1540). Stated another way, environment and situation provide the framework for understanding behavior (Parraga, 1990).

Though SCT upholds the behaviorist concept that consequence mediates behavior, it contends that behavior is largely regulated antecedently through cognitive processes (McCormack-Brown, 1999). Therefore, response consequences of a behavior are used to form expectations of behavioral outcomes (the cognitive aspect of the process) (Bandura, 1989b). In this way people can predict, to a large degree, what the consequences of their behavior will be (Rotter, 1960). In a process similar to that seen with CSDT, the mind constructs its own reality, selectively encodes information, performs behavior on the basis of values and expectations, and imposes structure on its own actions (Jones, 1989).

From a SCT perspective, human personality is flexible and can be influenced by both physical and social factors. As humans, we not only learn by doing, but we can learn vicariously by watching others (Bandura, 1977; Boeree, 2006). Basically, humans are neither intrinsically good nor evil but are creative beings that can choose themselves how to live their lives (Lantz, 1996). People can set and achieve goals and are not passive partners, but interface actively with the social environment (Bandura, 1989a,b). SCT gives us an empowering view of mankind, wherein people can, and often do, make logical choices about how and when to do things. SCT maintains that human behaviors are more than just the result of attempting to satisfy libidinal
drives or a response to an external stimulus (Bandura, 1977). From a therapeutic perspective, dysfunction is viewed as a result of learning inappropriate responses to cues in the environment (Bandura, 1989a). Treatment, therefore, is educational in nature and focuses on learning appropriate responses to feedback from the environment (Werner, 1965; Lantz, 1975, 1978).

CSDT, on the other hand, explains the method of direct and indirect traumatization of individuals and the results of that traumatization. Traumatization takes place on an individual basis and is impacted by the perceptions and history of that individual. CSDT is based on the premise, however, that external events that are contrary to the individual’s schema result in dysfunction or trauma. In this way CSDT and SCT have similar characteristics, i.e., SCT centers on learned behaviors in conflict with those found acceptable by the social environment. Thus, both theories are concerned with behaviors in response to external stimuli. Moreover, the therapeutic approach suggested by both theories is a learning process wherein the client is desensitized to intrusive stimuli and productive behaviors are introduced and learned. As asserted by Beck (1976), the SCT theoretical framework for interactive learning is used to develop constructivism and cooperative learning. As CSDT is based on constructivism, e.g., the development of new schemas in response to trauma, the theories also share some basic assumptions. Reality, for example, for the individual, would change in SCT because of “new cognitions,” while in CSDT the term “new schemas” is used. Further, while in SCT, cognition acts as a mediator between stimulus and response, placing individual control over behavioral responses to stimuli; in CSDT the person’s response to stress is an individual process based on the victim’s unique perceptions and history (Jones, 1991; Perry et.al., 1990; Woodward, 1982).

Despite their similarities and overlapping natures, SCT and CSDT do evince some important differences. The basic tenets of the two theories are not congruent in every case, e.g.,
SCT cites reward/punishment paradigms as influencing learning and, subsequently, behavioral change. SCT also notes vicarious learning through observation of others and through modeling (Beck, 1976). CSDT addresses STS, or vicarious traumatization, because of exposure to traumatized others, but this process is different than vicarious learning. What is most significant about CSDT and SCT in terms of STS is how they work in tandem. CSDT does a good job of identifying and explaining STS, while SCT provides an excellent basis for therapy. Together, CSDT and SCT can provide a basis for providing help to the helpers.

In summary, CSDT focuses on the individual trauma survivor’s subjective response to their traumatization in comparison to its objective context. The difference between the subjective self and the objective reality of the traumatization impacts the individual’s development and subsequent functioning within the social environment. STS presents the situation wherein the clinician is exposed to such a frequency and intensity of trauma, as experienced by others, that the clinician actually absorbs the trauma and manifests it as though it had been directly experienced. As a result, the individual’s schema and possibly even that person’s “self” are altered to accommodate the trauma. The utility of CSDT in relation to research centers on traumatized individuals and those who work with them. This is a diverse population in that all ages, nationalities, religions, cultures and both genders have been subject to trauma via various internalized events. Thus CSDT can explain the process of traumatization in such varied victims as sexually abused children, victims of intimate violence, veterans of military conflicts, and the clinicians or social workers who work with them. Projecting from this population, CSDT also explains how caseworkers and possibly their supervisors experience secondary traumatization.
Research Questions and Hypotheses

The review of literature related to the specific topic of CF, suggests that social workers in child welfare settings are susceptible to this phenomena as a consequence of working with trauma victims. These caseworkers generally have close relationships with their supervisors, and commonly share the details of their cases with them. As trauma is considered a phenomenon that is communicable, there is some question whether STS, and therefore CF, is similarly communicable. That is, if trauma is communicable, is CF also? The current study examined the extent to which child welfare supervisors experience CF in relation to that experienced by caseworkers in public child welfare settings. The questions addressed in this study (and their related hypotheses) were:

Q1. Do levels of self-reported CF symptoms in Child Welfare supervisors differ from levels experienced by caseworkers?
   H1: Child welfare supervisors experience symptoms of CF at greater levels than do caseworkers.

Q2. Do CW supervisors’ self-report levels of STS differ from levels reported by caseworkers?
   H2: CW supervisors will report higher levels of STS than do CW caseworkers.

Q3. Do CW supervisors’ self-report levels of BO differ from levels reported by caseworkers?
   H3: CW supervisors will report higher levels of BO than do CW caseworkers.

Q4. Do CW supervisors self-report levels of CS differ from levels reported by caseworkers?
   H4: CW supervisors will report higher levels of CS than do CW caseworkers.

Q5. Do personal and professional demographic characteristics, e.g., age, years of child welfare experience, position, and education, have the same influence on self-reported CF in both child welfare supervisors and child welfare caseworkers?
   H5a: Age will have an inverse relationship on levels of STS for both CW supervisors and CW caseworkers.
   H5b: Those participants with a MSW degree will exhibit lower levels of CF than those in other education groups.
   H5c: Experience will have an inverse relationship on levels of STS for both CW supervisors and CW caseworkers.
H5d: Female respondents will report higher levels of STS than male respondents for both supervisors and caseworkers.
CHAPTER III
RESEARCH DESIGN AND STUDY METHODS

Introduction

This study focused on the phenomenon of compassion fatigue and its components, secondary traumatic stress and burnout, as they relate to child welfare caseworkers and supervisors. The objective of this study was to determine if the level of CF (STS and BO), as reported by supervisors in child welfare agencies, differs from that reported by caseworkers in these agencies.

This study consisted of a secondary analysis of available data that will answer the research questions. This data was compiled by Pryce, Shackelford, and Pryce (2007) through a series of Secondary Traumatic Stress workshops conducted in the southern United States. The data set allowed for a comparison between the responses given by child welfare supervisors and those provided by caseworkers in the key area of CF. Although limitations raised due to the data being collected for another purpose were present, I believe that this data set allowed me to answer the research questions well.

Instruments

The principal tool used to measure the CF, STS, CS, and burnout constructs was the Compassion Fatigue and Compassion Satisfaction Self Test for Helpers (CFCSSTH). This instrument was part of a questionnaire distributed to participants that included items not directly related to the current study. Some minor word changes were made to the instrument with
permission from Charles Figley, the author of the instrument, in order to make it more pertinent for the population completing the questionnaire (Pryce, Shackelford, & Pryce, 2007).

The CFCSSTH is a self-report test developed by Figley and Stamm (1996) that is used to measure the risk of compassion fatigue and burnout and the potential for compassion satisfaction. Despite its name, there is no global measurement for compassion fatigue with the CFCSSTH. The term “Compassion Fatigue” as used by Figley and Stamm in this instrument, is actually a proxy for Secondary Traumatic Stress. At the time the instrument was developed, the terms CF and STS were generally interchangeable and were not viewed as distinct constructs as is the current trend. This is the apparent reason why the BO scale is a part of the CFCSSTH. (If the “CF” scale of the CFCSSTH actually measured CF in the modern sense it would include burnout items by default and a separate burnout scale would be unnecessary.) For this study, a true CF score was fabricated for comparison purposes by the summing of its parts, 23 STS/CF items and 17 burnout items, i.e., when the burnout and secondary traumatic stress scales were combined a global compassion fatigue score was realized. (This fabricated CF scale was intended for the comparison purposes of this study only.) The global compassion fatigue score produced by the supervisors was then compared to that produced by the caseworkers to address the main objective of this study. Accordingly, the compassion fatigue scale measures burnout and secondary traumatic stress as experienced by caregivers who work with victims of trauma. Further, the CF scale measures emotional, physical, and mental exhaustion, where one feels depleted, chronically tired, helpless, hopeless, and even cynical, about oneself, one’s work, life, and the state of the world (Gentry, 2002).

The construct of compassion satisfaction, as measured by the CS score, represented the participants’ “sense of happiness with what one can do to make the world in which one lives a reflection of what one thinks it should be” (Stamm, 2002, p. 113). In terms of CF, the literature
suggests that even though individuals may experience secondary stress through their relationship with trauma victims, they remain “on the job” because they are so dedicated to the purpose of that job and their CS measures high. Moreover, the CS construct is the antithesis of CF and, as suggested by the literature, the two constructs are often found to be negatively correlated.

This instrument provides a scale to measure STS (identified as the Compassion Fatigue scale), burnout, and CS. For each construct, a series of Likert-scale items are presented and participants are asked to rate their experiences for each item where 1 = rarely/never, 2 = at times, 3 = not sure, 4 = often, and 5 = very often. Higher scores on either the STS or burnout dimension indicate a higher risk for that dimension, secondary traumatic stress, or burnout respectively (Pryce, Shackelford, & Pryce, 2007). A higher CS score represents greater CS potential.

Each outcome variable on the CFCSSTH has its own scale. The scores are ranked as extremely low risk for STS = 26 or lower, 27-30 = low risk, 31-35 = moderate risk, 36-40 = high risk, and 41 or higher = extremely high risk of STS. For the burnout dimension, scores were <36 = extremely low risk, 37-50 = moderate risk, 51-75 = high risk, and >75 = extremely high risk of burnout. For CS, 118 and above = extremely high potential, 100-117 = high potential, 82-99 = good potential, 64-81 = modest potential, and 63 and below = low potential (Figley, 1995; Stamm, 2002).

Stamm notes that the CFCSSTH has two main uses: (1) research to assist in establishing the constructs of secondary exposure to Trauma (e.g., CF or VT) and (2) as a personal exploration of one’s risk for the positive and negative aspects of helping (p. 114). The original population sampled for this instrument was comprised of 113 females and 66 males from five locations. These sources included 29 conference attendees at the 13th Annual Meeting of the
International Society for Traumatic Stress Studies in Boston in 1996; the Alaska Public Health Nurse Annual Convention in Anchorage (n=20); the American Red Cross in Anchorage (n = 10); Inter-Psych, an on-line mental health organization (n=19); and the University of Alaska (n = 101) (Stamm, 2002). Thus the sample represented a wide range of trauma workers and trauma experiences (Rudolph, Stamm, & Stamm, 1997). Psychometric studies conducted by Rudolph, Stamm, & Stamm (1997) and Figley and Stamm (1996) for instrument reliability provided good results with the following alphas: CS (.87), burnout (.90), and CF (.87) (Stamm). Another validation study was also conducted, this with a sample including 210 health care providers and 160 caregivers plus internet participants, yielding a sample of 374. All of these participants described their work as dealing with crisis intervention and caregiving. The results of this survey were compared with a second administration given three months later and there was no significant difference. These results corroborated the results from a study by Figley & Stamm (1996) who reported reliabilities of .85 to .94 on a sample of 142 psychotherapy practitioners (Stamm, 2002). Thus, with a sample of different types of trauma workers, the CFCSSTH was both valid and reliable. The CFCSSTH has been utilized with samples of child welfare personnel, e.g., Conrad and Kellar-Guenther (2006). In this study the authors surveyed 363 child protection staff in Colorado. The results of this study revealed that participants were significantly more likely to have high risk of CF, extremely low risk of burnout, and good potential for CS. Those participants with high CS had lower levels of CF (p = .000; mean = 35.73 high CS group, mean = 43.56 low group) and lower levels of burnout (p = .000; mean = 32.99 high CS group, mean = 41.69 low group). These results suggest that CS does have an inverse relationship to burnout. A difference in the samples utilized by Conrad and Kellar-
Guenther and the current study is that this study includes casework supervisors and compares their CF, CS, and burnout levels to those of the other child welfare personnel.

**Data Collection**

The focus of the Pryce workshops was to educate trauma workers about STS and provide them with self-help tools to enable its prevention. Workshops were held in five southern U.S. states, but for this study data from three states, Alabama, Mississippi and Louisiana, were made available for secondary analysis. The data from the remaining two states was collected using different instrumentation and, therefore, could not be considered as valid for the current study. The data that was available to this researcher were the STS, burnout, and CS (for Louisiana) scores, along with demographic data. The construct scores were considered outcome variables and the demographic data were categorized into predictor variables. The demographic, or predictor, variables in the dataset are: job position, age, gender, years of experience, and education level. The attributes of the demographic variables may be seen in Table 3.1.

Table 3.1

*Demographic Variables and their Attributes*

<table>
<thead>
<tr>
<th>Variable Name</th>
<th>Variable Labels</th>
</tr>
</thead>
<tbody>
<tr>
<td>Job position</td>
<td>Child welfare caseworker or supervisor</td>
</tr>
<tr>
<td>Age</td>
<td>The number of years the person lived at the time the questionnaire was completed</td>
</tr>
<tr>
<td>Gender</td>
<td>Female or male participant</td>
</tr>
<tr>
<td>Years of experience</td>
<td>The number of years the respondent has been working in the field of child welfare at the time the survey was taken</td>
</tr>
<tr>
<td>Education level</td>
<td>The level and type of education of the participant:</td>
</tr>
<tr>
<td></td>
<td>BA/BS – bachelor degree in non-Social Work major</td>
</tr>
<tr>
<td></td>
<td>BSW – bachelor degree in Social Work</td>
</tr>
<tr>
<td></td>
<td>MA/MS – master degree in non-Social Work area</td>
</tr>
<tr>
<td></td>
<td>MSW – master degree in Social Work</td>
</tr>
<tr>
<td></td>
<td>other – an education degree not listed above</td>
</tr>
</tbody>
</table>
Sample

Child welfare agencies in the five states in the southern U.S were provided with information on a series of STS workshops. These agencies were encouraged to solicit in-house volunteers who would be interested in learning about the topic of STS and how to buffer themselves from its affects. Participants were presented with the option of completing a questionnaire associated with the training, which included the CFCSSTH. Since completing the CFCSSTH during the workshop was completely voluntary, not all participants chose to do so, and consequently, the data provided by these participants could not be used in the analysis. These personnel included all types of child welfare workers, including caseworker aides, homemakers, and family aides. For the purposes of this study, however, only the data for case workers and supervisors will be included. The net sample size for the purposes of this research, therefore, will be 561, including 458 caseworkers and 103 supervisors. This sample size is lower than the original 666 participants the Pryce study featured, as a number of respondents did not complete their survey sufficiently to be included in the current study. The demographic characteristics of the participants are presented in Table 3.2.
Table 3.2

Demographic Variables Frequency Distribution

<table>
<thead>
<tr>
<th>Variable</th>
<th>Mississippi</th>
<th>Alabama</th>
<th>Louisiana</th>
<th>Total Sample</th>
</tr>
</thead>
<tbody>
<tr>
<td>N= 329</td>
<td>N= 158</td>
<td>N= 74</td>
<td>N= 561</td>
<td></td>
</tr>
<tr>
<td>Age (mean)</td>
<td>37.35</td>
<td>36.68</td>
<td>41.19</td>
<td>37.64</td>
</tr>
<tr>
<td>SD = 10.09</td>
<td>SD = 9.55</td>
<td>SD = 7.75</td>
<td>SD = 9.76</td>
<td></td>
</tr>
<tr>
<td>Years of exp.</td>
<td>8.24</td>
<td>6.32</td>
<td>12.31</td>
<td>8.22</td>
</tr>
<tr>
<td>(mean)</td>
<td>SD = 7.68</td>
<td>SD = 7.09</td>
<td>SD = 7.65</td>
<td>SD = 7.71</td>
</tr>
<tr>
<td>Education:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-SWK BA/BS</td>
<td>31.9% (105)</td>
<td>46.8% (74)</td>
<td>0% (0)</td>
<td>31.9% (179)</td>
</tr>
<tr>
<td>BSW</td>
<td>48.6% (160)</td>
<td>24.7% (39)</td>
<td>36.2% (25)</td>
<td>39.9% (224)</td>
</tr>
<tr>
<td>Non-SWK</td>
<td>6.1% (20)</td>
<td>12.0% (19)</td>
<td>14.5% (10)</td>
<td>8.7% (49)</td>
</tr>
<tr>
<td>MA/MS</td>
<td>10.6% (35)</td>
<td>13.3% (21)</td>
<td>14.5% (10)</td>
<td>11.7% (66)</td>
</tr>
<tr>
<td>MSW</td>
<td>2.7% (9)</td>
<td>3.2% (5)</td>
<td>49.0% (20)</td>
<td>6.0% (34)</td>
</tr>
<tr>
<td>Other</td>
<td>.06% (2)</td>
<td>.12% (2)</td>
<td>6.8% (5)</td>
<td>1.5% (9)</td>
</tr>
<tr>
<td>No response</td>
<td>.06% (2)</td>
<td>.12% (2)</td>
<td>6.8% (5)</td>
<td>1.5% (9)</td>
</tr>
<tr>
<td>Gender:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>90.2% (292)</td>
<td>87.3% (137)</td>
<td>86.1% (62)</td>
<td>87.5% (492)</td>
</tr>
<tr>
<td>Male</td>
<td>9.8% (32)</td>
<td>12.7% (20)</td>
<td>13.9% (10)</td>
<td>11.4% (62)</td>
</tr>
<tr>
<td>Position:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Caseworkers</td>
<td>84.2% (277)</td>
<td>85.4% (135)</td>
<td>62.2% (46)</td>
<td>81.6% (458)</td>
</tr>
<tr>
<td>Supervisors</td>
<td>15.8% (52)</td>
<td>14.6% (23)</td>
<td>37.8% (28)</td>
<td>18.4% (103)</td>
</tr>
</tbody>
</table>

Data Analysis

The Statistical Software Package for Social Sciences (SPSS) Version 11.5 was used to conduct data entry and statistical analysis of the data.
Protection of Human Subjects

Institutional review board (IRB) approval for the protection of human subjects was obtained for the original collection of data protocols by the University of Alabama Institutional Review Board by Pryce, Shackelford, and Pryce. Prior to the workshops wherein data was collected, participants were asked to read the human subjects consent form and, if they chose to, could anonymously contribute to the data collection by completing the Compassion Fatigue Self Test. Further, for the purposes of this study, procedures for the protection of human subjects were submitted to the University of Alabama IRB and approval for this study was granted (see IRB approval documentation in Appendix C). Only anonymous data in aggregate form were used in the current study, thereby maintaining complete anonymity of the participants. Since I did not interact with any of the participants in any way, and all of the data are coded providing anonymity, there was minimal risk of harm for the participants in this study.

Analysis Strategy

The focus of this research was to explore the relationship between CF and child welfare supervisors, i.e., did child welfare supervisors experience CF, and if so, how did this compare to CF as experienced by child welfare caseworkers? The research questions and their associated hypotheses addressed the four main outcome variables of CF, STS, burnout, and CS, comparing caseworkers to supervisors. A fifth area of analysis looked at the impact of demographic variables on the outcome variables for both supervisors and caseworkers.

At this point, the manner in which the hypotheses were formulated will be discussed. It is generally accepted that caseworkers are usually closer to the origin of trauma, i.e., they have more direct contact with trauma victims, than their supervisors. Because of this, it would be logical to assume that caseworker trauma as measured by CF, STS, and burnout scores would be
greater than that reported by supervisors. Proximity to the source of trauma is, however, one of many variables to consider in assessing communicability of trauma and its intensity. Several demographic characteristics, e.g., age, years of child welfare experience, education type, and gender, which impact likelihood of experiencing CF, have already been discussed within the scope of this study. I propose that because of the “distillation” process of trauma by caseworkers, supervisors are exposed to a more virulent form of trauma over time. This concentrated trauma is the accumulation of the most disturbing incidents from numerous caseworkers over a span of time that may encompass decades. Consequently, given the level of trauma that supervisors are exposed to, I hypothesized that it is they who would be experiencing greater levels of CF, STS, and burnout. Moreover, as CS is antithetical to CF, I proposed that it was the supervisors who experienced higher levels of this as well. That is to say, I hypothesized that supervisors would experience higher levels of CS as they were helping the helpers in a manner of speaking.

**Hypothesis Testing**

*H1: Child welfare supervisors experience symptoms of CF at greater levels than do caseworkers.* To test H1, a comparison of group means took place. As this analysis is comprised of only two groups, a t-test was conducted. A quick look at each group’s mean CF score indicated which group experienced CF at a greater rate. The t-test indicated whether this difference was significant or not. If the supervisors’ mean CF score was significantly higher than that of the caseworkers, H1 would have been accepted. If the opposite were true and caseworkers’ mean CF scores were significantly greater that the supervisors’ mean score, then H1 could not have been accepted. If there is no significance between the mean scores of the two groups then the null hypothesis would have been accepted.
**H2: CW supervisors will report higher levels of STS than do CW caseworkers.**

Testing H2 required a statistical analysis similar to that seen in H1 except that STS mean scores were used instead of CF mean scores. A look at the group means provided the information about which group reported higher levels of STS and a t-test revealed if the observed difference was significant.

**H3: CW supervisors will report higher levels of Burnout than do CW caseworkers.**

In order to test H3, a t-test was used, as above, to compare group means. If the burnout levels reported by supervisors were significantly greater than that reported by caseworkers, H3 would have been accepted. If, on the other hand, the caseworkers’ mean burnout score was significantly higher than that of the supervisors, H3 could not have been accepted. Finally, if there was no significant difference between the groups’ means burnout scores the null hypothesis would have been accepted.

**H4: CW supervisors will report higher levels of CS than do CW caseworkers.**

This was the fourth and final hypothesis that compared groups’ means on an outcome variable. This particular outcome variable was CS and H4 predicted that supervisors would have reported significantly higher levels than did caseworkers. If the results of the t-test indicated so, H4 would have been accepted. If the caseworkers reported significantly higher levels of CS than did the supervisors, H4 would have been rejected. If there was a difference between the two groups, but it was not significant, the null hypothesis would have been accepted.

**H5: The fifth hypothesis for this study was actually comprised of four parts that examined the effect of demographic variables plus position (caseworker or supervisor) on STS levels.** For this set of hypotheses, caseworker and supervisor data were viewed separately in terms of
correlations to assess what type of relation exists between the variables. Each of these will be addressed separately.

*H5a: Age will have an inverse relationship on levels of STS for both CW supervisors and CW caseworkers.* The variables of “age” and “STS score” were entered into a correlation analysis for the group of supervisors and then again for the caseworkers. The direction (positive or negative) and the strength of the correlations was then compared. If age had an inverse relationship with STS for both caseworkers and supervisors, H5a was accepted. If an inverse relationship did not exist for both groups then H5a would not be accepted.

*H5b: Those participants with a MSW degree will exhibit lower levels of STS than those in other education groups.* For this hypothesis a comparison was made between five educational levels (BA/BS, BSW, MA/MS, MSW, and other) and two professional levels (caseworkers and supervisors). In order to efficiently address this hypothesis an ANOVA statistical analysis was completed. The STS means for all of the groups were compared simultaneously and the results of the analysis revealed whether or not the MSW participants exhibited lower levels of STS than the other participants.

*H5c: Experience will have an inverse relationship on levels of STS for both CW supervisors and CW caseworkers.* In order to address the hypothesis H5c, correlation analysis was done on caseworkers and supervisors independently and then compared. In order to accept H5c, the child welfare experience of both caseworkers and supervisors must have had a negative correlation with STS levels, i.e., the more years of child welfare experience a participant has, the lower the level of reported STS.
H5d: Female respondents will report higher levels of STS than male respondents for both supervisors and caseworkers. For this final hypothesis a comparison of group means was made. Female caseworkers’ mean level of STS was compared to that of the male caseworkers. Similarly, the female supervisors’ mean level of STS was compared to their male counterparts’ level. As such, this required a visual comparison of means and a validating t-test. In order to accept hypothesis 5d the females of both groups would have had reported greater levels of STS than the males of their respective groups.
CHAPTER IV
RESULTS

This chapter presents the results of the analysis performed to address the questions posed in the present study. First, a profile of the participants in the sample is presented through an explanation of the demographic variables utilized in the study. Second, findings for each of the four main research questions are presented.

Sample Characteristics

Though the original sample included 666 responses the total number of eligible participants for this sample was reduced to 561 from three states because of incomplete responses. The greatest number of participants were from Mississippi with 329 (58.7% of the total sample), 158 (28.2%) were from Alabama, and 74 (13.1%) were from Louisiana. The majority of the participants were female (n = 492, 85.5% of the total sample) and 62 (11.1%) were males. Seven respondents (1.25%) did not indicate their gender.

The participants in this study held a variety of positions within child welfare agencies. Four hundred fifty eight (73.6%) self-reported their positions as direct service personnel, referred to as caseworkers, 103 (16%) reported their position as supervisors. (One respondent, equaling .2% of those responding to the original survey, did not indicate job position and was not included in any statistical analysis. Consequently, the final sample for this study included 561 responses.)

Reporting their highest educational earned degree, the participants identified a variety of academic majors at both the baccalaureate and graduate levels (see Table 4.1). The majority of
the participants reported having bachelor’s degrees (n = 403 or 71.8% of the total sample). Of these, 224 (39.9%) reported having a BSW degree and 179 (31.9%) reported having a bachelor’s degree in a field other than social work. Of those respondents having a graduate degree, 66 (11.7% of the sample) reported having an MSW degree, and 49 (8.7%) reported having a master’s degree in a field other than social work. Twenty five (5.8%) of the respondents reported their formal educations as “other.” Seventeen of the respondents (2.8%) did not respond to this item. These individuals were excluded from any analysis involving the variable of formal education type though they were included in the analysis of other demographic variables for which they provided responses.

Table 4.1:

<table>
<thead>
<tr>
<th>Formal Education of Participants (N=561)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Education Type</td>
</tr>
<tr>
<td>Undergraduate</td>
</tr>
<tr>
<td>BA/BS Non-Social Work</td>
</tr>
<tr>
<td>BSW</td>
</tr>
<tr>
<td>Graduate</td>
</tr>
<tr>
<td>Non-Social Work Masters</td>
</tr>
<tr>
<td>MSW</td>
</tr>
<tr>
<td>Other</td>
</tr>
<tr>
<td>No Answer</td>
</tr>
</tbody>
</table>

Participants’ reported from zero to forty years of child welfare experience. The mean number of years of such experience was 8.22 with a standard deviation of 7.68. Those respondents from Louisiana reported the most years of experience (mean = 12.31, s.d. = 7.65), while those respondents from Alabama reported the least (mean = 6.32, s.d = 7.09).
Caseworkers had an average of 6.62 years (s.d. = 6.8) of child welfare experience while the supervisors reported an average of 15.333 years (s.d. = 7.53).

Age was the final demographic variable used for this study. The mean sample age was 37.64 years (s.d. = 9.75) while the median age was 37. Respondents’ ages ranged from 23 to 80, providing a sample range of 57. In terms of the individual states, the mean age for the Mississippi respondents was 37.35, for Alabama respondents it was 36.68, and for Louisiana respondents it was 41.19. An ANOVA test revealed that the mean age for those from Louisiana was significantly greater than those from the other two states F (2, 545) = 5.56, p = .004. In regards to position, the mean age for caseworkers was 36.31 years (s.d. = 9.58) and that for supervisors was 43.8 (s.d. = 8.09). An independent sample t-test revealed that there was a significant difference between the mean ages for the caseworkers and the supervisors: t = -7.17, p = .005. Please refer to Table 4.2 and Table 4.3 for graphic representation of the distribution of the demographic variables.

**Outcome Variables**

The four dependent or outcome variables in this study were Compassion Fatigue Score, STS Score, Burnout Score, and Compassion Satisfaction Score. Respondents from all three states provided data on CF, STS, and BO. However, data for Compassion Satisfaction was only available from the respondents from Louisiana so the analysis for this variable was limited in this manner.

**Secondary Traumatic Stress**

Possible scores on the STS variable on the CFCSSTH can range from 0 to 115. In the current total sample, the distribution of scores on this variable ranged from a low of 6, indicating extremely low CF risk, to a high of 94, suggesting a very high risk of CF. The range for this
variable in this sample was therefore 88. The sample mean for CF was 40.93 (s.d. = 12.64), indicating moderate-bordering-on-high risk for this group (Figley, 1995).

Table 4.2:

Demographic Characteristics (Education Type, Gender, and Job Position) of Study Participants (N=561)

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Mississippi</th>
<th>Alabama</th>
<th>Louisiana</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participants</td>
<td>329 58.65</td>
<td>158 28.16</td>
<td>74 13.19</td>
<td>561 100.00</td>
</tr>
<tr>
<td>Education</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BA/BS</td>
<td>105 31.90</td>
<td>74 46.80</td>
<td>0 0</td>
<td>179 31.90</td>
</tr>
<tr>
<td>BSW</td>
<td>160 48.60</td>
<td>39 24.70</td>
<td>25 33.80</td>
<td>224 39.90</td>
</tr>
<tr>
<td>MA/MS</td>
<td>20 6.10</td>
<td>19 12.00</td>
<td>10 13.50</td>
<td>49 8.70</td>
</tr>
<tr>
<td>other</td>
<td>9 2.70</td>
<td>5 3.20</td>
<td>25 41.90</td>
<td>74 13.20</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>female</td>
<td>292 90.20</td>
<td>137 87.30</td>
<td>62 86.10</td>
<td>492 87.50</td>
</tr>
<tr>
<td>male</td>
<td>32 9.80</td>
<td>20 12.70</td>
<td>10 13.90</td>
<td>62 11.00</td>
</tr>
<tr>
<td>Position</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>caseworker</td>
<td>277 77.80</td>
<td>135 75.40</td>
<td>46 43.50</td>
<td>458 81.50</td>
</tr>
<tr>
<td>supervisor</td>
<td>52 11.60</td>
<td>23 12.80</td>
<td>28 32.60</td>
<td>103 18.30</td>
</tr>
</tbody>
</table>

Table 4.3:

Age and Years of Experience of Study Participants (N=561)

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Mississippi</th>
<th>Alabama</th>
<th>Louisiana</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>37.35 10.09</td>
<td>36.68 9.55</td>
<td>41.19 7.75</td>
<td>37.64 9.76</td>
</tr>
<tr>
<td>Years of C.W. Experience</td>
<td>8.24 7.68</td>
<td>6.32 7.09</td>
<td>12.31 7.65</td>
<td>8.22 7.71</td>
</tr>
</tbody>
</table>
For caseworkers, the mean CF score was 41.87 (s.d. = 13.04). For supervisors, the mean was 36.75 (s.d. = 9.66). The distribution of levels of CF symptoms as reported by caseworkers and supervisors is seen in Table 4.4. The statistical analysis for hypothesis testing follows this section.

Table 4.4:

STS Risk for Caseworkers and Supervisors

<table>
<thead>
<tr>
<th>CF Risk</th>
<th>Caseworkers (n=458)</th>
<th>Supervisors (n=102)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td>Extremely low</td>
<td>(26 or less)</td>
<td>40</td>
</tr>
<tr>
<td>Low</td>
<td>(27 to 30)</td>
<td>30</td>
</tr>
<tr>
<td>Moderate</td>
<td>(31 to 35)</td>
<td>65</td>
</tr>
<tr>
<td>High</td>
<td>(36 to 40)</td>
<td>93</td>
</tr>
<tr>
<td>Extremely High</td>
<td>(41 or more)</td>
<td>230</td>
</tr>
</tbody>
</table>

Burnout

The possible scores for BO on the CFCSSTH can range from 0 to 85. For the current sample of caseworkers and supervisors, the variable of Burnout Score exhibited a range of 69, going from a low score of 6 (very low risk) to a high of 75 (high risk). The sample mean was 36.83 (s.d. = 11.40), indicating a low risk as a whole. For caseworkers, the mean BO score was 37.77 (s.d. = 11.80) and for supervisors, the mean was 33.05 (s.d. = 9.13). The distribution for the variable of burnout risk for position is seen in Table 5 on the following page. No caseworkers or supervisors scored in the range identified as an extremely high risk of burnout. Rather, the greatest number of caseworkers (50.9%) and supervisors (75.7%) scored in the extremely low risk category.
Table 4.5:

*Burnout (BO) Risk for Caseworkers and Supervisors*

<table>
<thead>
<tr>
<th>BO Risk</th>
<th>Caseworkers (n=457)</th>
<th>Supervisors (n=102)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td>Extremely low</td>
<td>233</td>
<td>50.90</td>
</tr>
<tr>
<td>Moderate</td>
<td>159</td>
<td>34.70</td>
</tr>
<tr>
<td>High</td>
<td>65</td>
<td>14.20</td>
</tr>
<tr>
<td>Extremely High</td>
<td>0</td>
<td>0.00</td>
</tr>
</tbody>
</table>

**Compassion Fatigue**

As indicated previously, the CFCSSTH does not have a global indicator for CF. For the purposes of this study, however, one was fabricated from the components of CF, i.e., STS and burnout. The CF scale is only intended for comparison purposes within the participants of this study and could not be generalized for any other purpose. For caseworkers, the minimum CF score achieved was 15 and the highest was 146 (mean = 79.68, s.d. =23.23). For supervisors, the minimum CF score was 41 and the highest was 95 (mean = 68.62, s.d. =11.39).

**Compassion Satisfaction.**

Possible CS scores on the CFCSSTH can range from 0 to 130. In the one-state sample used for this analysis, CS scores ranged from 47 (low potential) to 122 (extremely high potential). The mean score for the total sample was 90.53 (s.d. = 12.74), representing good potential. For caseworkers, the mean CS score was 90.00 (s.d. = 12.5) and for supervisors, the mean CS score was 92.33 (s.d. = 14.51). The distribution for CS potential scores by position is presented in Table 4.6 below. Both supervisors and caseworkers evinced CS potential in the “good” range, though caseworkers produced a higher percentage of their scores in that range than did supervisors.
Table 4.6:

*Compassion Satisfaction Potential for Caseworkers and Supervisors*

<table>
<thead>
<tr>
<th>CS Potential</th>
<th>Caseworkers</th>
<th>Supervisors</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td>Low (&lt; 63)</td>
<td>1</td>
<td>.02</td>
</tr>
<tr>
<td>Modest (64-81)</td>
<td>7</td>
<td>15.22</td>
</tr>
<tr>
<td>Good (82-99)</td>
<td>31</td>
<td>67.40</td>
</tr>
<tr>
<td>High (100-117)</td>
<td>6</td>
<td>13.04</td>
</tr>
<tr>
<td>Extremely High (118 or above)</td>
<td>1</td>
<td>.02</td>
</tr>
</tbody>
</table>

Hypothesis Testing Results

The current study tested four main hypotheses. The results of the analyses testing these hypotheses are presented here.

**Hypothesis 1: Child welfare supervisors experience symptoms of CF at greater levels than do caseworkers.**

This hypothesis was tested by comparing the mean CF score of the caseworkers with the mean CF score of the supervisors via a t-test. The group mean for caseworkers was 79.64 (s.d. = 23.22) and for supervisors 69.80 (s.d. = 17.32), indicating that caseworkers reported greater levels of CF than did the supervisors (t = 4.06, p = .003). However, because the difference was in the opposite direction of that which was hypothesized, H1 is rejected.

**Hypothesis 2: Child welfare supervisors will report higher levels of STS than do child welfare caseworkers.**

In order to test this hypothesis, an independent sample t-test was used to compare the STS means of the two job groups. The mean STS score for the caseworkers was 41.87, s.d. = 13.04 while
that for the supervisors was 36.75, s.d. = 9.66. There was a significant difference between the secondary traumatic stress reported by caseworkers as compared to that reported by the supervisors (\( t = 4.535, p < .001 \)). This analysis indicates that supervisors did not experience symptoms of STS at greater levels than did caseworkers. The inverse was actually the case, wherein caseworkers reported significantly higher levels of STS than did supervisors. Thus the data does not support H2. Although supervisors do experience STS, the level that is experienced is significantly less than that of caseworkers.

**Hypothesis 3: Child welfare supervisors will report higher levels of BO than will child welfare caseworkers.**

Hypothesis H3 examined the relationship of the respondents’ current job to levels of reported symptoms of burnout. Again, in order to test this hypothesis a t-test was used to compare the means of reported burnout for two job groups. The mean burnout score for caseworkers was 37.77, sd =11.80 while that for supervisors was 33.05, sd = 9.13 (\( t = 4.48, p < .001 \)). The result of analysis was significant, however it was in the inverse direction of the stated hypothesis: Child welfare supervisors do not report higher levels of burnout than do caseworkers. The opposite is indeed the case, i.e., child welfare caseworkers report significantly higher levels of burnout than do supervisors. As caseworkers scored higher than did supervisors on the burnout scale of the CFCSSTH Hypothesis H3 is rejected.

**Hypothesis 4: Child welfare supervisors will report higher potential for CS than do child welfare caseworkers**

The data available to test this hypothesis was only available for those respondents from the state of Louisiana. Consequently, the analysis for hypothesis H4 did not reflect the entire study sample but was limited to Louisiana caseworkers and supervisors. Hypothesis H4 was tested via
a t-test as two group means were being compared. The mean CS potential for caseworkers was 90.00, sd = 12.5 (n=60). The mean for supervisors was 92.33, sd = 14.5 (n = 9). The caseworkers’ CS scores ranged from a low of 47 to a high of 122 (producing a formal range of 75), while that of the supervisors was a bit tighter; ranging from 69 to 115 (formal range of 44). T-test results reveal that t = -1.918; p = .06 indicating that the data did not support hypothesis H4. Although job position may have impacted potential for CS, as the supervisors’ mean score was slightly higher than that of the caseworkers, the difference between the two groups was not significant.

Hypothesis 5
The fifth hypotheses, in four parts, compared the influence of demographic variables on CF levels for both caseworkers and supervisors. The first part of this hypothesis related to the workers’ ages.

Hyopthesis 5a: Age will have a negative relation with levels of CF in both CW supervisors and CW caseworkers. In order to assess the relation between age and levels of CF for both supervisors and caseworkers, a correlation analysis was conducted. Age and CF have an inverse relation that is significant with this total sample: r (561) = -.161, p < .01. For caseworkers, the correlation analysis revealed an inverse relation: r (450) = -.142, p<.01. Supervisors, conversely, exhibited no relation, between age and CF: r (94) =.001, p = .99. These results indicate that supervisors and caseworkers do not experience the same relation in terms of age and CF and that the data does not support the hypothesis H5a.

Hypothesis 5b: Those participants with a MSW degree will exhibit lower levels of CF than those in other education groups. Descriptives indicated that those caseworker respondents with a BSW degree exhibited the highest mean CF scores (84.67, s.d. = 23.99) of all
education degree categories. In comparison, respondents with a non-Social Work BS/BA exhibited a 75.45 mean CF score (s.d. = 21.57); those with non-Social Work master’s degrees had a mean of 76.05 (s.d. = 25.88); and those respondents reporting the MSW degree exhibited a CF mean score of 77.44 (s.d. = 18.52). The result of an ANOVA revealed that reported CF levels varied widely for those holding differing educational degrees, F (5, 451) = 3.47, p=.004. Ad hoc testing (Bonferroni) revealed a significant difference between the CF mean score achieved by the BSW caseworkers and the BA/BS workers (-9.222).

Comparable descriptive results for supervisors revealed that those who held the MSW degree reported relatively high levels of CF (mean = 74.97, s.d. = 11.86) in comparison to the other supervisor groups. Those supervisors with BA/BS degrees scored the next lowest CF levels at mean = 66.95 (s.d. = 9.98), followed by BSW supervisors (mean = 70.35, s.d. = 10.64), MA/MS supervisors at mean = 68.18 (s.d. = 12.14), and then those indicating “other” as their formal education (mean = 75.41, s.d. = 10.68). An ANOVA for the supervisors provided, F (5, 96) = 2.25, p = .055. Overall, education type impacted CF level more so with caseworkers than with the supervisors. (Please refer to Table 4.7.) Hypothesis 5b is accepted, as the MSW supervisors had the lowest CF mean score of all educational groups in both job types (caseworker and supervisor).

**Hypothesis 5c: Experience will have a negative relationship with CF in both CW supervisors and CW caseworkers.** The connection between “years of experience” and CF (sometimes indicated as STS symptoms) is reported in the literature to be an inverse relationship, i.e., as experience increases, self reports of STS symptoms are reduced (Bride, et al., 2007; Briere, et al., 2008; Chrestman, 1995; Cornille & Meyers, 1999). In testing Hypothesis H5c, a correlation analysis was utilized. For caseworkers, r = -.058, p = .221 indicating an inverse
relationship between years of experience in child welfare and reported level of CF supporting the hypothesis. For supervisors, however, analysis reveals $r = .109, p = .282$, indicating that no correlation existed between years of experience and reported levels of CF. Data analysis indicates that the supervisor data does not support hypothesis H5c and, consequently, it is rejected.

**Hypothesis 5d: Female supervisors will report higher levels of CF than male supervisors.** The literature suggests that female trauma workers tend to score higher on STS scales that their male counterparts (Becker-Blease & Freyd, 2005 and Cornille & Meyers, 1999, for example). To test this hypothesis, means for females versus males were compared on the variable “CF score” via a t-test. Female supervisors produced a mean CF score of 68.77 (s.d. = 12.04) while their male counterparts produced a mean CF score of 68.08 (s.d. = 7.80). The t-test revealed $t = -.3191, p=.075$, indicating that there was not a significant difference between the mean CF score of the two groups. Thus, hypothesis H5d is rejected, as female supervisors did not exhibit a significantly higher mean CF score than male supervisors.

**Summary of Research Findings**

The results of the current study revealed that caseworkers reported significantly greater symptoms of CF and burnout than did the supervisors for this sample. Caseworkers also experienced greater CS potential than did supervisors. In terms of demographic variables, aside from “current job” impacting STS scores, and therefore CF scores, for both caseworkers and supervisors, there was only one analysis that produced a significant difference. When formal education type was used as a predictor of STS score, the BSW group reported significantly greater symptoms of STS and CF than any other group. The demographic variables age, years of child welfare experience, and gender did not significantly impact self-reported levels STS
symptoms. Please refer to Table 4.7 for a summary of trauma in terms of educational type and job position.

Table 4.7:

*Mean Trauma Scores: Education Type by Job Position*

<table>
<thead>
<tr>
<th>Trauma</th>
<th>STS</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td>s.d</td>
<td>M</td>
<td>s.d</td>
<td>M</td>
<td>s.d</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Caseworkers’ education</td>
<td>N</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BA/BS</td>
<td>158</td>
<td>39.17</td>
<td>11.99</td>
<td>36.28</td>
<td>11.11</td>
<td>75.45</td>
<td>21.57</td>
<td></td>
<td></td>
</tr>
<tr>
<td>BSW</td>
<td>201</td>
<td>45.00</td>
<td>13.42</td>
<td>39.67</td>
<td>12.31</td>
<td>84.67</td>
<td>23.99</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MA/MS</td>
<td>37</td>
<td>39.92</td>
<td>13.76</td>
<td>36.14</td>
<td>13.41</td>
<td>76.05</td>
<td>25.88</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MSW</td>
<td>36</td>
<td>40.50</td>
<td>11.74</td>
<td>36.94</td>
<td>8.53</td>
<td>77.44</td>
<td>18.52</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>22</td>
<td>38.50</td>
<td>13.42</td>
<td>37.67</td>
<td>11.63</td>
<td>5.36</td>
<td>23.91</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Supervisors’ education</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BA/BS</td>
<td>21</td>
<td>38.33</td>
<td>7.48</td>
<td>28.62</td>
<td>4.98</td>
<td>66.95</td>
<td>9.98</td>
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<tr>
<td>BSW</td>
<td>23</td>
<td>37.70</td>
<td>11.49</td>
<td>32.65</td>
<td>7.85</td>
<td>70.35</td>
<td>10.64</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MA/MS</td>
<td>11</td>
<td>34.91</td>
<td>9.01</td>
<td>33.27</td>
<td>5.52</td>
<td>68.18</td>
<td>12.14</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MSW</td>
<td>29</td>
<td>36.83</td>
<td>9.42</td>
<td>38.14</td>
<td>5.87</td>
<td>74.97</td>
<td>11.86</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>17</td>
<td>36.53</td>
<td>9.77</td>
<td>38.38</td>
<td>6.10</td>
<td>75.41</td>
<td>10.68</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
CHAPTER V.

DISCUSSION

Basis of Study

The current study examined the phenomena of Compassion Fatigue (CF) and its impact on personnel in public child welfare settings. Specifically, the study compared the experiences of CF, Secondary Traumatic Stress (STS), and Burnout (BO) reported by child welfare caseworkers to those reported by agency supervisors. The essential purposes of this study were twofold: (1) to explore the possibility that child welfare casework supervisors experienced CF and, if so, (2) to examine how the supervisors’ level of experience compared with that reported by the caseworkers. The current study was conducted via a secondary analysis of data collected from participants at workshops in several Southern states that were focused on the topic of CF and its components of secondary traumatic stress and burnout.

Though originally equated with STS, the phenomenon of CF is typically defined as a cluster of symptoms that includes both those of STS and BO (Adams, Boscarino, & Figley, 2006; Figley, 1995). The literature is rich with references to BO and its characteristics of emotional exhaustion, depersonalization, and a sense of inefficacy. Moreover, the literature review revealed that many studies have been published on BO and child welfare caseworkers including the topic of job turnover (Maslach, Schaufeli, & Leiter, 2001). Far less has been published on the phenomena of STS however. STS is the result of being exposed to the psychological and emotional trauma of others. STS produces symptoms quite similar to direct
traumatization or PTSD and has a major impact on the victim’s ability to interface with their social environment (Figley, 1995; McCann & Pearlman, 1990; Pearlman and Maclan, 1995). Researchers have shown that traumatic stress is communicable and can be transferred from trauma victim (client) to trauma worker (caseworker) (Bloom, 1999; Danieli, 1988; and Eth & Pynoos, 1994). Thus, in studying CF in child welfare caseworkers and supervisors, both the characteristics of STS and BO are being examined. Further, like its components, the phenomenon of CF is seen as impacting trauma workers’ psychological, social, physical, and emotional functioning (Figley, 1995).

The literature suggests that certain conditions tend to facilitate trauma transference, including a worker’s experience in child welfare, a prior history of traumatization, formal education, age, caseload characteristics, and gender. (Nelson-Gardell & Harris, 2003; Salston & Figley, 2003). For the current study, the type of job that one held in the child-welfare agency, i.e., either caseworker or supervisor, was of particular interest. Despite a growing number of studies in the literature connecting CF to child welfare workers, none were found specifically addressing child welfare supervisors and CF. This is to say that the possibility of whether supervisors experienced CF had not been addressed. This question is important due to the vital role that supervisors played in public child welfare agencies.

**Discussion of Results**

The aim of this study was to explore the connection between the phenomena of STS, BO, CS, and CF and casework supervisors, a largely unexplored area. The results of this study were informative of child welfare supervisors in that a link between them and CF was found. Further, the results may have applicability to supervisors in other settings as well; a fertile area for continued study. The results of this study also supported research previously conducted on
caseworkers with CF. In doing so, this study expanded the scope of trauma research by comparing and contrasting caseworkers’ and supervisors’ reports of traumatic experiences. A discussion of the study’s results follows.

**Compassion Fatigue**

The main research question addressed by the current study compared the level of CF reported by caseworkers and supervisors. It is thought that through their direct contact with victims, and subsequent greater exposure to traumatic material, caseworkers would typically experience the transference of trauma at higher rates than supervisors. Trauma is transferred by absorbing some of the victim’s traumatic material (experiences), resulting in the worker’s own traumatization (Figley, 1995). This phenomena, in conjunction with or the presence of BO, results in CF (Figley). In light of the communicability of the elements of CF, one must consider the possibility that supervisors may also experience CF, even though the trauma might have been received through different sources than those impacting caseworkers. An analysis of the data demonstrated that, regardless of the source of trauma and burnout, supervisors do experience CF. The level of intensity reported by the supervisors, however, was not as high as that reported by caseworkers. Supervisors, in the role of trauma workers, may experience CF if they are assigned a caseload of victims of their own because of organizational needs (Smith, 2005; Strolin, McCarthy, & Caringi, 2006). This arrangement is not considered the norm but may be seen in smaller or rural counties where supervisors must cover for caseworkers absent from the office for some reason. Another consideration is that a supervisor may carry a caseload consisting of the more challenging cases because of a lack of experienced personnel within that particular agency.

One of the questions posed at the outset of this study was whether or not trauma could be transferred from secondarily traumatized caseworkers to supervisors. In consideration of the
possible vertical transference of trauma from caseworker supervisee to supervisor, a direct line of association would have to be established. That is to say, a researcher would necessarily have to connect the CF experienced by a supervisor to the CF experienced by their specific supervisees. This analysis was not possible in the current study, as the data collected did not allow us to connect specific workers and their supervisors. It is noteworthy that, as Briere et al., (2008) and Allan and Lauterback, (2007) argued, the source of the trauma is probably not as important as are the personal characteristics of the victim; in this case, the supervisor. Consequently, some supervisors, because of personal traits, may suffer from CF experiences at a level similar to that of their supervisees regardless of the source. In this particular study, the CF reported by supervisors may not have been as acute as that of their supervisees, as the supervisors are usually more removed from the original traumatization suffered by clients.

Hypothesis 1 addressed the question of whether supervisors experienced CF symptoms and the extent of those symptoms as compared to the caseworkers. The results of my analysis revealed that, though child welfare supervisors did report experiencing symptoms of CF, the CF level they reported was significantly less than that reported by the caseworkers. The results of the analysis also indicate that supervisors are not impervious to CF, making this an area worthy of additional research. A supervisor suffering the effects of CF could be considered impaired and may have difficulty performing the responsibilities of the position, constituting a liability to their supervisees, the agency, and clients. As such, agencies should consider developing a policy of not only screening caseworkers for CF, but doing so for supervisors as well. Moreover, if screenings indicate that an individual is experiencing CF, the agency should assume a legal and ethical obligation to provide treatment options to that individual regardless of whether they are a caseworker or supervisor.
STS and BO Comparison

Since CF is comprised of STS and BO, an analysis of differences between caseworkers and supervisors experiences of these phenomena was considered beneficial. The results of my testing of H2 and H3 address this issue. Consistent with the findings regarding CF, caseworkers reported greater levels of both STS and BO than did supervisors. One reason that STS levels may be higher for caseworkers is, as previously suggested with CF, because of the nature of their work, they typically have more exposure to trauma victims than do supervisors. Consequently, the likelihood of transference is greater for caseworkers than for supervisors. In terms of BO, the likelihood of experiencing this phenomenon is also likely to be greater for caseworkers than for supervisors. Burnout has been described as resulting from long-term organizational stressors. These stressors are more often attributed to the role of the caseworker than to that of the supervisor (Maslach, Schaufeli, & Leiter, 2001). Essentially, the position of caseworker, in terms of BO, is quite different than that of the supervisor and, consequently, may be more acutely impacted by organizational factors. With respect to the hypotheses H2 and H3 comparing caseworker and supervisor STS and BO, supervisors did experience both phenomena though not at the levels experienced by caseworkers. These results highlight the fact that STS/BO/CF is a real concern for casework supervisors, and is worthy of further empirical study; particularly given the key role of the supervisor in the child welfare organization.

The results of the data analysis indicate that both caseworkers as well as supervisors experience STS, BO, and CF and would therefore benefit from therapeutic services. For instance, Myers and Cornille (2002) argue that “there are a number of interventions and prevention techniques child protection agencies, supervisors, and direct service professionals themselves can use to reduce the risk of secondary traumatization” (p.50). The authors suggest a
five-part intervention procedure. The first intervention suggests an improved method for training trauma workers, particularly those working in the Child Protective Services (CPS) department of child welfare agencies. Meyers and Cornille maintain that, currently, new hires are taught all about “housekeeping duties,” e.g., paperwork chores, but not about the victims they will face and try to help. The authors argue that all child welfare workers and supervisors should be trained to both recognize and normalize STS symptoms. These same workers need to be taught how to come to terms with themselves in regard to family-of-origin and personal trauma issues, suggesting that trauma workers ought to deal with their own traumatic experiences prior to attempting to help others. Further, workers and supervisors need to receive training in developing coping strategies. Organizations simply cannot assume that employees, at any level, have automatically developed effective coping skills because of their formal education or qualification for employment by the organization. Workshops educating and training child welfare workers and supervisors in particular are needed. Another facet of trauma intervention suggested by Myers and Cornille (2002) is that of a supportive work environment. By debriefing those faced with trauma transfer, workers and supervisors would have the opportunity to express themselves in a “safe” environment and discuss the experience. The authors assert that this would help minimize the trauma and put it into perspective. Optimally, peer support groups would be in place to deal with secondary traumatization quickly. Similar programs have been proposed by Pryce, Shackelford, & Pryce (2007).

A somewhat different approach was suggested by Munroe et al. (1995) who wrote that trauma workers who experience STS should receive treatment via a team approach similar to that seen with combat veterans suffering from PTSD. Moreover, the authors suggest that trauma treatment teams be available for not only primary victims of trauma but for those trauma workers
who have experienced a transfer of trauma as well. These teams would not only treat traumatized individuals, but also screen workers for traumatization as well as provide training in self preservation.

In view of the results of the current study, it would behoove child welfare organizations to provide all personnel who may have experienced a transference of trauma with the opportunity to receive treatment and supportive interventions. The whole process begins with training, however, as the employees themselves must be their own first line of defense (Myers and Cornille, 2002). Each employee of the organization, whether a caseworker or a supervisor, should be able to recognize the characteristics and symptoms of CF. Further, each employee must know how to protect themselves from the possibility of traumatization and burnout through various means of relaxation on both a personal and social level. Finally, a process of educating administrators of the devastating effects of CF would be helpful. Though employees may be in favor of reduced work hours, exercise facilities, and other accommodations that would reduce the impact of CF, administrators must also be “on board” in terms of understanding that dealing with CF is a cost of doing business for human service agencies. The attitude that must be encouraged is that CF is an organizational issue and not just a personal problem.

Compassion Satisfaction Potential

The current study looked at the variable of CS potential in Hypothesis 4. Figley (1995) described CS as “happiness with what one can do to make the world in which one lives a reflection of what one thinks it should be” (p.113). Essentially, this is interpreted as the sense of joy and satisfaction one may experience knowing that they have helped someone. In order to experience CS, trauma workers must have a close relationship with clients, the same factor that may influence their likelihood of experiencing CF. As caseworkers are typically more closely
connected with clients than are supervisors, the likelihood of experiencing higher levels of CS is
greater. The literature also suggests that CS is a “counter balance” to CF, or a buffer to it
(Stamm, 1995). This is to say that while CF can be severely damaging to the individual both
personally and professionally, CS provides trauma workers with a sense of accomplishment and
of purpose. This reportedly explains how trauma workers who are faced with the most difficult
conditions remain on the job, i.e., CS supports job retention (Stamm). Despite the fact that the
caseworkers’ CS scores were significantly higher than those of the supervisors, both groups of
respondents exhibited good CS potential

**Impact of Demographic Variables**

In comparing caseworkers and supervisors on the variables of CF, STS, and BO, it was
clear that caseworkers, who tend to have a more direct relationship with trauma victims than do
supervisors, reported significantly higher levels of traumatic experiences. The current study
also explored the impact of demographic variables on the likelihood of experiencing CF, STS,
and BO.

**Age.** The first demographic variable that was studied was the age of the respondents.
The literature suggests that as a worker’s age increases they are better able to deal with CF and,
therefore, are less likely to suffer from its effects (Bride, 2007; Chrestman, 1995; Cornille &
Meyers, 1999). Statistical analysis revealed that for the combined sample of caseworkers and
supervisors, reported levels of CF were inversely related to chronological age. This overall trend
reflected that of the caseworkers, as the caseworkers exhibited an inverse relation between age
and CF as well. The supervisors’ reports indicated no correlation between age and level of CF.
One explanation for this similarity between the caseworker relation and that of the entire sample
may lie in the fact that the sample had many more caseworkers than supervisors and, therefore,
would be similar for that reason alone. Further, the difference in outcomes for supervisors and caseworkers may be a reflection of the different responsibilities for their respective jobs. In the case of supervisors, who tend to be older than caseworkers, age may not provide a significant buffer to CF level or, alternatively, there is possibly less CF to buffer. For younger caseworkers, however, there could be a lack of job or even life experience that could help them to identify symptoms of CF and take appropriate actions to protect themselves. Consequently, it appears that those caseworkers that are older are better able to negotiate CF experiences while, among supervisors, age was not a significant factor.

Additional analysis was conducted looking at both age and child welfare experience as factors in experiencing CF. This was done because, while age may reflect life stressors impacting likelihood of CF, the variable of work experience would be more specific in terms of stressors experienced during the course of service provision. The analysis revealed that supervisors, as a group, were significantly older (mean age = 43.80) than the caseworkers (mean age = 36.30). The supervisors also evinced significantly more experience (mean = 15.33 years) than the caseworkers did (6.62 years). The current literature is supported by the results indicating an inverse relationship between age, child welfare work experience, and CF level for caseworkers. The hypothesis, i.e., that both caseworkers and supervisors would experience an inverse relation between age and CF, however, was not supported by the data because of the lack of correlation exhibited by the supervisors when viewed independently. When an index of age, job position, and experience was formulated, participants showed a significant inverse relation between the index and CF, $r (561) = -.153$, $p<.01$. Consequently, the overall results indicate that the variables of age, child welfare experience, and position act as moderating variables on CF level, a conclusion supported by the literature.
The reason for the disparity between perceived CF levels by age as reported by caseworkers and supervisors is unclear at the present. As supervisors reported far less CF than caseworkers, yet evinced a weak but positive correlation between the variables, age may not have such a pronounced mitigating or buffering affect for them as for the caseworkers. Further, there may be a diminishing returns effect for the supervisors. That is to say that possibly the impact of age can only moderate CF so far and, after that, age is no longer a significant factor. Since the level of CF reported by caseworkers is relatively high, however, age may have a more manifest impact. It may also be the case that the smaller range of ages in the supervisors (as compared to the range of ages of the caseworkers) had an impact on the results of these analyses. Another consideration is that the number of supervisors in the sample was low in proportion to the number of caseworkers. Consequently, when the sample was viewed in its entirety, the expected inverse relationship was realized simply because of the influence of the significantly higher number of caseworkers.

In terms of policy and practice, if further research substantiates the correlation of age and CF, it would behoove organizations to focus CF training on their younger employees although not to the total exclusion of older caseworkers and supervisors. Further, infusing content about CF into both the BSW and MSW curriculum would help prepare social work students for the reality of a workplace that could be dangerous to their emotional and even physical health.

**Years of experience.** A second demographic variable that was tested was “years of child welfare experience.” The literature suggests that those trauma workers who have more work experience tend to report lower levels of CF. Such was the case in the current study for caseworkers although not for supervisors. Despite the fact that caseworkers had an average of 6.63 years of experience, and supervisors had an average of 15.32 years, experience was no
longer a moderating factor for the supervisors. Possibly, as seen with the variable of age, the law of diminishing returns comes into effect and more work experience simply does not translate into more resistance to CF. This result implies that there is a “cut off point” of sorts; that is, at what point is experience (or age for that matter) no longer a moderating or buffering factor for CF?

**Education.** The third demographic influence on CF levels to be explored was that of the participants’ formal education and CF level. H5b predicted that education would have a negative relation with levels of CF in both CW supervisors and CW caseworkers. The literature indicates that the type and level of a trauma worker’s education influences the likelihood of experiencing STS and, consequently, CF (Bride, 2007). Hypothesis H5b was based on the argument that as formal education level increases (i.e., as one progresses from the bachelors level to the masters) the less likely one would be to experience CF. The results of the data analysis for this hypothesis indicated that the hypothesis was not supported by the data. Though, in general, bachelor’s level personnel scored higher CF levels than masters’ level for both supervisors and caseworkers, a non-significant positive correlation was realized rather than the inverse one hypothesized.

Further analysis of the impact of education type on CF revealed that there were other trends to be considered. The caseworkers that identified themselves as having the BSW degree exhibited the highest levels of CF of any degree group. BSW caseworkers produced a mean score of 85 while the caseworkers that were educated outside of social work produced a mean score of 75. Further, those caseworkers that identified themselves as having the MSW degree had the second highest CF rate of the group (mean = 77). For the supervisors, BSW recipients indicated a very high relative level of CF. Second only to those supervisors indicating “other” as their formal education background, BSW supervisors scored a mean of 70.35. Conversely, MSW supervisors scored a mean of 65, the lowest score of the group. Compared to MSW supervisors,
there were few BSW supervisors who responded to the original survey. Though the data provided no information as to where the respondents were geographically located other than state, personal experience suggests that the BSW supervisors may have been from counties with relatively low population, e.g., rural counties where a large child welfare staff would not be warranted. Another consideration is that the BSW supervisor might have been from those agencies where a worker may have been “grandfathered” into the position of supervisor. These results, however, have lead to some consideration as to why those specifically trained in Social Work, particularly at the BSW level, should report the highest level of experienced trauma of all participant groups. A review of the literature did not provide a satisfactory explanation and one is left with speculation or conjecture at this point. The common characteristic of the BSW and MSW caseworkers was formal social work education; this factor also distinguishes them from the other respondents. Thus, at face value, the question arises about the possibility of curriculum-related factors impacting social work. Despite some similarities, three major differences exist between social work education and other educational programs usually represented by child welfare personnel, e.g., sociology, psychology and others: (1) the emphasis on the use of empathy, (2) a “person in the social environment” perspective, and (3) an emphasis on a client-centered, strengths-based approach.

**Gender.** The final demographic variable that was examined was that of gender. The impact of this variable on CF level was examined for both caseworkers and supervisors. In terms of gender composition, the two groups were quite similar. Women comprised 89.2% of the caseworkers and 87.8% of the supervisors. Males comprised 10.8% of the caseworkers and 12.2% of the supervisors. Data analysis revealed that female and male supervisors reported almost identical levels of CF (mean = 68.77, s.d. = 12.04 for females; 68.08, s.d. = 7.80 for
males). Similar results were achieved for the caseworkers as well (mean = 80.2, s.d. = 23.8 for females; mean = 76.0, s.d. = 18.7). In consideration of the entire sample, the mean CF score for females was 78.5 and for males, 74.3, a non-significant difference. The females and males were similar to each other in other ways as well. In terms of child welfare work experience, for example, female and male caseworkers had almost identical mean scores: females = 6.6 years and males = 7.0 years. For supervisors there was a non-significant difference as well: females reported 16.1 years of experience while males reported 12.1 years. These results are in contrast to those found in the literature wherein female trauma workers are reported to experience significantly greater levels of CF than do males. The basis for the contrasting results of the current study with those seen in the literature is essentially unknown. One consideration for this difference may be that the unit of study was not exactly the same for all published articles. In a number of articles, trauma workers were the focus of study rather than, specifically, child welfare workers or supervisors. Though the term “trauma worker” typically includes child welfare workers, not all child welfare workers face the same level of trauma. Foster care or adoption workers, for example, work with trauma victims but the intensity of their experience may differ from that of CPS workers who work with both perpetrators and victims in life-threatening situations. The sample used for the current study did not provide data as to which department the participants worked in. It is possible that some of the female participants worked in areas that held a lower potential for traumatization and, therefore, experienced less CF. A study comparing CF experienced by the workers in different departments of the child welfare agency might suggest an answer to the present conundrum. Finding out which workers are most likely to experience CF would also help an agency focus its resources in the most efficient manner.
Use of Empathy

The use of empathy, though important for engagement and the therapeutic process, may expose child welfare workers to the trauma experienced by their clients. Through this exposure, transference takes place facilitating the possibility of secondary traumatization. The literature cited suggests that those trauma workers who are less empathic run a lower risk of transference and subsequent secondary traumatization (Benson & Magraith, 2005; Figley, 2002; Figley, 1995; Huggard, 2003). Conversely, it is then possible that those caseworkers that have been taught and encouraged to develop and employ empathy with trauma victims expose themselves to a greater risk of traumatization. If we assume that schools of social work promote the development and use of empathy, then this possibility of greater susceptibility to traumatic response is supported in the current study, as those caseworkers with an MSW degree also scored high on the CF scale. At the supervisor level, however, a different scenario emerged. The data analysis revealed that at the MSW supervisor level, scores for CF were lower than for other educational categories, while the BSW supervisor respondents still scored relatively high. Possibly this is a reflection that by the time one achieves the MSW degree and is a supervisor, one is more able to empathize effectively, i.e., sustain a proper detachment from trauma victims, without transference. This concept may be supported by the fact that MSW supervisors scored lower CF levels than BSW, BA/BS, or MA supervisors.

Person-In-Environment Perspective

A second possible influence on BSW caseworker CF levels is the person-in-environment emphasis in social work education. “A person-in-environment perspective sees people as constantly interacting with various systems around them. The individual is portrayed as being dynamically involved in each. Social work practice then is directed at improving the interactions
and the various systems” (Kirst-Ashman & Hull, 2008, p.12). Further, the person-in-
environment approach views the individual and his or her multiple environments as a dynamic,
interactive system in which each component simultaneously affects and is affected by the other
(Hare, 2004). Does utilizing this perspective expose caseworkers to greater levels of trauma and,
therefore, a greater chance of transference? While other disciplines typically focus on the
“problem” at hand, i.e., the identified patient in a medical model approach, social work education
teaches the use of the strengths perspective and the evaluation of the client’s interactions with
their social environment. Through a person-in-environment (PIE) perspective, the trauma worker
considers a much wider and multifaceted situation. In such a situation, BSW caseworkers may
be exposed to the trauma experienced at multiple levels in the victim’s social environment, not
solely the trauma of the victim. In the cases where the dynamics are quite complex, the stressors
may be considerable and, in conjunction with the traumatic material from other cases, serve to
overwhelm the caseworker. This may be particularly true for those caseworkers who are new to
child welfare and have not yet developed self-preservation skills. Certainly the person-in-
environment perspective has been an exceedingly useful and important approach in working with
clients at all levels of intervention: micro, mezzo, and even macro. Sarri (1992) argues “…an
understanding that the individual and his or her problems cannot be comprehended outside of an
appreciation of the milieu in which that person functions seems to have served the profession
well.” (p. 205). Thus, the person-in-environment perspective is central to modern social work
practice and should not be abandoned (Greene, 1999). At the same time, utilizing the PIE
perspective appropriately is key to effective practice while also promoting safe practice for
caseworkers. Greene and Watkins (1988) explain the PIE perspective has established social
work’s conceptual reference point and has delineated the practitioner’s role. Despite the overt
importance of the PIE perspective, there is some question as to whether or not social workers actually practice it. Weiss-Gal (2008) conducted a study examining this issue with social workers in Israel and stated” The findings point to a disparity between social workers' professional ideology and their actual practice. Although the person-in-environment approach is reflected in the respondents' views of the goals and the fitting activities of the profession, it is hardly evident in their day-to-day work” (p. 72). Weiss-Gal projects that one explanation for this lack of consistency is that schools of social work do not teach integrative practice but “compartmentalize the teaching of intervention strategies, e.g., intervention with individuals, with families, with groups, with the community and so on are all taught as a separate set of skills.” (p. 73). Given the official importance of the PIE perspective for both social workers and social work practice, it is imperative that schools of Social Work guide students to a clear understanding of the PIE perspective so that it may be implemented appropriately without overwhelming stress on the part of the social worker.

A Client-centered, Strength-based Approach

A third unique aspect of social work education is that of learning and using a client-centered approach that is strengths-based. With this approach there is an emphasis on what the client can accomplish or is accomplishing, i.e., their strengths. Any dysfunction is portrayed in the form of “needs” (rather than “problems”), which are addressed utilizing the client’s strengths with the worker’s guidance. Further, utilizing a client-centered approach suggests an empowerment of the client. This manner of supporting the client as they strive to achieve goals may come at a cost as the worker must expend considerable energy in order to maintain such a system. This is particularly true for caseworkers working towards a goal of family preservation in abusive situations or for family reunification post abuse. It is inconceivable that a caseworker
could expend such energy on a large number of cases over an extended period of time without experiencing some effect on their psychological well-being. This “effect” may be manifested in the form of BO, STS, or a combination of both, as in CF.

**Limitations**

Although limitations to the study hampered my ability to conduct an extensive analysis of the phenomena of CF among child welfare supervisors, the study’s hypotheses were tested. As the current study is a secondary analysis of data, the study limitations relate primarily to the data set. The data was originally collected for other purposes, so using the data set permitted only a limited analysis of the study questions. Though the results indicated that both caseworkers and supervisors suffered from BO, STS, and CF, and that caseworkers exhibited higher levels of trauma, the origin of this trauma was left unknown. That is, the data did not permit me to determine whether or not supervisors are traumatized as a result of their interaction with their supervisees who may, themselves, be traumatized. The data set presented other limitations to the current study as well. Because the data set was collected fourteen years ago, its age may come into question. Since the original study was conducted, the environment in public child welfare agencies may have changed because of a growing awareness of CF, at least with caseworkers. Were the original study to be undertaken today, different results might be had. Another data-related limitation concerns the geographic location of the data collection. The fact that the data was collected solely in the southern U.S. may have influenced the results due to the specific culture of the area. Moreover, the laws and policies may vary greatly from one locality to another, resulting in the caseworkers and/or supervisors being subject to conditions that could hinder or facilitate the development of CF. Despite the age of the data and the possible regional bias in the sample, the current study retains relevance as it illustrates the persistent existence of
trauma phenomenon in stressful work settings because of a historical organizational
unwillingness to address these problems. If future studies included geographic areas other than
those in the current study, external validity might be added to both this study and the original
study conducted by Pryce, Shackelford, and Pryce (2007).

An important limitation of the current study results from the language employed by the
survey instrument. The instrument that was used to measure trauma in child welfare personnel
presented items measuring STS and BO, but not specifically CF. Figley (1995) simply
identified STS as alternate nomenclature for CF. Only after the data for this study was collected
did scholars in this area, notably Figley, change the definition of CF to include both STS and BO
(Figley, 2002). As a result, the data used in the current study provided two separate scores, one
score for STS and one for BO. In the current study, scores for these two phenomena were
combined to form a third measure of trauma, CF. This recoding of the data is questionable and
the results may not be a valid representation of CF for the two groups of child welfare personnel.
Since the study during which this data was collected (Pryce, Shackelford, & Pryce, 2007), other
measures of CF have been developed that may provide us with a more accurate portrayal of the
trauma experienced by child welfare supervisors.

Implications

Though the current study produced some statistically significant results, its importance
lies not in the questions it answered, but those that it spawned. As a result of this study it can be
seen that child welfare supervisors do experience BO, STS, and CF, and this holds important
implications of its own. Realizing that supervisors, as well as caseworkers, may experience BO,
STS, and CF should prompt child welfare organizations and policy makers to address this serious
issue head-on with both pertinent and sufficient resources. Providing a supportive environment
in the child welfare agency, for example, could cost very little and yet do considerable good for psychologically and emotionally ailing supervisors and caseworkers. Peer training with the goal of making employees aware of the symptoms of CF and how to address them would also be a modestly priced yet effective intervention. The implication here is that both caseworkers and supervisors could address, or even prevent, symptoms of CF if given the organizational support they would require.

Even though questions regarding the connection between traumatized caseworkers and their supervisors cannot be answered in the current study, I believe the current study holds value and contributes to the knowledge base regarding child welfare personnel and CF because of the following reasons:

1.) This study opened a dialog about CF and child welfare supervisors, a topic virtually ignored in the literature. The implication here is that the phenomena of CF warrants further research, particularly for trauma workers and their supervisors. The current study was, for example, unable to answer the question of vertical traumatization. i.e., CF transfer from traumatized caseworker to supervisor. The answer to his question could be extremely important in terms of organizational functioning and policy development.

2.) By comparing and contrasting supervisors with caseworkers, this study demonstrated that supervisors do experience STS, BO, CF, and CS albeit in lower levels than do caseworkers. This information is significant because it allows agency administrators to take steps to safeguard the bio-psycho-social health of their employees; this could include screenings and, if necessary, treatment for both supervisors and caseworkers.
3.) This study both supported some findings in the literature and contradicted others. The variable of gender, for example, did not impact CF level although the literature suggested that females are more likely to report higher levels of CF than their male counterparts. Further, some variables would impact caseworkers but have little influence on the supervisors, e.g., age and years of child welfare experience. The variables of age and work experience “behaved” differently for supervisors than they did for caseworkers. For supervisors, in contradiction to the literature, there was a low but positive correlation between age, work experience, and CF level. For caseworkers, however, there was a strong inverse relationship between the variables, thereby supporting the literature. Given this information, further research might explore the exact nature of caseworker/supervisor differences. Possibly there are mediating or moderating variables which were beyond the scope of this study.

4.) A curious relation between education level and type and CF level emerged. The current study revealed that those caseworkers that held BSW degrees reported suffering from CF at higher levels than any other discipline or level. The etiology of this difference is conjecture at this point but could relate to different aspects of formal social work education. This result has serious implications for all aspects of social work, including social work education, training, practice, research, and policy. If, for example, the social work curriculum is somehow facilitating CF, this would impact the way future social workers should be educated. It is evident that further research is required on this topic. Such research could simply compare the educational backgrounds of caseworkers and supervisors with their level of CF. If, after sufficient replication, BSW graduates
continue to exhibit comparable results to those of the current study, a re-evaluation of the current system of social work education would be in order.

5. ) Since it is now apparent that casework supervisors can suffer from CF, organizations are urged to screen them, as well as caseworkers, for CF symptomology and provide supportive interventions if necessary.

6. Though the current study addressed supervisors in child welfare agencies in public settings, it is hoped that the findings of this research will serve as an impetus for studying supervisors in settings other than child welfare.

7. Despite a dearth of information about child welfare supervisors and CF in the literature, the study was able to offer some insight into the area. Possibly the most significant contribution made by the study would be to facilitate an awareness among researchers, practitioners, and policy-makers of the reality that supervisors as well as caseworkers can experience STS, BO, and CF and exhibit CS potential. This revelation may prompt necessary organizational accommodations for all child welfare staff to receive formal training in buffering themselves from or preventing the effects of CF.

The current study has brought to light the possibility that formal social work education, as it existed when the data collected, may actually facilitate the transference of trauma from primary victim to trauma worker because of the emphasis on certain key tenets in the social work curriculum. These tenets include the development and use of empathy with clients, a person-in-environment perspective, and a client-centered, strengths-based approach. Though it is acknowledged that these tenets have promoted client well-being and, in the case of child welfare, facilitated permanency for children, we must ask the question, “What is the worker’s cost of client well-being?” Nelson-Gardell and Harris (2003) implore, “Those who educate child
welfare workers should enable students to make an informed decision about using empathy in practice and inform them how their personal characteristics may increase that risk” (p. 25). Have we just exchanged one set of problems for another, albeit possibly less damaging and certainly less socially offensive? The fact that those caseworkers that are formally educated to work with children and families reported the highest levels of trauma of any degree group is troublesome. This is most pertinent now that many states have restricted hiring only those caseworkers with a background in social work education. It is apparent that considerably more research is indicated in this area, and the results of that research need to be utilized to help social work educators develop a more “caseworker supportive” curriculum.

Implications for Research

In consideration of the limitations and results of the current study, it is recognized that considerably more research is needed in the area of CF and child welfare workers and supervisors. Though progress has been made in the instruments used to measure STS, BO, and CF, it is likely that greater use of these instruments could yield positive outcomes for CW workers. There remains a serious dearth of research in this area. This is particularly frustrating as one considers the emphasis on evidence-based practice in child welfare. Specifically, further research needs to be conducted that would answer the question of whether or not formal social work education as it currently exists at the BSW or MSW level facilitates CF. Though the use of empathy and other client-centered techniques (e.g., child/family centered, strengths-based, culturally competent, developmentally appropriate practice) have produced therapeutic results and are in current vogue, there needs to be a way to mitigate their cost to the caseworker. That is to say, how can these techniques be used without exposing the caseworker or supervisor to the transference of trauma? In terms of CF and supervisors, though this study revealed that supervisors do experience trauma, it was not possible to cite the source of that trauma, i.e., this
study could not answer the question as to whether supervisors experience transfer of trauma from their afflicted supervisees. This is an important issue as it would suggest new organizational policies that would buffer supervisors from traumatized supervisees as well as supervisees from a traumatized supervisor. In general, the research implications of the current study are that further research in the area is warranted. Further, utilizing instrumentation that is both more valid and reliable in measuring CF is vital. Further, there is a need to identify and address issues of cultural diversity that may help address the previously identified demographic questions relating to age, years of experience, and gender.

The literature review for the current study revealed that the preponderance of research on the phenomena of CF was cross-sectional or correlational in nature. Certainly cause-and-effect type studies would provide a more robust base from which future studies could be attempted. Moreover, longitudinal studies would also be beneficial in terms of examining the long-term effects of CF on trauma workers. At the current stage of development for research on CF, however, there are some obstacles to more elaborate studies. At this time the instruments used to measure CF and its components are becoming more sophisticated and are considered more accurate as the conceptualization of these phenomena becomes more solidified. Once we have fully identified the phenomena, and have developed efficient and accurate methods of measuring it, cause and effect type studies may be considered more feasible. In terms of longitudinal studies, one must consider that the study of CF is a relatively new endeavor and, consequently, opportunities for long term studies have not yet developed. The nature of CF also makes it a bit challenging to study in longitudinal terms. Those who experience CF are suffering in many ways, including physically, emotionally, socially, and spiritually. Those who suffer the most tend to drop out of longitudinal studies most frequently. This “selective dropout” hampers
longitudinal studies as the participants tend to become lost to the researcher (Hooyman & Kiyak, 2008). Longitudinal studies on victims of direct traumatization have been conducted with Holocaust victims and subsequent generations of family members (Litvak-Hirsch & Bar-On 2006; Stessssman et al., 2008). These studies revealed that despite a span of some fifty years post Holocaust, the ex-prisoners continued to experience PTSD symptomology including psychosocial and functional impairment. Family members evinced fewer symptoms as time progressed and with each successive generation. Though these studies are dissimilar in terms of participants, the focus for both is experiencing trauma, suggesting that longitudinal studies for CF may be possible.

Implications for Policy

The results of the current study indicate that child welfare supervisors can suffer from CF, though probably not as severely as caseworkers. Child welfare organizations must assume the responsibility of protecting both caseworkers and supervisors from such job hazards. Moreover, organizational supports should be offered to caseworkers in both prophylactic and treatment modalities. The findings from the current study suggest that these protective measures be extended to supervisory staff as well. Further, the personnel of each child welfare agency need to be offered (1) training and education in identifying STS, BO, and CF, (2) prevention programs, and (3) associated treatment. Policy that promotes an atmosphere of self-care and peer support for both caseworkers and supervisors would be greatly beneficial to the mental health of the entire organization and would facilitate better care for clients. Finally, the possibility that social work education may inadvertently promote trauma transference needs to be explored more fully. The disparity between CF levels in caseworkers and supervisors with the
BSW degree and other degrees is rather perplexing. Empirical study in this area may precipitate policy governing formal social work education and training.

**Implications for Practice**

The current study holds some important implications for practice in child welfare agencies. If further research reveals that supervisor CF is a widespread issue, the current method of caseworker supervision may require examination. One example of this may be seen in the use of the parallel process in supervision. It is through this method that the supervisor and caseworker re-enact client-worker interactions. Caseworkers assume the role of clients as the supervisor role-plays the caseworker. The goal of this interaction is for the worker to emulate the techniques of the supervisor when they work with clients. The parallel process is used as a teaching tool and many caseworker roles may be explored. Though only a role-play, the intensity of the worker-client relation may be demonstrated. Consequently, one might wonder if the parallel process might actually facilitate vertical transference of trauma. Further research is required to address this question.

If supervisor-traumatization were found to be widespread, it would behoove agencies to address the issue by means of workload adjustment. As with caseworkers, a supervisory caseload with many trauma victims can be overwhelming. Providing supervisors with a more varied type of client caseload could relieve some of the stress. Similarly, supervisors may benefit from supervising caseworkers with a variety of caseload responsibilities. Another consideration is that those supervisors who have a caseload of their own be afforded a variety of clients and not all “difficult” cases.
Conclusion

The goal of this study was to explore the possibility that child welfare caseworkers experience CF. A secondary goal was to compare the level of CF that supervisors experienced to that experienced by child welfare caseworkers. The results of the study indicated that though caseworkers experienced CF at greater levels than did supervisors, the supervisors were also victims of trauma. Due to the inherent limitations apparent in this study, the origin of supervisors’ trauma could not be identified. It was noted, however, that the respondents’ formal education type had a significant impact on CF level. Those respondents who received the BSW degree experienced CF at greater levels than any other educational group. The results of this study call to question the relationship between formal social work education and elevated CF levels, suggesting that much more research is needed to understand this situation.
REFERENCES


Herman, J. L. (1992). *Trauma and recovery: The aftermath of violence from domestic abuse to political terror.* New York: Basic Books.


APPENDIX A

TIMELINE FOR DISSERTATION COMPLETION

Secondary analysis of the data will commence pending approval of the dissertation proposal by the committee and the release of the data set by Dr. Pryce. It is anticipated that data analysis could be completed within two weeks. The results of the data analysis would then be submitted to the committee for review. Pending approval of the analysis, the results will be incorporated into the body of the dissertation and submitted to the committee for consideration and feedback. After final changes are made, the dissertation will be submitted to the committee for defense.
MEMORANDUM REQUESTING USE OF DATASET

MEMORANDUM

To: Dr. Josephine Pryce, Associate Professor
    Ph.D. Social Work Program, University of Alabama

From: Dennis J. Weiss, doctoral student

Re: Request for permission and access to Pryce, Shackelford, Pryce (2007) dataset

I am requesting permission to access the dataset gathered during the Secondary Traumatic Stress (STS) training sessions as described in the book co-authored by you, *Secondary Traumatic Stress and the Child Welfare Professional* published in 2007 by Lyceum Books. This data would be used as part of my dissertation project as I planned to conduct a secondary data analysis. My primary research will focus on the phenomena of STS and how it impacts supervisors in public child welfare settings. I plan to use the scores obtained on the CFCSST instrument to compare caseworkers and supervisors on STS level. As an added benefit, burnout scores would also be available allowing a more full comparison between caseworkers and supervisors in terms of both organizational and traumatic stress.

I plan to analyze the data through several means to obtain an understanding of the variables that would impact the likelihood of experiencing STS. Demographic variables are present in the data set and these will help me address the hypotheses that I have formulated. These hypotheses relate to a gap in the literature on STS and child welfare personnel. I argue that supervisors are just as likely to experience STS as are caseworkers. Further, I hypothesize that those same variables that impact the likelihood of experiencing STS in caseworkers also impacts supervisors. Finally, the impact of organizational stress on both supervisors and caseworkers will be explored. Included in the data are also “knowledge questions” which reflect participants’ perceptions about the stressful nature of their jobs both prior to the workshops and afterward (pre and post assessments).

The proposed research offers an opportunity to examine the important role of the child welfare supervisor. Though there is a growing body of literature that addresses supervision in child welfare agencies, particularly in terms of job retention, little has been done to explore the caseworker-supervisor relationship in terms of the transfer of traumatic stress.
In order to address the hypotheses and issues discussed, I plan to use the data from three states, Alabama, Mississippi and Louisiana as they were gathered in a similar manner. The variables that I plan to use are age, gender, years of experience, position, STS score, burnout score, and education level. I also plan to compare the answers to the knowledge questions given the demographic variables.

I plan to obtain IRB for protection of human subjects approval from the University of Alabama. This data, although already anonymous, will be kept confidential and only shared with the members of my doctoral committee as necessary. Any statistical results will only be reported in aggregate form making it impossible to identify any single response with any individual.

I plan to use the results of this research to add to the knowledge about STS and child welfare personnel. Further, these results could be of benefit to agency administrators, policy developers and managerial staff in implementing policies and procedures in areas affecting caseworkers and their supervisors. Finally, the results could be useful to the caseworkers and supervisors of child welfare agencies as they could make them aware of the dangers of STS and burnout and their need to actively engage in a plan of self-care.

Thank You
Dear Ms Myles,

This letter is in response to the review of protocol id# 1037 wherein several changes were required. This application is titled “Compassion Fatigue In Public Child Welfare Casework Supervisors”. Dr. Gordon MacNeil, my advisor and dissertation committee chair, was designated as the principal investigator and I am the secondary investigator.

1) Please find enclosed a copy of my human subjects training certificate. I completed this course on-line in October of 2009 (Dennis Weiss : Member ID# 1442949)

2) I have elaborated, on the on-line application, on the terms “compassion fatigue” and “post primary traumatic stress” in an effort to help those outside my field of study more clearly understand these concepts and their relationship to others used in the study.

3) The study by Dr. Josephine Pryce (2007) was not given an IRB approval number or the number was lost by both Dr. Pryce and the IRB office. Dr. Pryce states that she spoke with you regarding this matter and has sent you a memo addressing such.

I look forward to working with the IRB and if you require any other changes or information for this application, please do not hesitate to call me at the numbers listed above or e-mail me at weiss003@bama.ua.edu.

Respectfully,

Dennis J. Weiss
### Course Completion History

**Dennis Weiss (Member ID: 1442949)**

#### CITI Collaborative Institutional Training Initiative

**Resources**

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<tr>
<th>Stage</th>
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<th>Elective Modules</th>
<th>Score</th>
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<td>10/11/09</td>
<td>10/11/11</td>
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#### Social and Behavioral Responsible Conduct of Research Course 1.

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</table>
From : jgraham@fa.ua.edu
To : weiss003@crimson.ua.edu

Date: Fri, Feb 26, 2010 at 9:24 AM
Subject: Protocol approved, Gordon Macneil 1037

The following human subjects protocol application has been approved by the IRB, effective 03/12/2010. In order to view the approval letter, along with the approved consent documents or other approved documents, as applicable, open the protocol and view attachments. If you have problems viewing the IRB Approval document, please call the Office for Research Compliance at 205.348.5152.

Protocol Principal Investigator: Gordon Macneil

Protocol Title: Compassion Fatigue and Casework Supervisors in Public Child Welfare Settings

Protocol Number: 1037

Submission include Macneil EX-10-CM-010
February 24, 2010

Gordon Macneil, PhD
School of Social Work
Box 870314

Re: IRB: EX-10-CM-010, Compassion Fatigue and Casework Supervisors in Public Child Welfare Settings

Dear Dr. Macneil:

The University of Alabama Institutional Review Board has granted approval for your proposed research.

Your application has been given exempt approval according to 45 CFR part 46.101(b)(4) as outlined below:

(4) Research involving the collection or study of existing data, documents, records, pathological specimens, or diagnostic specimens, if these sources are publicly available or if the information is recorded by the investigator in such a manner that subjects cannot be identified, directly or through identifiers linked to the subjects.

This approval expires on February 16, 2011. If the study continues beyond that date, you must complete the appropriate portion of the Continuing Review and Closure Form. If you modify the application, please complete the Modification of an Approved Protocol Form. When the study closes, please complete the Continuing Review and Closure Form for closure.

Should you need to submit any further correspondence regarding this application, please include the assigned IRB application number.

Good luck with your research.

Director & Research Compliance Officer
Office of Research Compliance
The University of Alabama
APPENDIX D.
DATA USE AGREEMENT

Data Use Agreement

This agreement is made between Dr. Josephine Pryce, faculty member in the University of Alabama Social Work Ph.D. Program, and Dennis Weiss, Ph.D. candidate in the same institution. Through this agreement Dr. Pryce agrees to allow Dennis Weiss access to data collected though her work, in conjunction with Dr. Kimberly Shackelford and David Pryce, in the assessment of child welfare personnel via Secondary Traumatic Stress workshops conducted in five states commencing in 1997. This data will be used for the purposes of secondary analysis as part of Weiss' dissertation on the topic of Compassion Fatigue and Casework Supervisors in Public Child Welfare Settings.

The data set includes demographic variables (age, years of child welfare experience, position, education and gender). The data will also include the anonymous responses to the Compassion Fatigue —Compassion Satisfaction Self Test for Helpers. There are three scales to this instrument; one scale measures Compassion Fatigue, one measures Burn Out and the third measures Compassion Satisfaction. The questions addressed in this study (and their related hypotheses) are:

Q1: Do levels of self-reported CF symptoms in Child Welfare supervisors differ from levels experienced by caseworkers?

H1: Child welfare supervisors experience symptoms of CF at greater levels than do caseworkers, as measured by the CFCSSTH

Q2: Do personal and professional demographic characteristics, e.g., age, years of child welfare experience, position, and education, have the same influence on self-reported CF in both child welfare supervisors and child welfare caseworkers?

H2a: Age will have a negative relationship with levels of CF in both CW supervisors and CW caseworkers.

H2b: Education will have a negative relationship with levels of CF in both CW supervisors and CW caseworkers.

H2c: Experience will have a negative relationship with CF in both CW supervisors and CW caseworkers.

H2d: Female supervisors will report higher levels of CF than male supervisors

Q3: Do CW supervisors self-report levels of STS differ from levels reported by caseworkers?
H3: CW supervisors will report higher levels of STS than do CW caseworkers, as measured by the CF scale of the CFCSSTH

Q4: Do CW supervisors self-report levels of BO differ from levels reported by caseworkers?

H4: CW supervisors will report higher levels of BO than do CW caseworkers, as measured by the BO scale of the CFCSSTH

Q5: Do CW supervisors self-report levels of CS differ from levels reported by caseworkers?

H5: CW supervisors will report higher levels of CS than do CW caseworkers, as measured by the CS scale of the CFCSSTH

The aforementioned data set will be used to examine the extent to which child welfare supervisors experience Compassion Fatigue (CF) in relation to that experienced by caseworkers in public child welfare settings.

This data may not be shared with any other researcher, student or faculty without the express written consent of the author, Josephine K. Pryce.

Any studies that may result in publication using this data set written by Dennis Weiss, post dissertation, will be submitted to Josephine Pryce for review and will be considered “co-authored” for a period of two years.
### APPENDIX E

**WORKSHOP QUESTIONNAIRE**

Compassion Fatigue and Compassion Satisfaction Self-Test for Helpers

*(Adapted with Permission)*

Helping others puts you in direct contact with other people’s lives. As you probably have experienced, your compassion for those you help has both positive and negative aspects. This self-test estimates your compassion status: How much at risk you are of burnout and compassion fatigue and also the degree of satisfaction with your helping others. Consider each of the following characteristics about you and your current situation. Using a pen or pencil, circle the number that honestly reflects how frequently you experience these characteristics in the last week.

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<td>17. I am a sensitive person.</td>
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<td>18. I have flashbacks connected to those I help.</td>
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<td>19. I have good peer support when I need to work through a highly stressful experience.</td>
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<td>20. I have had first-hand experience with traumatic events in my adult life.</td>
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<tr>
<td>21. I have had first-hand experience with traumatic events in my childhood.</td>
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<td>22. I think that I need to &quot;work through&quot; a traumatic experience in my life.</td>
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<td>23. I think I need more close friends.</td>
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<td>24. I think that there is no one to talk with about highly stressful experiences.</td>
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<td>25. I have concluded that I work too hard for my own good.</td>
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<td>5</td>
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<td>26. Working with those I help brings me a great deal of satisfaction.</td>
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<td>27. I feel invigorated after working with those I help.</td>
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<td>5</td>
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<td>28. I am frightened of things a person I helped has said or done to me.</td>
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<td>5</td>
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<td>29. I experience troubling dreams similar to those I help.</td>
<td>0</td>
<td>1</td>
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<td>3</td>
<td>4</td>
<td>5</td>
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<td>30. I have happy thoughts about those I help and how I could help them.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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<td>31. I have experienced intrusive thoughts of times with especially difficult people I helped.</td>
<td>0</td>
<td>1</td>
<td>2</td>
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<td>5</td>
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<tr>
<td>32. I have suddenly and involuntarily recalled a frightening experience while working with a person I helped.</td>
<td>0</td>
<td>1</td>
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<td>33. I am pre-occupied with more than one person I help.</td>
<td>0</td>
<td>1</td>
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<tr>
<td>34. I am losing sleep over a person I help's traumatic experiences.</td>
<td>0</td>
<td>1</td>
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<td>35. I have joyful feelings about how I can help the victims I work with.</td>
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<td>36. I think that I might have been &quot;infected&quot; by the traumatic stress of those I help.</td>
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<td>1</td>
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<tr>
<td>Question</td>
<td>Never</td>
<td>Rarely</td>
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<td>Somewhat Often</td>
<td>Often</td>
<td>Very Often</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
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<td>--------</td>
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<td>----------------</td>
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<td>------------</td>
</tr>
<tr>
<td>37. I think I might be positively &quot;inoculated&quot; by the traumatic stress of those I help.</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>38. I remind myself to be less concerned about the well being of those I help.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>39. I have felt trapped by my work as a helper.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>40. I have a sense of hopelessness associated with working with those I help.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>41. I have felt &quot;on edge&quot; about various things and I attribute this to working with certain people I help.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>42. I wish I could avoid working with some people I help.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>43. Some people I help are particularly enjoyable to work with.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>44. I have been in danger working with people I help.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>45. I feel that some people I help dislike me personally.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

**Items About Being a Helper and Your Helping Environment**

<table>
<thead>
<tr>
<th>Question</th>
<th>Never</th>
<th>Rarely</th>
<th>A Few Times</th>
<th>Somewhat Often</th>
<th>Often</th>
<th>Very Often</th>
</tr>
</thead>
<tbody>
<tr>
<td>46. I like my work as a helper.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>47. I feel like I have the tools and resources that I need to do my work as a helper.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>48. I have felt weak, tired, rundown as a result of my work as a helper.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>49. I have felt depressed as a result of my work as a helper.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>50. I have thoughts that I am a &quot;success&quot; as a helper.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>51. I am unsuccessful at separating helping from personal life.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>52. I enjoy my co-workers.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>53. I depend on my coworkers to help me when I need it.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>54. My co-workers can depend on me for help when they need it.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Question</td>
<td>Never</td>
<td>Rarely</td>
<td>A Few Times</td>
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<td>Often</td>
<td>Very Often</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>55. I trust my co-workers.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>56. I feel little compassion toward most of my co-workers.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>57. I am pleased with how I am able to keep up with helping technology.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>58. I feel I am working more for the money/prestige than for personal fulfillment.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>59. Although I have to do paperwork that I don't like, I still have time to work with those I help.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>60. I find it difficult separating my personal life from my helper life.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>61. I am pleased with how I am able to keep up with helping techniques and protocols.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>62. I have a sense of worthlessness/disillusionment/resentment associated with my role as a helper.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>63. I have thoughts that I am a &quot;failure&quot; as a helper.</td>
<td>0</td>
<td>1</td>
<td>2</td>
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<td>4</td>
<td>5</td>
</tr>
<tr>
<td>64. I have thoughts that I am not succeeding at achieving my life goals.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>65. I have to deal with bureaucratic, unimportant tasks in my work as a helper.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>66. I plan to be a helper for a long time.</td>
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<td>1</td>
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<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>
APPENDIX F.

*Vicariously Traumatized: this may also be called tertiary traumatic stress

Figure 1. Vicarious Traumatization: A Progression

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A. input that matches current cognitive schema requires no adjustment and is viewed as normative

B. non-normative input, that which does not match current cognitive schema, results in stress and change is required

C. the self changes in order to accommodate the non-normative input

D. the formerly non-normative input is assimilated into the cognitive schema and a new self emerges impacting interfaces with the social environment (Adapted from McCann & Pearlman, 1992)