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Compassion Fatigue in Child Welfare

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Imagine for a moment you are a police officer on a call in which violence is occurring. The people involved have been reported to have a history of drug use. On your way to this call, you are thinking about the potential dangers, including people who could currently be under

the influence of a substance and physically harming others. You find out along the way that among the individuals included in this call are children on the scene who reside in this home. Upon your arrival on this scene, one of the individuals displays a weapon.

Although this scenario doesn't always occur when you go into a situation, you have been trained and have the means to protect yourself. As a police officer, you are able to carry a gun and sometimes other weapons such as a taser gun and mace. Now imagine you arrive at this scene to discuss how this situation affects the safety of the children. You have no weapon as you did as a police officer, yet the same safety concerns are present. If you have not yet guessed, you are not the police officer—you are a child welfare social worker. You work in some of the most dangerous situations and touch on some of the most vulnerable issues with parents—their children. You do all of this and, yet, you are ultimately defenseless.

Sadly, this situation is more common than one would hope. The concerns in this field became a reality with the death of West Virginia social worker Brenda Yeager, who was sexually assaulted and killed as she made a visit to the home of a family. It can also be seen in the death of Teri Zenner, a social work student from Kansas who was killed while making a routine home visit. Anecdotal observation and discussions with caseworkers reveal that the apparent perceived powerlessness that they feel and the way this job affects their families, coupled with the perception that they have no support or understanding in regard to their job and the work they perform on a daily basis, creates an untenable and intolerable situation for many workers.

Many social workers, administrators, lawmakers, and state policy makers question why there is such a high turnover rate for child welfare employees. The average length of employment in the area of child welfare is said to be approximately one year. Compared to years of social work accomplished in other areas of the field, why is the retention rate of social workers that come into the job with enthusiasm, excitement, and a hope to help someone falling at such drastic rates?

This article will explore the current literature that studies the problem of compassion fatigue in child welfare, what the causes are, the consequences, and what can be done to address the problem.

Causes

Compassion fatigue, which can include Secondary Traumatic Stress (STS), has been documented fairly frequently and experienced by many child welfare workers. What is not as common, however, is the number of studies that appear to have been completed researching what can be done about this problem. When describing secondary traumatic stress, Nelson-Gardell, Harris, and Deneen (2003) state that STS presents a risk of negative personal psychological consequences. They also describe STS as a reaction in a person who has empathetically listened to the bad things that have happened to other people. Stamm (1999) defined STS, in an article titled Childhood Abuse History, Secondary Traumatic Stress and Child Welfare Workers, as "a syndrome of symptoms nearly identical to PTSD except that exposure to a traumatizing event experienced by one person becomes a traumatizing event for the second person."

Child welfare work is typically omitted when it comes to being listed as one of the top stressful jobs of society, as evidenced by the lack of media coverage. This can be evidenced by viewing the Web site of a popular television network, ABC, at www.abc2news.com, whose list of most stressful jobs did not even include social worker.

Many researchers attribute this oversight to ignorance about the responsibilities and job duties of a child welfare worker. The Child Welfare League of America (2007) describes the job duties as utilizing the ability to engage families through face-to-face contacts, assessing the safety of children at risk of harm, monitoring case progress, ensuring the essential services and supports are provided, and facilitating the attainment of the desired permanency plan. Each caseworker in the area of child welfare maintains what is known as a caseload and a workload, which is the amount of time that workers devote to direct contact with clients and the time required to perform tasks associated with the families. The Child Welfare League suggests that the maximum number of families that a caseworker works with during a 30-day period is approximately twelve cases. The reality is that caseworkers carry caseloads much higher in number.

Unlike any other "caring professional," child welfare caseworkers have the burden of assessing whether abuse or neglect has occurred, as well as the responsibility of confronting the alleged perpetrator and having to deal with, and possibly testify against, the perpetrator should the allegations be determined to be true. Nelson-Gardell, Harris, and Deneen (2003) pointed out that an assessment can mean the difference between life and death for a child. The National Council on Crime and Delinquency (2006) stated that three out of four (75%) caseload-carrying workers said that their caseloads were too large. The average daily caseloads for caseworkers ranged from one to 89 families with an average of 31 families. Along with the high caseloads and workloads, many caseworkers in the child welfare field do not appear to be getting paid accordingly.

According to The National Council on Crime and Delinquency (2006), the average full-time caseworker earns an annual salary of $45,097. Bedford County (PA) Children and Youth Services starts employees with a salary of $20,900. Whereas this seems like a far cry from the annual average salary given, most studies have concluded that most of the child welfare workers cited that salary was not one of the main causes of their departure from the job. According to Russell and Hornby (1987), states that minimally require a BSW or an MSW degree experience far lower turnover and vacancy rates than do other states. Furthermore,

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they reported that individuals with degrees in social work are better prepared than others for work in child welfare.

A sample taken by the National Council on Crime and Delinquency (2006) showed that the most common motivation for leaving was the feeling that work was never done, heavy caseloads, lack of promotional opportunities, not feeling valued within the agency, and incompetent administration. Workloads were cited as one of the major causes of stress in the child welfare workforce. Those caseworkers who received flex time as opposed to being paid overtime reported that gaining flex time was useless because it just created more work. This work piles up and they cannot get their jobs done, which in turn causes more stress. Not only does that cause stress to the caseworker, but client families suffer, because they are unable to spend quality time with them and effectively help them to become better, more healthy, and educated families.

According to Flower, McDonald, and Sumski (2005), recent research findings have shown that worker turnover rates in child welfare are negatively related to achieving permanency for children. Another surprising finding of the study done by the National Council on Crime and Delinquency (2006) was that unsupportive agency management practices were a leading cause of burnout and compassion fatigue. As reported by Ellett, Ellis, Westbrook, and Dews (2007), there are some organizational factors that contribute to employee turnover and burnout. One factor is the extremely large caseloads that require caseworkers and supervisors to work 50-60 hours, and at times, 70 hours per week. Other factors are that the salaries in child welfare are not competitive with other social and human service agencies, and employees are not valued by policy makers or the general public.

Consequences

In a study by Jo Ann Jankoski (2002) on the impact of secondary traumatic stress on the Pennsylvania child welfare system, many of the same factors appeared. In this study, Ms. Jankoski went to numerous child welfare agencies in Pennsylvania and interviewed the caseworkers, and at times the supervisors, within the agencies. These interviews showed the stressors that caseworkers feel; the emotional state that they are in; and the lack of hope, pride, and enthusiasm they have for their jobs. The employees spoke of how the job affected their personal lives and the lives of their families and the strong emotions this produced, including anger, fear, paranoia, and sadness.

One job stressor that Landsman (2007) pointed out that may not be evident to outsiders is the number of ineffective staff. In child welfare in Pennsylvania, the only requirement is that the employee has taken the civil service test and has a degree in any field. This leaves room for much inexperience in the area of child welfare, child development, family relationships, and so forth. Landsman (2007) pointed out that ineffective staff place burdens on the rest of the staff, the supervisor, the agency as a whole, and the agency's clients.

Cure

The cure for this serious problem can be summed up in two points. The first point would be to change child welfare at a higher level, including passing current legislation like the Teri Zenner Social Worker Safety Act. This particular Act would set up a grant program that would provide workplace safety measures, as well as equipment and training for social workers and others who work with potentially dangerous clients (NASW, 2007). In conjunction with the passage of this law, there should be focus on the changing of civil service requirements. For example, the current requirements in Pennsylvania for a beginning level caseworker in the field of child welfare include having a bachelor's degree in any field with the condition that the applicant has taken at least twelve credits in sociology, social welfare, psychology, gerontology, criminal justice, or other related social sciences (PA State Civil Service Commission, 2006).

By hiring caseworkers who have an education from an accredited social work school, the competency in the field and the training dollars will decrease for training in basic social work skills. Many child welfare agencies feel that the training that child welfare employees receive is substantial enough to produce a competent worker. As Curry, McCarragher, and Dellman-Jenkins (2004) point out, some studies indicate that only ten to 13 percent of learning transfers to the job, thus resulting in a skill dollar loss of 87-90 cents of each training dollar. According to Cornerstones for Kids (2006), "if replacing a frontline worker who makes $27,000 per year costs $10,000, the price of the current turnover rate is enormous." In a government relations update, NASW (2003) lists some fast facts of the child welfare workforce. Among these fast facts are that turnover is consistently higher in states that do not require any kind of degree for child welfare positions and consistently lower in states that require a master's degree in social work. The update also points out that the child welfare staff with BSW and MSW degrees were found to be more effective in developing successful permanency plans for the children who were in foster care for more than two years.

Currently, NASW has succeeded in helping to get a bill enacted in Pennsylvania that protects the title of "social worker" by allowing only those with a degree in social work to work under that title. This new law defines a social worker as "a person who holds a current license under this act or has received a bachelor's, master's, or doctoral degree from an accredited school or program of social work or social welfare" (Act 68 of 2008). By helping to get this law passed, the state forms the beginning of a "clean up" of the system that has continued to fail Pennsylvania for years.

Would you seek the treatment of a doctor who hasn't completed his education? Would you allow your child to undergo a surgical procedure by someone who hasn't touched an instrument more than a few times, if at all? In beginning the process of lowering compassion

fatigue in child welfare, the system needs to start by putting social workers back in the roles for which they have been trained and educated.

The second point would be the safety of the social workers in child welfare. By passing the Teri Zenner Social Worker Safety Act, child welfare workers should use that grant money to attend mandatory safety trainings and to purchase equipment in order to ensure their safety. As evidenced from the deaths of social workers Brenda Yeager, Teri Zenner (a social work student), and Boni Frederick, within the last 10 years, safety is a growing concern. The suggested usage of this grant money would be to train child welfare workers working in the field to protect themselves, along with giving them the equipment to protect themselves, such as taser guns and pepper spray or mace. Just as police officers are trained everyday to use the least restrictive force by using their verbal skills, they are also enabled to protect themselves should the need arise and all other skills have failed. The skills that social workers are trained with, such as empathy, understanding, and a systems approach, create a much greater ability to de-escalate situations. This method, however, is not "fool-proof" protection, especially for clients with violent histories or using or abusing substances.

One can see that by integrating social workers back into an area of the field from which they seem to have been removed and ensuring that they can do their jobs safely, the child welfare system can improve greatly. Allowing social workers to work with families while utilizing the empathic and ethical practices on which their education was based will not only create a better system in which to work, but a better system for the families that are involved.

Stress as a Child Welfare Caseworker

Child welfare work is complex, demanding, and inherently stressful for all caseworkers. This can be especially true for new caseworkers who may have unrealistic expectations for themselves as they begin their new job. It's important for them to look to other caseworkers and the unit supervisor for support and assistance.

Factors that may increase stress for caseworkers include:

- Administrative and/or public scrutiny
- Ensuring compliance with all mandates as well as agency policies and procedures
- Changes within the organization (staff, policies, etc.)
- Inadequate or ineffective supervision
- High caseloads
- Increased work demands due to brief and/or long term staff vacancies
- Lack of adequate support within the agency
- Removing a child from the home
- Hostile clients
- Case crises
- High profile / traumatic cases
- Terminating parental rights
- Lack of community resources for clients
- Values and ethics conflicts
- Getting behind in documentation
- Testifying in court
- Criticism from other colleagues - both within the agency and from other organizations
- Performance evaluations

Activity:

Ask the unit supervisor about resources the agency has to help caseworkers manage job related stress. How are they accessed?

Talk with the unit supervisor about the availability of a staff support group.

Excessive stress can manifest itself in a number of different ways. Being familiar with some of the more common emotional, behavioral and physical indicators will assist caseworkers in their self care. Child welfare professionals will also find the information beneficial as they work directly with children and their families.

Emotional Indicators

- Unable to make decisions
- Feeling anxious, tense, nervous, unable to relax
- Easily irritated
- Diminished sense of humor
- Getting angry over minor things
- Feeling unworthy or not good enough
- Depression

Behavioral Indicators

- Withdrawing from friends, family, and co-workers
- Working harder but getting less done
- Excessiveness (e.g. in smoking, drinking, eating, spending, etc.)
- Scapegoating (blaming others, finding fault, being critical or hard to please)
- Difficulty having normal conversations with family and friends
- Arriving late to work and/or to appointments, etc.
- Argumentative
- Deteriorating work performance
- Taking increased time off for minor ailments

Physical Indicators

- Frequent headaches, colds
- Digestion problems
- Abdominal pain
- Diarrhea or constipation
- Unexplained changes in weight
- Clumsiness / accident prone
- Decreased interest in sex
- Deterioration in personal appearance
- Poor concentration
- Change in sleep habits (too much or too little sleep)
- Sleep disturbances (e.g. interrupted sleep, difficulty getting to sleep, not be able to get back to sleep if awakened in the night, difficulty getting up in the morning)

Key points

- There is a personal cost to working with traumatised children.
- There are several different terms that describe the damage done by being a helping professional, these include: vicarious trauma, secondary trauma, compassion fatigue and burnout.
- If the emotional consequences of this work are not mitigated they will affect a professional's wellbeing as well as their ability to work effectively.
- Vicarious trauma can accumulate over a long period of time or it can be brought about by one-off traumatic events.
- One way to manage levels of vicarious trauma among professionals is with rigorous supervision and peer support.
- When particularly serious cases occur, it can be helpful to have an externally-run, structured and intensive debriefing process to ensure that the team can move on and continue to work effectively.

Definitions of vicarious trauma

To help victims of trauma, professionals develop empathy with their client. The Collins dictionary (1995) defines empathy as:

"the ability to sense and understand someone else's feelings as if they were one's own."

This means professionals who work with traumatised children and families take on some of the physiological, psychological and emotional consequences of the abuse (Tehrani, 2011).

Professionals must be accessible to the child or family that they are working with and understand their particular issues (Conrad and Kellar-Guenthar, 2006).

The damage felt by professionals empathising with those they are trying to help is referred to in a number of different ways: vicarious trauma, secondary trauma, compassion fatigue and burnout.Even though these terms mean broadly the same thing and have similar outcomes they are treated differently in the literature.

Conrad (2011) describes both vicarious trauma and secondary trauma as the stress and personal damage caused by helping or wanting to help a traumatised person. Other authors (Conrad and Kellar-Guenthar, 2006; Baird and Jenkins, 2003; and Richardson in Tehrani, 2011) group these terms in other combinations but all agree that there are long term consequences to reliving a client's experiences, especially when those clients are abused children.

The key concept is that by working with people who have experienced trauma and in trying to help them, professionals take on part of their client's emotional trauma for themselves.

Prevalence of vicarious trauma

Conrad and Kellar-Guenthar's study published in 2006 found that 50% of the social workers in Colorado were showing significant signs of compassion fatigue.

There is currently no research on the prevalence of vicarious trauma among social workers in the UK.

Different kinds of vicarious trauma

Vicarious trauma can occur over a long period of time or be caused by a single traumatic occurrence (Conrad and Kellar-Guenthar, 2006).

Over time it can be brought about by the volume and range of cases that a professional is exposed to (Tehrani, 2011).

A serious or shocking case can bring about trauma in a professional very quickly. Often, these are the cases that receive a great deal of public attention like the deaths of James Bulger or Peter Connelly (Tehrani, 2011). In such cases a new range of pressures come into play as a result of the public's reaction and the increased scrutiny that is placed on professionals and departments.

Horwath and Tidbury (2009) examined how professionals felt and moved on after a child's suffering was missed and the child died. The professionals reported feelings of guilt and worthlessness which needed to be addressed fully so that they did not affect the care given to other traumatised children.

Single instances of vicarious trauma can form part of the long term burnout of a professional. A single incident can also prove to be a tipping point for a professional whose long term vicarious trauma has not been properly addressed (Conrad and Kellar-Guenther, 2006).

Professionals who work with offenders and perpetrators can experience vicarious trauma because they have to suppress their personal views and emotions (VanDeusen and Way, 2006). In such cases, having to manage anger and sometimes disgust whilst trying to empathise and treat an offender can significantly impact on the effectiveness of a practitioner (Tehrani, 2011).

Professionals may also experience direct trauma, violence and abuse at the hands of families with whom they work (Tehrani, 2011). In these cases professionals can experience ongoing fear and anxiety about a potential recurrence of any violence and this can also increase the traumatic effects, especially if that professional finds themselves in similar situations. Assaults on colleagues can affect whole teams because of their exposure to similar situations and the fear that they could be subject to a similar attack (Littlechild, 2005).

Effects of vicarious trauma

On individuals

Social workers, especially those who work with abused children, are some of the most stressed professionals and are particularly susceptible to vicarious trauma (Braithwaite, 2007; Coffey et al, 2004; Dillenburger, 2004). Needing to invest emotionally in each case, combined with high caseloads and insufficient recovery time can also cause compassion fatigue.

Experiencing some of the worst aspects of human nature on a daily basis and over time can have a variety of effects on a professional including low self-esteem, emotional numbing, cynicism and a loss of confidence (VanDeusen and Way, 2006; Pogue and Yarborough, 2003).

It can also lead to a depersonalisation of the children that a particular professional is working with, resulting in a lower quality of care as the professional is unable to empathise with that child and provide them with proper support (Tehrani, 2011).

Some professionals reported physical symptoms such as headaches and nausea from the worry and reflected trauma of certain cases. One study reported that social workers frequently vomited on their way into work because of the emotional effects of their work (Pack, 2011).

On agencies

The impact of vicarious trauma on individual professionals inevitably has a significant impact on departments and services.

If the quality of care of one professional falls it can place greater pressure on other members of the team and greater risk of vicarious trauma among those other members of the team who may have to increase their own caseloads to help the struggling team member.

Interagency relationships and communication can also be affected by vicarious trauma (Horwath and Tidbury, 2009). A high staff turnover can bring less experienced professionals into high stress and high pressure positions, increasing the likely damage that those situations may cause the professional (Horwath and Tilbury, 2009).

Braithwaite (2007) argues that the current culture of accountability and performance management is incompatible with social care and that this could be adding considerable stress to professionals.

Munro (2012) highlighted the development of a blame culture saying that social workers were expected to perform their role faultlessly and this means that when mistakes did occur there was a disproportionate amount of criticism, putting even more pressure on them.

Both Braithwaite and Munro highlight the importance of supporting professionals so that there are fewer mistakes caused by vicarious trauma and compassion fatigue.

Combatting vicarious trauma

Even though there are a range of terms and types of vicarious trauma, the coping strategies mentioned in the literature are similar.

The majority of prevention strategies mention the importance of providing adequate levels of managerial supervision as well as peer support mechanisms. This will prevent professionals becoming isolated from their teams and help colleagues and managers assist one another to the benefit of children and families (Pack, 2011; Pogue and Yarbrough, 2003; VanDeusen and Way, 2006).

There needs to be a balance between the damage done by working with traumatised children and families, and, any positive factors such as recognition of good work and the time to heal after particularly difficult cases (Pack, 2011).

There also needs to be a culture within the department or service that recognises the seriousness of vicarious trauma and that it is not just "part of the job" so that professionals have an outlet through which they can raise concerns and get help (Hoff et al, 2009).

Supervision and support work well at combating the long term forms of vicarious trauma but for serious single traumas, there should also be a chance to fully debrief all those involved. This will not only help future learning but will allow professionals to move on and remain effective (Horwath and Tidbury, 2009; Braithwaite 2007).

Such major trauma can affect team morale and break up groups of colleagues who would otherwise act as a support network. In these cases it is important for the service to focus on the importance of its job and to remain aware of its successes (Braithwaite 2007).

Pulido and Lacina (2010) focused specifically on supporting a group of American child protection workers after a fatality and used the RRR (Restoring Resiliency Response) debriefing protocol to accelerate healing. They found that having a set procedure of debriefing, self-reflection and self-monitoring coupled with flexibility in timescales (recognising that people heal at different speeds) meant that, as long as the procedure was completed, outcomes improved and instances of secondary trauma were reduced. They also found that when the protocols and interventions were administered by an external organisation, participation improved.

A regularly mentioned protective barrier to vicarious trauma is professional experience (Baird and Jenkins, 2003; Hoff et al, 2009; Pack, 2011; Conrad, 2011). Whilst exposure to trauma increases the likelihood that it will negatively affect a professional, in the right environment that same exposure can improve resilience and help professionals empathise with their clients whilst staying emotionally healthy (Conrad and Kellar, 2006).

Future research on vicarious trauma

Many social workers choose their profession because of past personal experiences. The literature differs over whether these past experiences have a positive or negative affect on professional practice (Baird and Jenkins, 2003; Tehrani, 2011).

Research has not fully explored whether previous personal trauma can add resilience to a professional or weaken them when a case echoes their own history or whether over time a professional with no history of personal trauma may be more susceptible to vicarious trauma.

Research into the prevalence of vicarious trauma among social workers in the UK would also be useful in helping to understand the scope of the problem.

Conclusions about vicarious trauma

Vicarious trauma is an aspect of any profession that involves caring for others, but can be much more acute for professionals who work with traumatised children.

Social workers are often exposed to families who need the most help and to children who have been through harrowing experiences.

Empathising with clients and service users is an essential part of this role but it means taking on board some of the trauma experienced by those that they are working with.

As already discussed, by taking on part of that trauma a professional can experience negative long term emotional and psychological consequences.

For services and professionals to remain effective and to get the best possible outcomes for traumatised children it is essential to make sure that professionals have access to the help and support that they need to protect themselves.