UNIVERSITY OF CENTRAL OKLAHOMA

Edmond, Oklahoma

Jackson College of Graduate Studies

Child Welfare Specialists and Secondary Traumatic Stress: The Effects of Empathetic Caring

A Phenomenological Study

A THESIS

SUBMITTED TO THE GRADUATE FACILITY

in partial fulfillment of the requirements

for the degree of

MASTER OF SCIENCE IN FAMILY AND CHILD STUDIES / FAMILY LIFE EDUCATION

By

Jenny K. Milner

Edmond, Oklahoma

2016

Child Welfare Specialists and Secondary Traumatic Stress: The Effects of Empathetic Caring

A Phenomenological Study

A THESIS APPROVED FOR THE

DEPARTMENT OF HUMAN ENVIRONMENTAL SCIENCES

April 14, 2016

By _____

Dr. Brandon Burr
Committee Chairperson

_____

Dr. Kaye Sears
Committee Member

_____

Dr. Glee Bertram
Committee Member

_____

Dr. Gary Steward, Jr.
Committee Member

Dedication

This paper is dedicated to the compassionate, giving and dedicated Child Welfare Specialists and supervisors of the Oklahoma Department of Human Services. You give your all each and every day to the children of Oklahoma. This is for you.

ACKNOWLEDGEMENTS

I would like to thank Dr. Brandon Burr for all his guidance and support throughout this process. There were many, many emails, questions, concerns, and meltdowns along the way but it was all worth it in the end.

I would also like to thank Dr. Gary Steward, Jr. for all his encouragement throughout my graduate school career, for believing in me and encouraging me to take the road less traveled and giving me the courage to finish.

To Dr. Kaye Sears and Dr. Glee Bertram, you ladies have been a never-ending source of support, kindness and encouragement. I am grateful every day for your leadership and friendship.

Finally, to my friend Michelle, you have been there through every rough patch and hurdle. You are my guardian angel. Thank you all for taking this journey with me.

TABLE OF CONTENTS

ABSTRACT

Working with abused and neglected children is one of the most difficult jobs imaginable. The stressful conditions of a Child Welfare Specialist or supervisor are enormous and they often internalize the traumatic stress of their young clients and their families. This type of traumatic stress, referred to as Secondary Traumatic Stress (STS), inputs its toll on these employees each and every day making their jobs even more difficult. The research on this topic shows that positive coping mechanisms and peer support are greatly effective at combatting STS and the anxiety, depression and physical ailments that it produces. The main focus of this phenomenological study is to examine the ways STS affects the Child Welfare Specialists and supervisors of the Oklahoma Department of Human Services (OKDHS). It also seeks to find which positive and negative coping mechanisms are being applied to combat this type of stress and in what ways the agency can make changes to better care for its Child Welfare front-line staff and their mental health needs. Ten front-line employees of the OKDHS Child Welfare Services division were recruited to participate in an interview regarding their experiences as Child Welfare Specialists. Two common themes emerged after reviewing the interview transcriptions and selective highlighting: The need for accessible mental health resources and specialized training. Counseling for workers who experience the effects of STS should be available and easily accessible. The current arrangement for mental health services is not conducive to those employees working 40+ hour work weeks, on-call and weekend hours. A need for more specialized training is also a factor. Workers leaving CORE (specialized training for new Child Welfare staff) often feel completely unprepared for the realities of a child welfare caseload and the trauma they will face.

Chapter I: Introduction

Introduction and Background of the Problem

According to the 2013 U.S. Department of Health and Human Services Child Maltreatment report, more than an estimated 3.5 million reports of child abuse involving 6.4 million children were made that year in the United States. This resulted in 1.8 million child abuse investigations. Tragically, a total of 1,520 children died from abuse and neglect that same year. Seventy-three percent of child fatalities due to abuse and neglect were children younger than age three. The report concluded that children younger than age one (infants) are 3 times as likely to die from maltreatment as a 1-year-old child (U.S. Department of Health & Human Services, 2013).

The Oklahoma Department of Human Services (OKDHS) State of Change Annual Report 2015 states "A total of 140,072 children were alleged to be victims of abuse and neglect, 15,252 children were confirmed or substantiated victims of child abuse and neglect" and 3,707 children "were successfully reunited with their families (includes trial reunification)" (OKDHS, 2015, p. 56). In Oklahoma, child neglect is noted as the highest single category of child maltreatment at 69.04% of substantiated cases (OKDHS, 2013). Millions of children are severely abused and neglected by family members each year in the United States and the numbers continue to grow.

Working with children whose most basic needs are not being met is one of the many challenges faced by Child Welfare Specialists (also referred to as specialist[s] or worker[s]). The responsibility of the specialist "is perhaps the most complex in social work because employees are legally mandated to protect children who often are in families affected by substance abuse,

mental illness, mental retardation, violence, adolescent parenthood, incarceration, homelessness, and poverty" (Ellet, Ellis, Westbrook, & Dews, 2006, p. 265). Research indicates specialists assume this responsibility and often internalize these feelings of desperation themselves. Not only do they take on the trauma of their young victims, but they are also prone to workplace violence as they visit the places where the children in their caseload reside. These visits are often at great personal risk to the specialist. The specialist can never be certain what they will encounter when they investigate alleged abuse or neglect. Specialists risk physical or even fatal assault while investigating these cases in hostile environments.

Statement of the problem

In every state of the union, social workers are tasked with protecting these innocent children and intervening to protect them from further trauma or abuse. Social workers in the field of Child Welfare Services are empathetically involved in the lives of abused and neglected children and are prone to a form of compassion fatigue. Compassion fatigue indicators are the natural outcome of the stress of caring for others. Traumatologist Eric Gentry suggests that people who are drawn to this type of work are often already predisposed to this type of stress. They are what Gentry refers to as those drawn to "other-directed care giving" and were taught from a young age to put the needs of others before themselves. They often lack real, ongoing self-care in their own lives (Gentry, 2013). These specialists are also exposed daily to the trauma faced by their young victims. These men and women often find themselves dealing with a form of trauma known as Secondary Traumatic Stress (STS).

This study will identify the indicators and examine the effects of STS on the lives of Child Welfare Specialists. Examining this issue through a phenomenological lens will offer a unique perspective into this type of stress. By interviewing these specialists, a richer and deeper

view into the lives and experiences of those working with abused and neglected children and their families will be obtained. This unique perspective will provide an excellent starting point in evaluating coping strategies to combat this type of traumatic stress. Specialist turnover in this field is problematic and understanding the phenomenon of STS may provide clues to alleviating some of its impact on specialists.

Glossary of Terms

- **Burnout** - Cumulative process marked by emotional exhaustion and withdrawal associated with increased workload and institutional stress, NOT trauma-related (Compassion Fatigue, 2015).
- **Child Abuse and Neglect** - The OKDHS defines child abuse and neglect as, "any recent act or failure to act on the part of a parent or caretaker which results in death, serious physical or emotional harm, sexual abuse or exploitation; or an act or failure to act, which presents an imminent risk of serious harm" (OKDHS, 2013).
- **Child Welfare Services** - The basis for government's intervention in child maltreatment is grounded in the concept of parens patriae—a legal term that asserts that government has a role in protecting the interests of children and in intervening when parents fail to provide proper care ("The Child Abuse," 2010). Child Welfare Services is also the division within the OKDHS dealing with abuse and neglect of minor children.
- **Compassion Fatigue** - Also called "vicarious traumatization" or secondary traumatization (Figley, 1995). Compassion fatigue is the emotional residue or strain of exposure to working with those suffering from the consequences of traumatic events. It differs from burn-out, but can co-exist. Compassion Fatigue can occur due to exposure on one case or can be due to a "cumulative" level of trauma (Compassion Fatigue, 2015).
- **CORE Training -** OKDHS training required for all new Child Welfare Specialists. Consists of four weeks classroom training and two weeks of on-the-job training that covers: Foundation Level Knowledge, Skill Competencies and Child Welfare Policy. New Child Welfare Workers must attend CORE training no later than six weeks after their hire date.

- **KIDS** - Child Welfare Services confidential information system utilized by Child Welfare Services employees.
- **Oklahoma Department of Human Services (OKDHS) State of Change Annual Report** - This report contains annual statistical data on the various state and federal programs administered by the agency including: Adult and Family Services, Adult Protective Services, Aging Services, Child Care Services, Child Support Services, Child Welfare Services, Developmental Disabilities Services, and the Office of Inspector General. The report also contains a section on accountability and statistical data for all divisions (OKDHS 2015).
- **The Oklahoma Pinnacle Plan** - On January 4, 2012, the Oklahoma Department of Human Services (OKDHS), jointly with the Governor's Office and the Oklahoma Commission for Human Services, reached an agreement with the plaintiffs in class action litigation DG vs. Yarbrough, Case No. 08-CV-074. As part of this agreement, OKDHS was to develop an improvement plan for child welfare services (Pinnacle Plan) with assistance of key internal and external stakeholders and approval of the Co-Neutrals. The Pinnacle Plan details a five-year plan, beginning with State Fiscal Year (SFY) 2013, to address 15 performance areas identified in the agreement.
- **Phenomenological Method** - Phenomenology is the study of experience and how we experience. It studies structures of conscious experience as experienced from a subjective or first-person point of view, along with its "intentionality" (the way an experience is directed toward a certain object in the world). It then leads to analyses of conditions of the possibility of intentionality, conditions involving motor skills and habits, background social practices and, often, language ("The Basics of," 2015).

- **Secondary Traumatic Stress** - is the emotional duress that results when an individual hears about the firsthand trauma experiences of another (NCTSN, 2011).

Chapter II: Review of Literature

Understanding the experiences of specialists when subjected to repeated exposure of the trauma suffered by abused and neglected children will help us textualize the phenomenon of STS. These workers, caring for society's most vulnerable citizens, often find themselves immersed in complex and difficult environments that require empathetic caring as well as objectivity to manage a caseload of this type. Dangerous work environments coupled with the daily stress of the job is problematic. But STS is not just stress, it is a form of trauma all its own. By having a mental picture of the trauma specialists are exposed to, one may better conceptualize the difficulty faced when they must separate themselves from the trauma.

Through the Eyes of an Abused and Neglected Child

In order to understand the concept of STS, one must first understand the abuse and neglect of children may be defined in many different ways. The OKDHS defines child abuse and neglect as:

> Any recent act or failure to act on the part of a parent or caretaker which results in death, serious physical or emotional harm, sexual abuse or exploitation; or an act or failure to act, which presents an imminent risk of serious harm (OKDHS, 2013).

Children suffer not only physical abuse, which may result in injury, but also mental abuse, emotional abuse, sexual abuse, and many forms of neglect; all of which may result in lifelong repercussions. A child, for instance, whose most basic needs are not met as an infant, may develop a variety of attachment disorders keeping them from forming healthy relationships throughout the remainder of their lives. Children suffering from physical abuse may have lasting disabilities than can be mental, physical or both. Another dark area is sexual abuse which can scar a child in many ways, far into adulthood. A specialist trying to protect these broken

children, bringing them to a place where they can begin to heal, will be directly and indirectly affected by this trauma as well. How could one not be?

The realities of abuse and neglect are reflected rather poignantly in this wish list compiled by an Oklahoma foster child. This "wish list" recently went viral when shared on social media by the organization, Dream Catchers for Abused Children, founded by Christine Schoenwald (2015). The child listed a number of things that he or she wished for in a family:

> Things I want in my family. I want food and water. Don't hit on me. A house with running water and lights. I want love. Mom and Dad don't fight. I want no drugs. Don't kill my pets. Help with school. Nice clean clothes. No lice, no bug(s) in house. Clean house. Clean bed with covers. Don't sell my toys. Treated fair. Don't get drunk. TV in house. Let me keep my games. School stuff. Nice shoes. My own comb and soap. Nice house and safe (with) AC and heater. Coat. Toothbrush.

Secondary Traumatic Stress Theory

When someone in a caring position such as a specialist witnesses this very real type of abuse or neglect as a part of their job, they are experiencing a form of secondary or vicarious trauma. This type of reaction and response has been labeled Secondary Traumatic Stress (STS). The STS theory was developed by Charles Figley (1999). This theory proposes that those who work directly with victims of trauma on a regular basis tend to experience the same traumatic stress symptoms as those they are trying to help. Figley (1995) defines STS as "the natural, consequent behaviors and emotions resulting from knowledge about a traumatizing event experienced by a significant other. It is stress, resulting from helping or wanting to help a traumatized or suffering person" (p. 10). In addition to being exposed to the trauma suffered by the young victims in their caseloads, specialists often find themselves in positions of danger

which can result in either physical harm or the threat of physical harm. This increases their susceptibility to traumatic stress (Cornille & Meyers, 1999).

Secondary Traumatic Stress and Post-Traumatic Stress Disorder

Not only are these specialists experiencing stress in their jobs, but in all areas of their lives. Researchers have stated that some specialists have experienced individual STS indicators to such an extent they would also meet the criteria for a Post-Traumatic Stress Disorder (PTSD) diagnosis (Figley, 2002). Bride (2007) mentions that even with the extensive review of available literature, studies still fail to document the vast amount of indicators in this area and the true extent of the problem. In a study of Master's-level social workers, Bride, Robinson, Yegidis, & Figley (2004) used an instrument referred to as the Secondary Traumatic Stress Scale. This study revealed that nearly all (97.8 %) of the respondents had clients who had experienced trauma and most (88.9 %) stated that their work included addressing these trauma issues with their clients. A majority (70.2 %) stated that they had experienced at least one indicator of STS themselves within the last week, more than half (55%) experienced enough to meet the criteria for core indicator clusters, and 15.2 % of his respondents also met the criteria for a diagnosis of PTSD (Bride, et al., 2004). Specialist turnover in this field also tends to be quite high and it should not come as a surprise that these stressors not only affect the person's work life and job effectiveness but their personal lives as well.

In completing research for this subject, 22 articles on the subject of STS and burnout were reviewed. These two topics are often mistakenly interchanged and the differences will be explained later in this thesis. Coping mechanisms used by specialists experiencing STS indicators are also a topic explored as another layer of STS. Research on STS is fairly recent-all but two of the articles used for the literature review have been written within the last 10 years.

Ultimately, two of the research articles were not included as the information contained was not as relevant to the topic as first thought. Although interesting and probably excellent for one of the many sub-categories of this problem of practice, they did not fit the parameters of this particular study. The first article discarded from the project was "Calculating Child Welfare Separation, Replacement, and Training Costs" (Dorch, McCarthy, & Denofrio, 2008). This article examined the high turnover rate of specialists, their qualifications, and associated training expenses. Another article that was excluded was from *Child Abuse & Neglect* entitled "Effects of a Citizens Review Panel in Preventing Child Maltreatment Fatalities (Palusci, Yager, & Covington, 2010). This particular article, while of some interest as well in the area of child abuse and neglect, does not specifically address the needs of specialists.

The remaining 20 articles are quantitative studies, employing some type of survey instrument. One study used a mixed-methods approach utilizing a survey coupled with in-depth interviews on a select number of the survey participants. These participants were specialists who were taking part in a training seminar on STS. The interview data gave a richer view of the day-to-day experiences in this field. Many of the studies refer to or use the STS scales developed by Charles Figley. Because of the key terms used for the search, several empirical studies addressing the subject of STS were available.

Cornille and Meyers (1999) list several types of scales used when surveying participants in their studies on STS. These include: the Brief Symptom Inventory (Derogatis & Melisaratos, (1983), the Impact of Event Scale-Revised (Weiss & Marmar, 1996), and the Structural Family Interaction Scale (Perosa, Hansen, & Perosa, 1981). The Compassion Satisfaction and Fatigue Test by Figley and Stamm (1996) was also used in several of the studies. Questionnaires were utilized in several studies and two of the studies performed in-depth interviews for a qualitative

research approach. Another scaled used to measure STS among specialists was the Secondary Traumatic Stress Scale (STSS) (Bride, et al., 2004).

A consistent finding in reviews of STS is that nearly all specialists surveyed or interviewed had experienced the indicators of STS and a smaller percentage consistently met the clinical criteria for a diagnosis of PTSD. Also noteworthy, is that the differentiation between job burnout and what is actually considered to be STS is a fairly new concept. Unfortunately, little information or research being done on the treatment and prevention of STS could be located. This is an area that certainly warrants further research and exploration.

Burnout vs. Secondary Traumatic Stress

Often, STS and burnout are assumed to be interchangeable. While there are a few common indicators, strict parameters must be maintained. Many specialists would indicate that they are simply experiencing "burnout," however what they may actually be experiencing are the effects of trauma. We must review the indicators of both burnout and STS to appreciate the differences. Then treatment to reduce or eliminate the effects is more likely. During an STS educational workshop, participants were asked to list as many terms as they could upon hearing the word "trauma." Many of the words listed by the participants included: "danger, life threatening, hopelessness, helplessness, death, disability, blood, emergency room, sickness, panic, chaos, loss of control, shock, etc." …and the list goes on (Pryce, Shackelford & Pryce, 2007, p.53).

When questioned about what burnout might look like the participants responded with terms such as "tired, detached, overwhelmed, non-productive, underpaid, frustrated, messy desk, postal, irritable, absent, isolated, and apathetic" (Pryce, et al., 2007, p.53). Again, the list is illustrative but incomplete. When asked to compare the two, there are a few terms that overlap.

However, what is distinctive in this comparison is that the participants do not identify things like blood, emergency room, chaos, or death when they think of burnout. The indicators of traumatic stress are derived from helping other people who are experiencing a traumatic situation or event. Burnout is more of a systemic problem that occurs within the organization, not within the person. The high demands placed on staff with a job that is not personally rewarding are key factors in the cause of burnout among employees (Pryce, et al., 2007). Employees experiencing burnout typically feel disconnected and report very little feeling of accomplishment in their jobs. They may tend to depersonalize and withdraw, embrace feelings of apathy, and a general lack of caring. Burnout is a long term reaction to chronic stress and it is often difficult to pinpoint its exact cause (Mitani, Fujita, Nakata, & Shirakawa, 2005).

On the other hand, STS like PTSD, is an acute response to a type of stress or stressful event that can be linked specifically to a traumatic event (Mitani, et al., 2005). Dutton and Rubenstein (1995) suggest that specialists may come to their positions having already experienced personal trauma or may have previously worked in another helping profession. This prior exposure predisposes them to experiencing the effects of STS. Working with neglected and abused children may put them at further risk of experiencing such indicators as nightmares, feelings of depression, withdrawal, and isolation from others.

Conrad and Keller-Guenther (2006) further note, however, that some specialists do indeed experience job burnout. This is reflected in the high turnover rate found in one study conducted by Cyphers (2001). This study documents a 22 % annual turnover rate for Child Welfare Specialists in 43 states. The burned-out workers simply quit their jobs and move on to other employment. This may also be a reason why increased pay does not seem to be a strong incentive cogent to retention. It is this high stress that comes from dealing daily with people

living in extremely stressful life situations and being subjected to some of the worst experiences of their lives that cause workers in this field to leave in droves due to the pressure.

The high turnover of workers in this field of social services is of great concern. What can be done to slow the turnover and the costs and risks associated with it? Are children being put at further risk for harm with a continuously new staff of specialists? The research suggests this may be the case. Graef & Hill (2000) contend that the initial training required for all new specialists, places agencies in a position of working with relatively new staff for long periods of time. The continual turnover means that seasoned specialists must assume larger caseloads and thereby adding to their stress. These larger caseloads are less manageable and leave room for more error in judgment. These high turnover numbers not only affect the caseloads and morale of the specialists but seriously strain agency budgets as well. Reductions in state appropriations to these agencies simply add to the issue of resources. Turnover rates were often blamed on burnout, but there is a growing body of evidence that this may in fact be due to trauma (Balfour & Neff, 1993; Fryer, Miyoshi, & Thomas, 1989; LeCroy & Rank, 1986, as cited in Figley, 2002).

Indicators and Effects of Secondary Traumatic Stress

Trauma can produce a chronic and prolonged stress response in these individuals that has lasting effects on both the psychological and physical health of the individual (Mitani, et al., 2005). Unfortunately, there is little that can be done about burnout, short of changing the structure of the organization itself. Dissimilar to burnout, STS can be treated with the correct types of intervention.

People respond to trauma on many levels. First and probably the most recognized is the emotional level. Colorado Child Welfare Specialists from 12 counties were asked to participate in a seminar. This seminar was conducted on 36 separate occasions from June 2002 to April

2003. The participants, specialists and supervisors, were asked to complete the Compassion Satisfaction and Fatigue Test by Figley and Stamm (1996). The results of this study concluded that while almost 50% of the participants of the Colorado specialists and supervisors scored "high or extremely high" risk of compassion fatigue, only 7.7% were in the "high or extremely high" risk of burnout. For this same group, 75% ranked "extremely high," "high," or "good" in the area of compassion satisfaction. As expected, participants with higher compassion satisfaction scores also had significantly lower levels of burnout and compassion fatigue (Pryce, et al., 2007). Dutton and Rubenstein (1995) proposed that those who choose this type of work may have previously experienced a personal form of trauma in their own life. They argue that exposure to the trauma and suffering of the children with whom they are working places them at significant risk of experiencing STS.

Those experiencing STS listed the following indicators when asked about emotional trauma: feeling anxious or stressed, shame, depression, tearful, as well as feelings of rage, anger and sadness. They also experienced intrusive thoughts in the form of dreams, nightmares and flashbacks when recalling the traumatic event itself (Pryce, et al., 2007).

The perceptual cognitions experienced include a loss of memory, feelings of detachment, and being jaded or cynical. They may also lack focus or clear thinking, experience feelings of paranoia, and have poor concentration. Physiological symptoms are also a response to trauma. Participants reported experiencing increased blood pressure, panic and anxiety attacks, irritable bowel syndrome, stomach ulcers, headaches, migraines, fatigue, abuse of drugs and alcohol-the list of physical symptoms is quite extensive (Pryce, et al., 2007). When asked to list some of the behavioral responses they had experienced, participants expressed a decreased sense of spirituality where there was once more, an urge to hurt themselves or others, a proclivity to make

inappropriate comments, and unsympathetic, judgmental, impatient or aggressive feelings (Pryce, et al., 2007).

Lastly, the participants were asked about their interpersonal relationships and how those had been affected. Many experienced co-dependent relationships, suffered withdrawal from others and activities they once enjoyed, and had problems with family members, children and co-workers; they had also lost interest in sexual relations and often found themselves in inappropriate relationships. Many experienced the loss of friends, divorce, and damage to relationships in general (Pryce, et al., 2007). There is also a strong correlation with STS and the number of hours worked, large caseloads of specialists, the amount of contact with clients, and the length of the specialist's career with Child Welfare Services (Beaton & Murphy, 1995, as cited in Cornille & Meyers, 1999).

Coping Mechanisms

For those dealing with the abuse and neglect of children, the stress is enormous; however, when a death of a child in their caseload occurs, the stress is taken to an entirely new level. The specialist may be left with many unresolved feelings. Guilt, anxiety, grief, and shame may cause the person to doubt his or her ability to do their job, cause great feelings of personal inadequacy as well, and can lead to suicidal behaviors when left untreated. Many workers found that talking to their peers and other colleagues was an effective coping mechanism. Education about abuse and even humor were also mentioned as positive coping mechanisms (Pryce, et al., 2007).

Unfortunately, some resort to alcohol and other drugs, as well as, withdrawal from family members and friends while trying to escape the effects of STS and the traumatic event (Ting, Jacobson, & Sanders, 2008). Seeking positive ways to cope with the trauma is much more

effective than the use of negative coping mechanisms such as the use of drugs and alcohol, which can exacerbate harm in the end (Ruzek, 2005 as cited in Ting, et al., 2008).

Because trauma, unlike ongoing stress, is often sudden, unanticipated, and may cause feelings such as loss of control, the coping calls for a different set of skills (Ting, et al., 2008). One may feel they must make sense of what happened. In this way, trauma differs greatly from the regular or routine stress. There is no logic to trauma that has occurred, such as the death of a child in a Child Welfare Services related case.

Personal trauma in the life of the specialist can also play an important factor in the possibility and to what degree one may experience the effects of STS. Cornille and Meyers (1999) found that a large number (82%) of the specialists in their study had experienced trauma both prior to and after coming to work in the field of Child Welfare Services. Many specialists (77 %) had also experienced physical assault or been threatened while at work. They discovered an important factor in dealing with STS was that a strong administrative support system was essential in helping to reduce some of the strain that specialists face in their jobs.

This review of the literature on STS and its effect on specialists has clarified the parameters and the effects of STS. An important distinction between STS and burnout has been posited. STS is not burnout, it is an empathetic response to the trauma of another person. It is also naturally occurring and can be predicted in many individuals. We have learned that while females may be somewhat more predisposed to experiencing the symptoms of STS, males also may exhibit symptoms but they may be expressed in different ways. Those who have experienced a trauma previously in their lives may also be those called to this type of profession in order to help and care for others. However because of prior trauma, they may be more likely to experience symptoms of STS than someone who comes to the profession without a personal

traumatic experience. Another facet of this phenomenon is the role of education in abating the effects through the implementation of positive coping strategies. This may be helpful in combatting its effects on the forefront rather than waiting until the person is in the full throws of the experience. An understanding that STS is a naturally occurring experience for many in this type of work can help the specialist recognize its indicators when they begin to occur, possibly buffering the effects with proactive management, counseling, peer support, and other mechanisms put into place at the beginning of their career.

STS is pervasive. It is a very real issue and is not simply a case of burnout. The root causes appear to be based in empathetic caring which goes hand-in-hand when working with traumatized children. STS works against them, leaving them feeling traumatized themselves. Now that we have a more precise definition of STS, we should move forward in examining how this type of stress affects the specialists in Oklahoma.

This study of specialists employed by the OKDHS will take a deeper, more personal look into their experiences of protecting abused and neglected children. The study examines the coping mechanisms used, both positive and negative, and explores the ways that the OKDHS trains and assists them to combat this particular type of stress. By examining the issues and situations that are unique to their situation as specialists in the field of Child Welfare Services, we will gain a better understanding of effective ways to alleviate this stress, ways in which they seek and (hopefully) find support, and areas where growth may be made to better serve their needs.

Chapter III: Methodology

Phenomenology

The purpose of this phenomenological study is to study the effects of STS on specialists who manage caseloads of abused and neglected children for the State of Oklahoma. Phillips-Pula, Strunk, and Pickler (2011) discuss various phenomenological approaches to data analysis. Three general types of phenomenology were noted: transcendental, focusing on the essence or individual experience; existential, examining the nature that holds the concept together; and hermeneutic which looks at the structure and interpretation, focusing on language and communication (Douglas & Moustakas, 1985 as cited in Phillips-Pula, et al., 2011). Regardless the approach, the first step taken in this type of research is developing a question regarding the phenomenon one wishes to study. The second is to identify a sample pool of suitable participants willing to take part in the study. The data for phenomenological study are gathered by either observation, participant interview, or their own written statements describing the phenomenon experienced. The data are then analyzed by coding and categorizing methods and then finally, are presented.

The roots of phenomenological research may be traced back to the philosophical traditions of Edmund Husserl. He is considered one of the most influential philosophers of the 20th century and the father of modern phenomenology. His work pioneered new areas of research, exposing a place where lived experiences of participants could allow us to grasp the very essence of that experience. Husserl focused on the meanings and central themes of experiences as ways of gathering information about the experience or topic. Husserl also taught that intentionality, "the act of being present in a situation contains both a noema (perception) and a noesis (meaning), and that establishing inter-subjectivity with participants prepared a

researcher to step into their experiential shoes" (Husserl, 1970; Moustakas, 1994, as cited in Phillips-Pula, et al., 2011, p. 68). Husserl's focus was on significances or meanings and finding the "essence" or primary theme.

In this study, the participants were all specialists or supervisors who have managed a caseload of abused and neglected children while employed by the OKDHS. The primary aim of this study was to examine their shared experiences of working with this population and their families, drawing out the various essences, or underlying meanings of their common experiences. A phenomenological approach was chosen to draw upon the many experiences of these specialists while working toward the common theme of experiencing STS.

The participants in this study were asked to disclose information about experiences they may find to be traumatic or difficult. Some discomfort, either psychologically or physically, in recalling these memories might occur. However, sharing these feelings is often useful in the healing process for someone who has experienced trauma or secondary trauma. The participants were recruited on a voluntary basis and had the right at any time to withdraw from the interview process if they found it too difficult or uncomfortable. Resources for counseling were made available through the OKDHS Employee Assistance Program should they find the need to seek this type of support. These services are available free of charge to OKDHS employees, their spouses, and dependents.

Procedure

Participants were recruited through a snowball sample of Oklahoma Child Welfare Specialists. Once approved by the Institutional Review Board at the University of Central Oklahoma and by the director of Child Welfare Services for OKDHS, consistent with a snowball sample, the participants were recruited by initially contacting one to two specialists and after

obtaining their permission to participate in the study. They in turn recruited other participants using an informational letter regarding the study. Participants were purposefully recruited from both rural and urban Child Welfare offices in order to obtain a more accurate sample of specialists. All subjects in this study were informed that participation was voluntary and reminded of their right to withdraw at any time. The hope was to gain 10-12 participants willing to be interviewed for the purposes of this study. It was expected that interviews would last approximately one hour.

All participants were given a consent form at the time of their interview stating the general purpose of the study, assurance that the results and their participation will remain confidential, and that they may withdraw from the study at any time.

Participants

The participants in this study were both specialists and supervisors. There were two male and eight female participants ranging in age from 27 to 51. Seven of the participants had a Bachelor's degree and three held Master's degrees. All but one of the participants have minor children living with them at home and some also have foster children. Caseload numbers ranged from nine for a new specialist with a graduated caseload of 25% to between 35 and 40 for the full caseload size assigned to a more experienced specialist. The average number of hours worked per week was approximately 50 hours ranging between 40 at the lowest and 60 at the highest. The participant pool was drawn from two Oklahoma counties, one urban and one classified as both urban and rural.

Research Questions

The guiding research questions for this study were, "What are the experiences of Oklahoma Child Welfare Specialists in working with abused and neglected children; do these

experiences of empathetically caring for traumatized children and working with their families to resolve these circumstances, cause a secondary traumatic response in the workers who are caring for them and working to protect them?"

Participants were asked to answer some basic demographic questions and then were interviewed using the following open-ended questions to describe their experiences as a child welfare specialist:

Basic Demographics

Male/Female/Transgender

Age

College Degrees (University/degree type/major)

Income Level

Marital Status

Children – number, ages

a. At home

b. Grown/left home

County in which they are employed

a. Is this a rural or urban area?

Typical size of caseload

How many hours per week on average do you work?

Interview Questions

1. How long have you worked for the Department of Human Services?

    a. How long have you worked for Child Welfare Services?

    b. Did you previously worked for another OKDHS division?

2. Can you tell me why you were first interested in or motivated to work with the Child Welfare Services division of OKDHS?

   a. What do you like most about your job?

   b. What kind of training did you receive as a new worker?

   c. Do you feel it adequately prepared you for work as a Child Welfare Specialist?

      I. If not, what kind of training would you like to have had or would like to have now or on an on-going basis?

3. Do you feel safe?

   a. Do you feel safe in general?

   b. At home?

   c. At work?

4. Do you have anxiety or do you feel anxious when you are in the field?

   a. What aspects of your job cause you to feel anxious or concerned?

5. How would you describe your support system at work?

   a. Do you have a peer support group or system?

   b. Do you feel you have the support of supervisors or administration when you need support?

   c. Are continuing education courses or other types of additional training offered (outside the original new Child Welfare Specialist academy/CORE)?

6. Do you have any hobbies? (This is a question used to break up any tension the participant may be feeling at this point. It may also be moved around as needed as a diversion or "cooling off" question.)

7. How do you feel the OKDHS could better support you in your work as a Child Welfare Specialist?

    a. What do you think should be added to the current training that would be helpful to you and other workers who are new to this job or even those who are seasoned employees?

8. Final thoughts?

Because this study also proposes to differentiate between STS and burn out, if the word "burn out" or a similar term is used at any time by a participant in the interview process, the following questions will be asked.

1. What leads you to believe you may be experiencing burn out?

    a. What words or terms come to mind when you think about burn out?

Chapter IV: Findings

Data Analysis

The interviews were recorded electronically and transcribed verbatim with the exception of names and identifying information. Based on the focus of the phenomenological method, particular attention was given to the development of themes that centered on the perception and meaning that participants attached to their experience.

The purpose of this study was to examine the ways in which STS affects specialists. It is that essence or meaning which we draw from their experiences that help to explain this phenomenon, both how and why it occurs. In the process of interviewing the 10 participants of this study, common themes began to emerge. One of the concerns many of the participants shared was a lack of accessible mental health resources.

Specialists often work overtime and keep irregular hours. Because of these realities, it is difficult for them to maintain scheduled appointments and to access the traditional forms of counseling offered by their employer, the OKDHS through the Employee Assistance Program.

The second theme that emerged from the interviews with the participants was a need for more specialized training for new employees entering the field of Child Welfare Services. Many workers expressed concerns that they felt unprepared for the realities of the job when they finished their CORE training and began carrying a caseload of abused and neglected children and their families.

Many experienced a great deal of anxiety when dealing with traumatized children and their families, dangerous situations in the field, and other forms of stress they associated with this type of work. These shared experiences have prompted this study. A quote from the

OKDHS Publication "A Day in the Life of a Child Welfare Specialist" sums up this sentiment rather well.

> OKDHS Child Welfare Specialists serve children and families with severe problems-poverty, unemployment, substance abuse, domestic violence, illness – and multiple needs. Child welfare specialists deal with complex, painful and often life-threatening situations that require sound judgement and timely decisions ("A Day in the Life," 2013).

The Oklahoma Department of Human Services is a large and diverse agency with many components serving the needs of Oklahomans. Child Welfare Services is one of the major divisions within the agency.

Oklahoma Department of Human Services Organizational Structure

When discussing the findings of the research concerning employees of the OKDHS, it is important to look at the organizational structure of this, the largest state agency in Oklahoma. The OKDHS has a tiered leadership structure headed by a single director. Under that director are several divisions, each headed by a Division Director and several subdivisions. The OKDHS has just over 7,000 employees whose mission statement is: "We improve the quality of life of vulnerable Oklahomans by increasing people's ability to lead safer, healthier, more independent and productive lives" (OKDHS, 2015).

Child Welfare Services Organizational Structure

Child Welfare Services is also headed by a single director with Regional Deputy Directors who oversee the five child welfare geographical regions in Oklahoma as well as four other Deputy Directors of other program components The Child Welfare Supervisors are the next level followed by the Child Welfare Specialist III positions which are lead worker positions and help to train and mentor new specialists who are the front line staff and those most likely to

be affected by STS. The personal experiences of supervisors and specialists are the focus of this study. The mission statement of Child Welfare Services is as follows: "The purpose of Child Welfare Services is to improve the safety, permanence and well-being of children and families involved in the Child Welfare system through collaboration with the families and their community" (OKDHS, 2015).

The findings that will be highlighted in this chapter are themes that emerged after careful review and coding of the interview transcripts. Ten participants were interviewed for this research project with two major themes and several sub-themes emerging. The first major theme is a need for accessible mental health resources for specialists and supervisors. The second major theme is the need for specialized training for new specialists.

Accessible Mental Health Resources

The first theme that emerged is the very real need for mental health resources that are accessible to the specialists and supervisors of OKDHS. While the agency does offer counseling through the Employee Assistance Program, employees find it difficult to carve out a specific time to meet with a counselor on a scheduled basis due to the amount of overtime and on-call hours worked each week. One specialist stated this after dealing with a particularly difficult case:

> I can't talk to anyone about it and had no one TO talk to about it. If I had someone I could have called or gone to see, I would have gone. It has messed me up for months afterward. A toddler was seriously injured and could have died at any time, luckily he didn't but I couldn't stop thinking about it. Ever since that case, I have had some trouble. I can barely work through the day, I was doing so well and then my anxiety got so bad that my supervisor noticed. It's so hard to explain to people, you don't want them feel

> like you are incapable. My supervisor talked to me last week and I wanted to cry but didn't want to tell her what was wrong. It is getting better with smaller caseloads but my anxiety is out of control since that happened. It would have helped if someone were there to talk to. I am supposed to be able to handle this but I can't and I can't tell anyone.

When asked if they felt they had the support of their supervisor and the administration of OKDHS, one participant stated:

> I feel I can go to her but not people above her. It's hard to explain to someone. It is hard to just get through my day. I don't think I would feel comfortable going to someone higher up, I don't want them to know how I am feeling."

The respondent also reported after a particularly shocking and heinous case occurred, stating:

> I think it was neat that they brought someone (a professional counselor) in that time but they didn't really encourage us to go. You don't want to be the one who can't do their job or are having hard time dealing. They need to make it a more understood thing to use support that is available, normalize it. Warn the employee ahead of time, keep talking about it, and assure them it is normal to feel this way but it isn't normal to keep feeling this way.

Many workers echoed the thought that it was hard to be away from work to seek mental health services because they were concerned about getting their work done. One specialist mentioned, "I feel bad about taking off work to do it. There are many obstacles to getting help. Time to take off work is a problem." She also stated:

> I think we need someone trained in trauma, who really understands things like PTSD, I think a lot of people have that. I think people realize how hard it is but it is hard for them to actually put into any action or understand how much it affects your personal life.

New workers need a great deal of guidance and support during the first few months in their new position as a specialist. One participant spoke about how she hired on as a Specialist III, but had to serve as the interim supervisor with the departure of her supervisor. She was also carrying a full caseload at the time and was supervising several workers. Her reflection of this situation;

> Then I had to (actually) apply (for the supervisor position) and I think two or three days before my interview I had a child killed on my caseload. So, it was a very stressful time. We had very large units so I had about 10 people that I was supervising.

This supervisor also reported about her experience as a new specialist. "I was doing a lot of stuff by myself, where I shouldn't have been. I went to CORE but as far as training and mentoring…there was nothing."

Another specialist had prior experience while doing a practicum with OKDHS in a smaller county. Upon moving to a larger county, she was hired to work full time as a specialist. When asked if she felt like she would have been lost without her previous child welfare experience she said, "I wouldn't have lasted over six months." When asked about her knowledge of daily stress versus traumatic stress, she expressed that she had never drawn a distinction between the two. The worker stated, "I had never heard about it, until probably when I was a supervisor. I've heard a lot about burnout." In addition, she conveyed knowledge of the Employee Assistance Program by responding, "I didn't even know about this for a couple of years." As a supervisor, she now discusses traumatic stress with her employees on a regular basis and in monthly staff meetings.

> We discuss what you've dealt with this month, how we can get you time off next month, and in my monthly handouts at group meetings, I have that number. I tell them when I

> hire them on, this is in their package, and I say 'This is a $100 session so if you don't use this for anything whether it's marital counseling, talking about how your mother screwed you up…you're giving the state $600 bucks. Do you really want to do that?"

Specialized Training

Another theme that emerged from the interviews was the topic of specialized training that would better prepare a new specialist for the realities of the job. Child Welfare Services requires all workers to attend a new specialist training program entitled CORE. Once CORE is completed, workers must pass a test referred to as the HOT test (Hands On Testing). This is a requirement of the The Oklahoma Pinnacle Plan, Point 3, Initiative 7 which states "Effective September 1, 2012, training for new Child Welfare Specialists requires successful completion of a performance competency evaluation prior to caseload assignment" ("HOT: Hands on Testing," 2015, p. 2). The mission of the Child Welfare Training Section is:

> To support and enhance the OKDHS Child Welfare workforce through training, mentoring and educational opportunities, to improve the safety, permanency and well-being outcomes for children and families involved in the Oklahoma Child Welfare system ("HOT: Hands on Testing," 2015, p. 2) .

Many specialists expressed the desire for additional training; however the requisite time to complete this training is difficult. They find it challenging to leave their caseloads once they are past their Level One training requirements. One participant said she could not afford the time for additional training away from her caseload and the new workers she was mentoring. Another specialist shared, "I feel like they teach to the test in CORE" and also expressed concerns that she didn't feel adequately prepared for the "real life" situations she would encounter in the field. The things she learned in CORE focused on the paperwork, data entry

and interviewing skills associated with the job. While important, she felt completely unprepared for the reality of the job once he/she was given a caseload. The purpose of HOT, according to the handbook is: "This competency evaluation will assess critical skills needed for child welfare workers to achieve positive outcomes for children and families" ("HOT: Hands on Testing," 2015, p.2). The handbook also states that "Participants will achieve successful completion of Hands on Testing once they have demonstrated skills on all four components; child interview, adult interview, safety assessment, and KIDS navigation and documentation" ("HOT: Hands on Testing," 2015, p.2). (KIDS is the confidential information system used by OKDHS Child Welfare Services.)

Many of the participants indicated they had great support from their Specialist III's, who serve as mentors. They also reported positive feelings about their supervisors who helped to fill some of the gaps left between CORE training, the Level One training received during their first 18 months, and taking on a graduated case load when returning to their home office. Workers are not allowed to be assigned a caseload until they have completed CORE and passed the HOT testing. At the beginning of CORE the supervisors and Specialist III's (who serve as mentors) work extensively with the new workers to help prepare them for the HOT testing.

Some of the workers interviewed stated that when they were new to the position, they were given full caseloads and felt overwhelmed. This practice seems to be changing with the provisions in the Pinnacle Plan and with the hiring of additional specialists to fill vacant positions. Turnover has always been an issue. The agency has been filling many of its vacant specialist positions as part of compliance with the Pinnacle Plan. Workers stated that this has reduced tensions within their offices and lessened the number of on-call days as well. Most

participants reported that things definitely seemed to be improving and were in support of the Pinnacle Plan.

A few sub-themes also emerged as part of the need for specialized training including: supportive supervision, partnering for safety, peer support, and positive coping mechanisms. All these provide a general layer of extra support for workers in the front-line positions of Child Welfare Services.

Supportive Supervision of Child Welfare Specialists

Workers need to be supported by their supervisors but this isn't always the case. One participant reported about her job as a specialist:

> I think I've had one day or two since I've had this job that I didn't want to go to work. It had nothing to do with the job itself, it was the situation and the people…and usually deaths…it's so hard.

She also shared that she didn't feel supported by supervisors while working in the larger county. She claimed that a supervisor instructed her to bring her child to work;

> 'Oh you're home with a sick kid, go ahead and take your kid to court with you. It's okay.' No, it's not okay, this is my child. She was also told, 'Oh you're sick, I'm sorry, you've got court and you have to go in.' I've actually called my doctor and said I have diarrhea and I have court tomorrow and she's not going to cover for me. What can you give me?

This participant also shared other experiences from working in the larger county. She had a co-worker who was three months from being vested (for retirement). The co-worker suddenly decided to quit and said, "Couldn't do it, hate it! Cried when I had to go to work, sat at

work and cried, couldn't do it." She had confided in a friend who advised her to just quit. She shared this:

> She was also a supervisor, a great supervisor! Her friend said she was so burned out…and again, she uses the word burnout. We were in the same unit in (the larger) county, I went through supervisors faster than I did my wardrobe at home.

Additionally she shared this experience with an uncaring supervisor,

> I've had supervisors that when I've walked in and said, 'I need to staff this' and they told me 'to get the f*** out of their office!' I've had them clip their nails on the desk while I've tried to talk to them and they've said 'I don't know him, you know I retire in 6 months so I'm not going to find out.'

The participant also conveyed about her frustrations with workload and compensation,

> My first day on the job as a supervisor, I came in on a Monday and I had 11 case files sitting on my desk. All 11 came from one woman who is still [working] in the office. It took me over two weeks to physically find the children because none of the placements were current. She's one of these people who got kicked out of three or four court rooms. And that day, I had to actually go to court on a termination hearing, by myself, and introduce myself to the parents. I was getting paid the same amount of money as that lady did.

This participant also talked about the lack of resources and compensation for workers. The lack of available funds for things like cell phones is a real concern when it comes to safety.

> I don't think we pay anybody that does our jobs enough. I can't get our Child Welfare Assistants (who often transport children) cell phones and they're out there transporting kids, going in parents' homes, and going on supervised visits. They have to give out a

> number, they are on the road, sometimes traveling to Durant or wherever and they have to…it's like…I can't even get them a cell phone! Can't get it approved!

Partnering for Safety

The Oklahoma Pinnacle Plan, Point 3, Initiative 19 (2012) states, "The OKDHS will pilot the concept of partnering child welfare specialists in teams to improve safety, decision making, supports to families, case information provided to the supervisor, and stress associated with making very tough decisions" (p. 28). While this is a great plan and many new workers are partnered with a mentor or supervisor during the training period, most make all their field visits alone unless they feel there is a need to bring a co-worker or the police as a back-up. One of the supervisors interviewed had this to say about safety, "I totally tell my workers, you're not safe. I can go with you; I'm probably one of the few supervisors who actually go into the field." We also discussed her safety plans with her workers. "My workers have to text me when they get off work. I have one out to a parent home right now." She's just had a conversation with one of her workers during the interview and says, "That's why I was like, 'text me when you're done there because it's not safe,' I would have been glad to go with her." When asked if she thought her workers felt safe with the plan they have in place she shared;

> They feel safe most of time. We all have instances where we're not safe. We had somebody…we had a death threat this week at work. Somebody called and said they wanted to kill somebody there. We've had parents on YouTube with their faces masked and threatening us all.

She discussed many instances where she had not felt safe in the field. She once asked a foster mom;

> Why don't you let the kids play in the backyard? 'Because the bullets from that apartment house flying in my backyard---you want to see them?' 'If they play in the street I can see what cars are passing,' the foster parent had responded. Neighbors from the neighborhood were out walking. The man saw me and I did not belong. He came after me and his wife/girlfriend/I-don't- know and said, 'let her, leave her alone, she's doing her job.' Course I had my badge. I usually wear it, turn it over, put it inside, I don't advertise. We were outside and the kids were painting with (biological) Mom. There were four kids, foster parents, stepdad, and of course, I really didn't belong there. They actually told me I was the educated white woman. They like me and they told him to get out of here and leave me alone. (Biological) Mom would have sat there and watched and not done a thing. She was going to be fine with it. My whole thought was 'Oh my God, these kids are going to see this!'

This participant also spoke about other times she felt unsafe in the field;

> So…I've had people in a parking lot pull out guns when I've been turning around in the apartment houses, just to show me they had a gun. I've had people when I was taking a girl for a visit with her sister, step between me and her going up the stairs to the apartment and want to know who I was and what was I doing there. She's like 'leave her alone.' You know, I mean, it's not safe. I don't expect my workers to go as far as I do.

Peer Support

Peer support within the office serves as an effective positive coping mechanism for most people. When they are able to discuss cases, situations or how they may be feeling that day, peer support can be very effective at combatting STS. One specialist shared about the support system in their office;

> We sit and we talk, we talk a lot. I like my co-workers and my boss, she's really supportive. My supervisor and co-workers are all nice people. Some have more outward anxiety, they are very out there with their feelings and they seem to need people to comfort them, but those who are not outward about their feelings are suffering quietly. I feel like I can vent to my co-workers to an extent but you minimize it so you don't sound completely crazy. We staff stuff. My supervisor is a lot like me, takes a lot of things to heart. We dealt a case where a foster parent hurt a child and we talked for an hour. She was crying and several times over a month or two, we were both upset and supporting each other.

When asked if the workers and supervisors would participate if mental health professionals were to come to the office and be available for counseling either in groups or individually, one participant shared, "I think everyone would participate but there would need to be a person to kind of facilitate and keep things moving along."

In many of the interviews conducted, it was apparent that one of the offices from which participants were recruited had a fairly good peer support system in place. The workers seemed satisfied with the support given to them by their mentors and supervisors and felt they could go to their supervisors or Deputy Directors if need be. The "family-like" atmosphere in this office seemed to mollify tension and provide a safety net for their specialists not seen in some other county settings.

Positive Coping Mechanisms

While it has been shown through research that positive coping mechanisms are a highly effective way to combat the effects of STS, many of the workers and supervisors who were interviewed mentioned that they observed plenty of unhealthy coping mechanisms among co-

workers such as drinking, smoking, over-eating, etc. Many even admitted that they had themselves engaged in these types of behaviors when seeking relief from the stress of their jobs. However, a few also reported that they had found other, more positive ways to combat the stress such as exercise, family support, seeking counseling outside of work, a faith-based approach, and learning to rely on policy to help guide their decision-making processes. Others said they had developed a sort of "thicker skin" when it came to working with traumatized children and their families within dangerous work environments. Unfortunately, some also reported that some of their co-workers, and sometimes even themselves, had become cynical and uncaring toward the families they are working with. Generalizations are often made about families because of past history or because of what often seems to happen in certain situations. One supervisor when asked about the anxiety carried by her workers stated:

> I think they do have anxiety. I think they have to learn to cope with their stuff in a healthy way. Two of my workers were told recently at a health screening by a nurse 'Your liver levels, if you don't stop drinking now, you're going to have problems.' There are at least three people in my office that I know, are alcoholics. They tell me how much they drink. They know they are alcoholics.

This supervisor stated she was also told her blood pressure tested rather high at that same health screening.

Chapter V: Discussion

It has become abundantly clear that trauma, experienced even in a secondary manner, has a profound effect on people in the caring profession of Child Welfare Services. We have examined some of the coping mechanisms, both positive and negative, the difference between STS and burnout, and have drawn conclusions regarding the state of Child Welfare Specialists in Oklahoma. The purpose of this research was to examine the effects of STS, what factors contribute to its occurrence, what specialists do to combat STS, and what the agency can do to assist them in dealing with the emotional stress of their jobs.

Ten participants, including both workers and supervisors of Child Welfare Services, were interviewed regarding their experiences as employees in this division. Basic demographic information was gathered including the time they had been employed by OKDHS (and specifically by Child Welfare Services), the number of hours (on average) they work per week, and the average caseload size (for specialists). The participants answered questions regarding their jobs on topics such as safety, training, what they enjoyed about their job, and areas for improvement.

STS presents itself in many ways. Specialists interviewed expressed a variety of STS indicators they have experienced as well as the positive and negative coping mechanisms they use in dealing with the stress. In interviews with current specialists, it is evident that additional training on STS for new child welfare staff, as well as seasoned staff, is somewhat lacking and should be addressed more aggressively. Many specialists indicated that they felt ill-prepared for the realities of the job when they left CORE training and were assigned a caseload. Many also stated however, that they had great mentoring support both from their Specialist III's and their supervisors. It is also evident, however, that many workers continue to struggle with anxiety,

depression and fear but feel unable to share these feelings due to the stigma associated with seeking professional help for mental health care. With each participant, the Employee Assistance Program (which provides each State employee with 6 free counseling visits per year) was discussed. Many participants felt it was unrealistic to be able to keep an appointment each week with a counselor due to their irregular schedules. One participant shared, "It is difficult for people to put themselves on their own calendar sometimes." Many expressed they felt guilty about leaving their office to seek mental health services because of time away from their caseloads. When asked if they would utilize a counselor if one were available on an as-needed basis or speak to someone who came to the office on a regular basis, all participants agreed this would be a valuable asset and one they would consider using. Another idea was to consider virtual visits for counseling similar to the virtual health visits now offered online by some health care companies. A counselor one could access at any time on an as-needed basis.

Several participants also suggested that "normalizing" mental health resources would increase the likelihood that someone would seek out these services as well. By normalizing the discussion, the topic of self-care and caring for one's mental health would be discussed more frequently. The result would be a reduction in the stigma and barriers associated with mental health care. Teaching positive coping mechanisms, partnering for safety, and continued mentoring are all practices that are currently in place, but these practices should be stressed more in the supervisory level of training. The data show that specialists feel more secure and have higher levels of confidence in their jobs with the support of their supervisors and the guidance of a good mentor.

Safety concerns were also an issue. Many of the specialists stated that generally, field visits were completed alone without a partner. Some also felt like they "had something to prove"

to show that they could do it alone or that they might be perceived as weak or unable to do their job if they asked a co-worker or supervisor to accompany them. The lack of staff and time for specialists to partner with someone was also a factor. Unless a perceived threat was obvious by reading case history or past experience with a family or neighborhood, specialists stated they usually made their visits alone. However, among the supervisors that reported; they were always willing to go with the specialist if they felt like they needed backup. The Pinnacle Plan does provide for partnering, although it does appear to be a part of the cultural practices in the two county offices from which participants were interviewed.

Currently, the data show that many specialists do not understand the difference between STS and burnout. Many felt they were not trained proactively to recognize the indicators or how to develop positive coping mechanisms to combat STS. Without this knowledge, they may practice unhealthy coping mechanisms and behaviors, suffering silently and needlessly when help is available.

Finding accessible mental health resources for specialists and supervisors is also a crucial component of this study. Normalizing discussions regarding the importance of mental health is an excellent place to start. Breaking down the stigma and barriers to accessing mental health services is crucial. The workers will not seek this support if they feel they will be stigmatized or singled out for not being incapable of the demands of their job. The interview data show that many of the workers have experienced situations where they did not feel they could share their concerns with a supervisor or were experiencing the indicators of STS such as depression, anxiety, and physical ailments. Having repeated conversations regarding STS at the beginning of the specialist's career might better prepare them for its effects when they begin to experience them later on. A proactive approach to this disorder is the best approach. Normalizing it and

continuing the conversation even with seasoned specialists were also suggestions expressed by the interview participants.

Learning to recognize when one might be predisposed to experiencing STS is also an important factor. In his book, *Treating Compassion Fatigue*, Figley (2002) suggests that workers should be trained to look for patterns of interaction within their own family of origin. This may be an indicator of how they will react in situations of traumatic stress. If they come from a family that was overly intrusive in nature, they will in turn react in similar ways to the traumatic stress of working with the abuse and neglected children. These indicators might include intrusive thoughts and nightmares. Conversely, if they grew up in a family that was completely disengaged, they may have the response of withdrawal or isolation from others as a response to this trauma.

Figley also suggests women are more likely to exhibit symptoms that are different from their male counterpart. Men should be sensitive to this in order to provide the requisite support of their colleagues. This is not to say that males do not experience the same symptoms as their female co-workers, but they generally have different ways of expressing or not expressing their stress indicators. The men in this study seemed to be handling the stress of their jobs effectively and both have found ways to cope with the stress. They have the added component of feeling more competitive and protective as well.

Specific training should be put into place showing employees how to react to and defuse the stress through positive coping strategies when faced with STS. It is suggested by Figley (2002) that the American Red Cross might be an excellent source of training as they train their personnel for disaster relief situations. Specialists would benefit from this type of training as well.

By continuing to examine the individual experiences of Child Welfare Specialists in Oklahoma, we may find new avenues for proactive training methods to recognize and educate employees about STS, not only for new staff but seasoned specialists and supervisors as well. Training to prevent and combat the indicators of STS as they begin to occur is essential to maintaining positive mental and physical health. Positive support and coping strategies are the key to combatting this type of stress.

As long as there are children experiencing child abuse and neglect, there will be specialists tasked with the responsibility of caring for them, removing them from harm's way, and advocating for their safety. These professionals deserve our support and attention to keep them healthy, both physically and emotionally, as they carry out this difficult and stressful work. They will continue to experience the indicators of STS, but perhaps with training and adequate support systems, this will help to ease some of that burden.

Limitations

There were several limitations to this research. First, this study focused on the lived experiences of specialists and supervisors who encounter every day, the stress of working with traumatized children and their families. Because of the time required for in-depth interviews and the transcription process, the size of the sample was limited to 10 participants. While the results of this research reflected genuine attitudes across this sample size, qualitative methods, by definition, are predicated on a non-probability sampling. Therefore, results for such research, regardless of size, cannot be generalized to larger populations. The recruitment of participants for this study was also limited to workers in a two county area and based on the use of a snowball sample. The sample was further limited by the willingness of participants to fully

disclose their experiences with anxiety, depression or other STS indicators due to the stigma surrounding mental health issues.

Future Research

With a deeper understanding of STS and its origins, a larger qualitative study further documenting the experiences of Oklahoma Child Welfare Specialists would yield even more data, providing a better understanding of STS for professionals in this career. The researcher would have preferred to interview more participants from a greater number of counties as well as being able to relieve some of the stigma of this disorder in order to obtain a deeper level of understanding. Future researchers should address this stigma early and thereby put the participants more at ease through the interview process. By addressing the stigma early with the assurance of confidentiality, specialists might feel more at ease divulging sensitive information. In this study, even with the assurance of confidentiality, there seemed to be an undercurrent of fear among many of the participants that their superiors would somehow discover their weaknesses; putting their employment at risk.

STS takes a toll on a person in many ways: physically, emotionally and psychologically. In what ways does this type of stress affect the personal lives of those who care too much? Does this affect the ways that they parent their own children? Do they find themselves distancing themselves from family members and friends or perhaps the opposite response, extreme enmeshment or being overly intrusive? These are questions that could be further explored through more research into this topic.

This is an area ripe for discussion and further exploration. It is a phenomenon which will continue to plague the front-line staff of the OKDHS Child Welfare Services as long as there are children being abused and neglected. Continued research into STS, its causes, and ways of

combatting and treating it are essential. If the turnover rates are to be decreased and the morale of the employees increased, change is necessary.

Conclusion

As the agency moves toward a focus on self-care and learning new ways to function with fewer resources, it appears that the upward trend of employee retention in this division will continue. The Department of Human Services has always been one to care for people, not only the citizens of Oklahoma, but its own staff as well. Some minor adjustments to training modules, focusing more on self-care and the mental health of specialists in Child Welfare Services, would promote reductions in turnover and increase employee morale. The continued implementation on extended mentoring, partnering for safety on a more regular basis, and properly equipping the workers in the field to provide an added layer of safety, are also suggested. The addition of mental health professionals (as provided for in the The Oklahoma Pinnacle Plan, Point 3, Initiative 15) to the support system for the specialists and supervisors will also strengthen the safety net necessary to care for those serving our most vulnerable citizens. Caring for the mental health and training needs of its front-line staff is of the utmost importance if the OKDHS is to continue its high quality of care for the neglected and abused children of Oklahoma.

References

The Basics of Philosophy. (2008). Retrieved from http://www.philosophybasics.com/branch_phenomenology.html

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

Bride, B., Robinson, M., Yegidis, B., & Figley, C. (2004). Development and validation of the Secondary Traumatic Stress Scale. *Research on Social Worker, Practice, 14*, 27-35.

The Child Abuse Prevention and Treatment Act. (2010). Retrieved from http://www.acf.hhs.gov/sites/default/files/cb/capta2010.pdf

Compassion Fatigue | The American Institute of Stress. (n.d.). Retrieved from http://www.stress.org/military/for-practitionersleaders/compassion-fatigue/

Conrad, D., & Kellar-Guenther, Y. (2006). Compassion fatigue, burnout, and compassion satisfaction among Colorado child protection workers. Child Abuse & Neglect, 30, 1071–1080.

Cornille, T., & Meyers, T. (1999). Secondary traumatic stress among child protective service workers: Prevalence, severity and predictive factors. *Traumatology*.

Cyphers, G. (2001). Report from the child welfare workforce survey: State and county data and findings. Washington, DC: American Public Human Services Association.

Derogatis, L. & Melisaratos, N. (1983). The Brief Symptom Inventory: An introductory report. Psychological Medicine, 13, 595-605.

Dorch, E., McCarthy, M., & Denofrio, D. (2008). Calculating child welfare separation, replacement, and training costs. *Social Work in Public Health*, 39-54.

Dutton, M.A., & Rubenstein, F.L. (1995) Working with people with PTSD: Research implications. In C.R. Figley (Ed.), Compassion Fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized (pp. 82-100. New York: Brunner-Routledge.

Ellett, A., Ellis, J., Westbrook, T., & Dews, D. (2006). A qualitative study of 369 child welfare professionals' perspectives about factors contributing to employee retention and turnover. *Children and Youth Services Review*, 264-281.

Figley, C. (1995). *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized* (pp. 1-20). New York, NY: Brunner/Mazel.

Figley, C. (1999). Compassion fatigue: Toward a new understanding of the costs of caring. In B.H. Stamm (Ed.), *Secondary traumatic stress: Self-care issues for clinicians, researchers, & educators* (2nd ed.) 3-28. Lutherville, MD: Sidran Press.

Figley, C. (Ed.). (2002). *Treating compassion fatigue*. New York, NY: Brunner-Routledge.

Figley, C. R. & Stamm, B. H. (1996). Psychometric review of Compassion Fatigue Self -Test. In B. H. Stamm (Ed.), *Measurement of stress, trauma, and adaptation* (pp. 127–130). Lutherville, MD: Sidran Press.

Gentry, E. (2013). *What is compassion fatigue?* Retrieved from http://www.compassionfatigue.org/pages/compassionfatigue.html

Graef, M. I., & Hill, E. L. (2000). Costing child protective services staff turnover. *Child Welfare*, 79(5), 517-33. Retrieved from https://vortex3.uco.edu/login?url=http://search.proquest.com.vortex3.uco.edu:2050/docview/213804612?accountid=14516

Gusich, G. (2012). A phenomenology of emotional trauma: Around and about the things themselves. *Human Studies, 35*(4), 505-518. Doi:10.1007/s10746-012-9247-8

Mastin, L. (2008). *Phenomenology – by branch / doctrine – the basics of philosophy*. Retrieved from http://www.philosophybasics.com/branch_phenomenology.html

Mitani, S., Fujita, M., Nakata, K., & Shirakawa, T. (2005). Impact of post-traumatic stress disorder and job-related stress on burnout: A study of fire service workers. *The Journal of Emergency Medicine*, p.7-11.

Morgan, A. L. (2011). *Investigating Our Experience in the World: A Primer on Qualitative Inquiry*. Knoxville, TN, USA: University of Tennessee Press. Retrieved from http://www.ebrary.com.vortex3.uco.edu:2050

National Child Traumatic Stress Network, Secondary Traumatic Stress Committee. (2011). Secondary traumatic stress: A fact sheet for child-serving professionals. Los Angeles, CA, and Durham, NC: National Center for Child Traumatic Stress.

Oklahoma Department of Human Services. (2012). *The Oklahoma Pinnacle Plan.* Retrieved from http://www.okdhs.org/okdhs%20pdf%20library/OklahomaPinnaclePlanFinal_cfsd_07252012.pdf

Oklahoma Department of Human Services. (2013). *Oklahoma Department of Human Services 2013 Annual Report.* Retrieved from http://www.okdhs.org/okdhs%20report%20library/S13102_StateofChangeAnnualReport2013_11012013.pdf

Oklahoma Department of Human Services. (2013). *A Day in the Life of a Child Welfare Specialist*. Retrieved from http://www.okdhs.org/OKDHS%20Publication%20Library/07-02.pdf

Oklahoma Department of Human Services. (2015). *Oklahoma Department of Human Services 2015 Annual Report*. Retrieved from http://www.okdhs.org/OKDHS%20Report%20Library/S15048_DHS2015AnnualReport_12112015.pdf

Palusci, V., Yager, S., & Covington, T. (2010). Effects of a citizens review panel in preventing child maltreatment fatalities. *Child Abuse & Neglect*, 34, 324-331.

Perosa, L., Hansen, J., & Perosa J. (1981). Development of the structural family interaction scale. *Family Therapy*, *8*(2), 77-90.

Phillips-Pula, L., Strunk, J., & Pickler, R. (2011). Understanding phenomenological approaches to data analysis. *Journal of Pediatric Health Care*, 67-71.

Pryce, J. G., Shackelford, K. K., & Pryce, D. H. (2007). *Secondary traumatic stress and the child welfare professional*. Chicago: Lyceum Books.

Schoenwald, C. (2015). *This foster child's wish list makes us realize how good we have it.* Retrieved from http://www.yourtango.com/2015279192/foster-child-wish-list-makes-us-realize-how-good-we-have-it

Secondary Traumatic Stress. (n.d.). Retrieved December 7, 2015, from http://www.nctsn.org/resources/topics/secondary-traumatic-stress

Ting, L., Jacobson, J., & Sanders, S. (2008). Available supports and coping behaviors of mental health social workers following fatal and nonfatal client suicidal behavior. *Social Work,* 11, 211-221.

University of Oklahoma Child Welfare Training Program. (2015). *HOT: Hands on Testing Worker Handbook*. Retrieved from http://www.ou.edu/cwtraining/assets/pdf/HOT%20Handbook/AUG15%20-%20FY%202016%20Worker's%20HOT%20Handbook.pdf

University of Oklahoma Child Welfare Training Program. (2015). *CORE training*. Retrieved from http://www.ou.edu/cwtraining/core.htm

U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2015). *Child Maltreatment 2013.* Retrieved from http://www.acf.hhs.gov/programs/cb/research-data-technology/statistics-research/child-maltreatment

Weiss, D. S., & Marmar, C. R. (1996). The Impact of Event Scale - Revised. In J. Wilson & T. M. Keane (Eds.), Assessing psychological trauma and PTSD (pp. 399-411). New York: Guilford.

Appendix A

Approved IRB Letter

UNIVERSITY OF Central Oklahoma

December 18, 2015

IRB Application #: 15205

Proposal Title: Child Protective Service Workers And Secondary Traumatic Stress: The Effects Of Empathetic Caring

Type of Review: Initial-Expedited

Investigator(s):

Ms. Jenny Milner
Dr. Brandon Burr
Department of Human Environmental Sciences
College of Education & Professional Studies
Campus Box 118
University of Central Oklahoma
Edmond, OK 73034

Dear Ms. Milner and Dr. Burr:

Re: Application for IRB Review of Research Involving Human Subjects

We have received your materials for your application. The UCO IRB has determined that the above named application is APPROVED BY EXPEDITED REVIEW. The Board has provided expedited review under 45 CFR 46.110, for research involving no more that minimal risk and research category 7.

Date of Approval: 12/18/2015
Date of Approval Expiration: 12/17/2016

If applicable, informed consent (and HIPAA authorization) must be obtained from subjects or their legally authorized representatives and documented prior to research involvement. A stamped, approved copy of the informed consent form will be sent to you via campus mail. The IRB-approved consent form and process must be used. While this project is approved for the period noted above, any modification to the procedures and/or consent form must be approved prior to incorporation into the study. A written request is needed to initiate the amendment process. You will be contacted in writing prior to the approval expiration to determine if a continuing review is needed, which must be obtained before the anniversary date. Notification of the completion of the project must be sent to the IRB office in writing and all records must be retained and available for audit for at least 3 years after the research has ended.

It is the responsibility of the investigators to promptly report to the IRB any serious or unexpected adverse events or unanticipated problems that may be a risk to the subjects.

On behalf of the UCO IRB, I wish you the best of luck with your research project. If our office can be of any further assistance, please do not hesitate to contact us.

Sincerely,

Robert D. Mather, Ph.D.
Chair, Institutional Review Board
NUC 341, Campus Box 132
University of Central Oklahoma
Edmond, OK 73034
405-974-5479
irb@uco.edu

Appendix B

Letter of Informed Consent

UNIVERSITY OF CENTRAL OKLAHOMA

INFORMED CONSENT FORM

Research Project Title: Child Protective Service Workers And Secondary Traumatic Stress: The Effects Of Empathetic Caring

Researcher: Jenny Milner

Purpose of this research: The purpose of this research is to learn more about the OKDHS Child Welfare Specialists and their experiences in the field which may cause them to experience the indicators of Secondary Traumatic Stress.

Procedures/treatments involved: To begin, you will be asked to complete a short demographics survey. Next, you will be asked a series of questions by the interviewer regarding your job as a Child Welfare Specialist with the OKDHS and questions related to your experiences in the field while working with abused and/or neglected children and their families. The interview will be recorded on an electronic recording device. Your initials _____ indicate your permission to audio record the interview. The audio recordings will be destroyed following transcription and no identifying information will be included in the transcription.

Expected length of participation: The interview will take approximately one hour. Potential benefits: You may gain a sense of satisfaction helping researchers gain more complete data on the topic, as well as experience enjoyment and fulfillment out of discussing ways/topics to improve your job experience as a Child Welfare Specialist.

Potential risks of discomforts: The risks of participating in this study are not predicted to be greater than those encountered in daily life. Yet, if you experience distress, sadness, or overall discomfort, please refer to the list of counseling services available to you as an Oklahoma State employee through the Oklahoma Employee Assistance Program.

Medical/mental health contact information: Information on the Oklahoma Employee Assistance Program is provided to you along with a copy of this consent form.

Contact information for UCO IRB: You may contact the Office of Research Compliance, Academic Affairs if you have questions about your rights as a participant (E-mail: irb@uco.edu; Phone: 405-974-5497).

Explanation of confidentiality and privacy: All the information collected will be kept strictly confidential. No names will be included or collected with surveys or included in the transcription of the interviews. Only study personnel will have access to the data. All project data will be stored in a locked filing cabinet in the principal investigator's home. Electronic data files will be stored on the principal investigators' home computer which is password protected.

AFFIRMATION BY RESEARCH SUBJECT

I hereby voluntarily agree to participate in the above listed research project and further understand the above listed explanations and descriptions of the research project. I also understand that there is no penalty for refusal to participate, and that I am free to withdraw my consent and participation in this project at any time without penalty. I acknowledge that I am at least 18 years old. I have read and fully understand this Informed Consent Form. I sign it freely and voluntarily. I acknowledge that a copy of this

A copy of the Informed Consent Form has been given to me to keep.

Research Subject's Name: _____

Signature: _____

Date: _____