NCTSN The National Child Traumatic Stress Network

Secondary Trauma and Child Welfare Staff:
Guidance for Supervisors and Administrators

Introduction: Why address STS within child welfare

Child Welfare has the mission of promoting child safety, well-being, and permanence through the provision of child-focused, family-based practice. As part of their day-to-day work, child welfare staff interact with people who have experienced trauma, and frequently multiple traumas, over the course of years and often over the course of generations.

Secondary traumatic stress (STS) is the emotional duress that results when an individual hears about the firsthand trauma experiences of another person.[i] Given the nature of their work, child welfare staff are at very high risk of developing STS, and they can be at risk of experiencing trauma first-hand.[ii] In addition, the trauma and secondary trauma experienced by their clients and staff can affect organizations and the organizational culture. If left unaddressed, STS can have a negative impact on the ability of individuals and organizations to help children and families.

Child welfare supervisors and administrators have the challenging task of developing and maintaining high-quality practice in a traumatogenic environment. This fact sheet provides information on how STS manifests itself in child welfare, the kinds of staff who are at risk for STS, and strategies for prevention of and intervention for STS.

How Individuals Experience STS

As secondary traumatic stress plays out on both the individual and organizational levels, supervisors and administrators should recognize its warning signs on both fronts.

On the individual level, symptoms can echo those of post-traumatic stress disorder (PTSD)—people can become hypervigilant, experience intrusive thoughts, avoid reminders of past clients, or feel numb or detached. Staff experiencing such symptoms may become short-tempered with clients or colleagues, sometimes in response to things that seem benign to others, or avoid answering calls from or asking detailed questions of new clients whose experiences may remind them of former clients' trauma stories. There are several STS assessment tools to help people better understand how they are affected by this aspect of their work and keep track of their experiences over time (see Box 1).

Box 1: Individual STS assessment tools:

- PROQoL
  http://www.proqol.org/
- Bride STSS Scale
  http://academy.extensiondlc.net/file.php/1/resources/TMCrisis20CohenSTSScale.pdf
- IES-R
  http://www.emdrhap.org/content/wp-content/uploads/2014/07/VIII-E_Impact_of_Events_Scale_Revised.pdf

This project was funded by the Substance Abuse and Mental Health Services Administration (SAMHSA), US Department of Health and Human Services (HHS). The views, policies, and opinions expressed are those of the authors and do not necessarily reflect those of SAMHSA or HHS.

Individuals affected by STS can also experience changes in their worldview, which often is referred to as *vicarious trauma*.[iii] They can feel more negative and pessimistic, hopeless about the possibility for change, and overwhelmed by the obstacles they face. They may project their work experiences onto others; for example, they might see a father and daughter holding hands in the park and, instead of seeing a happy family, worry about whether the girl is being abused. Staff with vicarious trauma must deal with the effects on their personal lives and relationships, challenges that may be hard to reverse.

Organizations, too, can show signs of traumatic stress. In agencies affected by STS, the organization may be very reactive or avoidant, communication and collaboration may break down, and staff and clients may feel a lack of psychological safety.[iv, v, vi] Given how common trauma exposure is in child welfare, some organizations have a "stiff upper lip" ethos that discourages talking about the emotional impact of the work. Leadership should monitor these dynamics and, when necessary, directly address them. The Secondary Traumatic Stress Informed Organization Assessment (STSI-OA) is a tool organizations can use to identify how well they attend to secondary traumatic stress.[vii]

Understanding Who is at Risk

Although typically supervisors think that staff who have direct interaction with clients are at highest risk for developing secondary traumatic stress—given the pervasive presence of trauma in child welfare work—*all* staff in child welfare agencies are at risk. In fact, staff whose roles are supportive—receptionists, drivers, maintenance workers, among others—may be at higher risk because of a lack of opportunity to process the stories they hear as part of their jobs with clinically trained supervisors.

Supervisors have a particular STS-related challenge, as they are responsible for supporting staff affected by STS while potentially being affected themselves. Additionally, supervisors who are not trained to identify or manage staff STS-related symptoms can become overwhelmed and less effective.

Child welfare staff at all levels may have chosen to go into a helping profession because of their own history of trauma. While such experiences can be a source of strength and a basis for empathetic connection with clients, they can also make people more vulnerable to developing secondary traumatic stress symptoms.[viii, ix]
All staff should understand that their personal experiences may put them at higher risk of STS and should have access to appropriate supportive or therapeutic services.

Strategies for Mitigating STS

Evidence exists that organizational climate can mitigate some of the effects of STS. Child welfare staff who describe their work environments as supportive report less STS.[x, xi] Staff affected by their exposure to traumatic material should have access to support. Organizations should include information about STS symptoms, resources, referrals, and the process for accessing them, in new employee orientation materials and post such STS-related information in a prominent location. Staff should receive consistent supervision that includes not only developing administrative and case-based skills, but also acknowledges the effects of the work on the employee. In-service trainings should regularly feature self-care strategies, including how to manage difficult emotions.

As a sense of physical safety is essential in the prevention of STS, child welfare agencies should make this a core element of training, skill development, policies, and practices. Administrators should routinely survey staff about their sense of safety and their confidence in their ability to manage explosive or risky situations with clients.

Staff who feel that they are increasing competency in job skills—especially if they are employing evidence-based practices—also generally experience less STS.[xii, xiii] A particular hazard in child welfare is that an emphasis on complying with policies and procedures may detract from the central mission of protecting children and preserving families. Although the core task of child welfare work is protecting children, the system's legal and administrative requirements can make it difficult to sustain this focus.

One's feeling of *compassion satisfaction*, that is, the positive emotions that come through helping others, is another protective factor against secondary traumatic stress. However, the high-stakes nature of child welfare work means that the system's attention is often on the things that could or do go wrong—while the many things that go right are overlooked. Developing this kind of "negative lens" is a common outcome of trauma exposure. Helping staff to stay attuned to their motivations for working in the child welfare field and intentionally recognizing the positive impact they have on children's and families' lives can help mitigate secondary traumatic stress.[xiv]

As mentioned earlier, child welfare supervisors need training in identifying and managing staffs' STS-related symptoms and integrating this information into regular supervision. Organizations should also have a defined protocol for managing the emotional well-being of staff directly following critical incidents, such as the death of a client. The response should include a discussion of common reactions for staff to self-monitor, an opportunity for all to deal with difficult emotions, and a plan for addressing difficulties that may arise. The approach should encourage mutual support among team members, but also respect individual coping styles.

Strategies for Intervention

Supervisors should recognize and address staffs' emotional reactions to the often-intense nature of child welfare work during supervision so that they can normalize STS-related risk and emphasize self-care. Child welfare organizations should provide training to supervisors in reflective supervision techniques, which encourage looking at the personal impact of client-worker relationships and promote the exploration of perceptions and emotions that may be affecting worker effectiveness and impeding case progress. The demonstration and practice of skills such as cognitive reframing and mindfulness (e.g., visualization, conscious breathing) can be integrated into supervisory sessions to help workers become proficient in strategies that decrease reactivity and increase a sense of control.

Professional development efforts may focus on building skills associated with resilience and this skill-building can be accomplished in formal and informal ways. For example, ongoing "check-ins" and coaching that occur at the small group or unit level can reinforce resilience-focused training. As team members actively practice coping skills and other strategies for individual-level stress reduction and self-care, the ongoing collaborative discussion, reflection, and application of resilience skills can become integrated into agency practice and culture.

Formal peer mentoring programs can be an effective means of providing staff support, especially to newer staff who may have had expectations about child welfare work that do not match the reality of their jobs. [xv] For example, many people become caseworkers because they are interested in helping kids, but instead spend much of their time struggling with burdensome paperwork and overcoming challenges to accessing services. Peer mentors can support ongoing self-assessment regarding the personal impact of child welfare work and may assist the mentee in recognizing unhealthy changes in functioning and accessing additional support, if warranted.

Agency practices based on valuing and promoting self-care (e.g., taking a lunch break, asking for help, schedule flexibility, maintaining work-life boundaries) can help workers shift their focus from what they cannot control to what they can. Agency leadership should "practice what they preach" by not only modeling these things themselves, but also by ensuring that they are not sending inconsistent messages to staff by, for example, talking about the importance of home-work boundaries while still expecting staff to respond to routine emails at night and over weekends. Offering supportive services after critical incidents—in addition to consistent recognition of staff, agency, and system achievements—can also promote a sense of empowerment and connection between agency management and line staff.

---

[i] Figley, C. R. (1983). Catastrophes: An overview of family reactions. In C. R. Figley & H. I. McCubbin (Eds.), Stress and the Family: Volume II: Coping with Catastrophe. New York: Brunner/Mazel, 3-20.

[ii] Bride, B. E. (2007). Prevalence of secondary traumatic stress among social workers. *Social Work, 52*, 63-70.

[iii] Pearlman, L. & Saakvitne, K. (1995). *Trauma and the Therapist*. New York, W.W. Norton & Company, Inc.

[iv] Hopkins, K. M., Cohen-Callow, A., Kim, H. J., Hwang, J. (2010). Beyond intent to leave: Using multiple outcome measures for assessing turnover in child welfare. *Children and Youth Services Review 32*; 1380–1387.

[v] Pryce, J., Shackelford, K., & Pryce, D. (2007). *Secondary Traumatic Stress and the Child Welfare Professional*. Lyceum Books, Chicago, IL.

[vi] Regehr, C., LeBlanc, V., Shlonsky, A. & Bogo, M. (2010). The influence of clinicians' previous trauma exposure on their assessment of child abuse risk. *The Journal of Nervous and Mental Disease*, Vol. 198, No. 9; 614–618.

[vii] Sprang, G., Ross, L., Blackshear, K., Miller, B., Vrabel, C., Ham, J., Henry, J., & Caringi, J. (2014). Secondary Traumatic Stress Informed Organization Assessment (STSI-OA) tool. University of Kentucky, Center on Trauma and Children, #14-STS001, Lexington, Ky. www.uky.edu/ctac

[viii] Baird, K., & Kracen, A. C. (2006). Vicarious traumatization and secondary traumatic stress: A research synthesis. *Counselling Psychology Quarterly, 19*(2), 181-188.

[ix] Nelson-Gardell, D., & Harris, D. (2003). Childhood abuse history, secondary traumatic stress, and child welfare workers. *Child Welfare, 82*(1), 5-26.

[x] Regehr, C., Hemsworth, D., Leslie, B., Howe, P., & Chau, S. (2004). Predictors of post-traumatic distress in child welfare workers: A linear structural equation model. *Children and Youth Services Review, 26*(4), 331-346.

[xi] Bride, B. E., Jones, J. L., & Macmaster, S. A. (2007). Correlates of secondary traumatic stress in child protective services workers. *Journal of Evidence-Based Social Work, 4*(3-4), 69-80.

[xii] Janssen, O., & Van Yperen, N. W. (2004). Employees' goal orientations, the quality of leader-member exchange, and the outcomes of job performance and job satisfaction. *Academy of Management Journal, 47*, 368-384.

[xiii] Craig, C. D., & Sprang, G. (2010). Compassion satisfaction, compassion fatigue, and burnout in a national sample of trauma treatment therapists. *Anxiety, Stress, & Coping, 23*(3), 319-339.

[xiv] Dane, B. (2000). Child welfare workers: An innovative approach for interacting with secondary trauma. *Journal of Social Work Education, 36*(1), 27-38.

[xv] Warman, A., & Jackson, E. (2007) Recruiting and retaining child and families' social workers: The potential of work discussion groups. *Journal of Social Work Practice, 21*(1), 35-48.