

**The Other Side of Child Protection: The Lived  
Experiences of Front Line Child Protection Workers.**

by

Michael Gough  
Bachelor of Social Work  
University of Victoria, 1997

A Thesis Submitted in Partial Fulfillment of the Requirements for the Degree of

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in the School of Child and Youth Care

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## Supervisory Committee

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Dr. Sibylle Artz, School of Child and Youth Care, Supervisor

Dr. Roy V. Ferguson, School of Child and Youth Care, Departmental Member

Dr. Leslie T. Foster, School of Child and Youth Care, Departmental Member

## Abstract

### Supervisory Committee

Dr. Sibylle Artz, School of Child and Youth Care, Supervisor

Dr. Roy V. Ferguson, School of Child and Youth Care, Departmental Member

Dr. Leslie T. Foster, School of Child and Youth Care, Departmental Member

As a result of working in high-risk situations, child protection workers are often confronted by such traumatic incidents as the physical and sexual abuse of children, serious neglect situations, and personal threats. The perception of how workers deal with their emotional challenges has not received a great deal of attention in the literature. To date, a phenomenological study focusing on the descriptive experiences of child protection workers struggling with secondary traumatic stress has not been published. This study attempts to rectify this, by examining from a phenomenological perspective how secondary traumatic stress (STS) experienced by child protection workers impacts their practice and personal lives. This study found that child protection workers engaged in direct practice will be exposed directly and indirectly to traumatic events through their work with children and families and the risks of experiencing symptoms of STS are almost a certainty for a child protection worker. Participants described the day-to-day pressures of managing a caseload and dealing with traumatic events or traumatized people. From their responses, three major categories emerged: Professional Issues relating to case practice and effectiveness; the Personal Impacts of child protection work on the way workers function, both on the job and in their private lives; and Behavioral or Physical Changes experienced by child protection workers. It is these categories that best illustrate the dramatic way secondary trauma affects child protection workers as a whole.

**Keywords:** secondary traumatic stress, child protection workers, social workers, burnout.

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# Chapter One

## The Other Side of Child Protection: The Lived Experiences of Front Line Child Protection Workers

### Introduction

In general, society recognizes that those employed in child protection are working in a highly emotionally charged field. The perception of how workers deal with their emotional challenges has not received a great deal of attention in the literature. While researchers have investigated the ongoing organizational and workload strains placed on child protection staff, they have focused very little attention on the emotional stresses and demands experienced by individual practitioners.

There is considerable evidence that child protection workers experience pressures related to excessive workloads (Canadian Association of Social Workers, 2004). These workload manifestations include: unlimited and unwieldy caseloads, court appearances, overwhelming documentation requirements, poor working conditions, and low salary (Collings & Murray, 1996; Regehr, Leslie, Howe, & Chau, 2000).

Added to these challenges are the difficulties associated in working with involuntary clients and the responsibility of protecting society's most vulnerable citizens, based on incomplete information and inexact premises or procedures (Regehr et al., 2000). Child protection workers are called upon to balance the often-conflicting expectations of their clients, Ministry standards, organizational policies of their deputy minister, local managers, and team leaders.

In addition, child protection practice is fraught with broader social and political pressures. Expectations regarding the protection of children are often immense, while community resources are diminishing, placing more of the

burden of service on front line workers. Further, workers are often faced with the conflicting pressures of representing the best interests of the child, the parents, and imperfect public policy (Canadian Association of Social Workers, 2004). Moreover, child protection workers are charged with balancing society's wish to protect children from abuse while ensuring the family's freedom and rights (Regehr et al., 2000).

As a result of working in high-risk situations, child protection workers are often confronted by such traumatic incidents as the physical and sexual abuse of children, serious neglect situations, personal threats, and the potential injury or death of a child for whom the worker is "responsible."

There has been a growing recognition that exposure to tragic and traumatic incidents can themselves result in traumatic responses notably on the part of victims but also by emergency service workers (e.g., firefighters, police, and paramedics) responding to the event (Regehr et al., 2000). As a consequence of such exposure, these emergency personnel describe having ongoing symptoms such as recurrent dreams, feelings of detachment, guilt about surviving, anger and irritability, depression, memory or concentration impairment, sleep disturbances, alcohol and substance use, and the re-experiencing of symptoms when exposed to trauma stimuli (Regehr et al., 2000). Several authors have concluded that severe emotional reactions are normal responses to direct and secondary exposure to traumatic events in the line of duty (Canadian Association of Social Workers, 2004; Dane, 2000; Figley, 1995).

While these issues have garnered attention with respect to emergency services provided by police officers, firefighters, and paramedics, there has been relatively little attention focused on trauma responses in child protection workers. Indeed, workers in child protection services may be particularly vulnerable to workplace stress by virtue of their ongoing relationships with both the victims and perpetrators of traumatic incidents, and their capacity for empathic engagement (Figley, 1995; Horwitz, 2006). Also while individual child protection workers are affected by traumatic events, the impact of these events can spread beyond the

individual worker to all members of the team and other staff members connected through related capacities (Regehr, Leslie, Howe, & Chau, 2004).

Emphasizing the at-risk status of child protection practitioners, police, fire, and other emergency workers report that they are most vulnerable to traumatic impact when the incident involves children (Beaton & Murphy, 1995).

### **Personal View**

I believe there is a cost to caring. A professional who listens to his or her clients' stories of pain, suffering, and fear may feel similar pain, fear, and suffering. It has been my experience that female counsellors who work with domestic violence victims, for example, can begin feeling less secure or safe in the community because of their work, and report a distorted view in the "goodness" of males. Those who work with victims of other crimes may tend to feel more concerned about their own safety and sense of security. Clinical therapists may feel they are losing their own sense of self to the clients they serve. These costs are no less challenging for a child protection worker.

When working as an intake/investigations child protection worker with the Ministry of Children and Family Development, my role was one that dealt daily with a vast number of crisis situations including runaway teens, child sexual abuse investigations, physical abuse complaints, neglect concerns, and court and removal circumstances.

From my own experience, there are numerous feelings, in particular, anxiety, and conflicts that consistently interfere with effective case practice. Examples include: anxieties about dealing with difficult or angry clients; fear of difficult decisions of working without adequate support; feelings of incompetence; difficulties in separating my personal from professional responsibility; feelings of total responsibility for the families on my caseload; ambivalent or angry feelings towards clients and about my professional role; and the need to be in control.

But the greatest burden for me is one described to me by a co-worker, is "knowing that a child could be seriously hurt, neglected or even die if a worker

misjudges the risk to that child" (B. B, personal communication, December 12, 2009).

This constant assault on a child protection worker's sense of self, I believe, can be so overwhelming that, despite the workers' best efforts, they can exhibit some of the "cost of caring," that is, they can experience a change in their interaction with the world, themselves, and their family. Workers may also begin to have intrusive thoughts, nightmares, and generalized anxiety (Barford & Whelton, 2010).

Ever since starting as a child protection worker with the then Ministry for Children and Families, I have been aware that the constant stresses of working with dysfunctional, emotionally distraught, and traumatized children and families can lead to workers feeling vulnerable and experiencing burnout and risk of secondary trauma. For example, while I was a student, I found it very alienating to go from working the Friday shift, listening to a six-year-old girl telling me how Grandfather is touching her and how she wants Grandfather to stop (and that he lied because he didn't stop touching her when he said he was going to), to a classroom situation on Saturday, involving a discussion about the theory of child and family practice. For me, this was like walking from the night into the day. It was so different and it is hard to grasp the reality of the shift and get my head around it, and work effectively in both situations.

These transitions – going from witnessing and dealing first-hand with the constant crisis situations of child protection to the apparent normality of my personal life – prompted me to ask myself and my co-workers about how they deal with the first-hand and the cumulative effects of children's and families' traumatic stories.

I have therefore focused my study on how the constant stresses of listening to the traumatic stories of children and their families affects a protection worker's world view, social life, family interactions, and view of self.

## Chapter Two

### Literature Review

In this chapter I highlight the literature relevant to this study. I first provide an overview on social work and the child welfare system and seek to define child protection practice. I also define and provide conceptual clarification to the multiplicity of terms used to describe the “costs of caring.” Finally, I review the existing literature on the impacts of burnout, stress, and secondary trauma on child protection workers.

#### **Definition of Social Work and a Discussion**

The International Federation of Social Workers (IFSW) general meeting in Montréal, Canada, July 2000, adopted a definition of social work as a profession that “promotes social change, problem solving in human relationships and the empowerment and liberation of people to enhance well-being. Utilizing theories of human behavior and social systems, social work intervenes at the points where people interact with their environments. Principles of human rights and social justice are fundamental to social work” (International Federation of Social Workers, 2005, para. 1). J. Turner and F. Turner (1986) describe “Social Work” as follows:

the formal title for the profession whose aim is to enhance, restore, or modify the psychosocial functioning of individuals, groups, families, or communities. Social Workers frequently but not exclusively practice in the social services. The field utilizes the body of knowledge derived from the biological and social sciences and uses methods of individual, group, and community interventions to assist clients to make optimum use of their available resources.” (p. 5)

Johnson and Yanca (2000) describe social work as a professional and academic discipline committed to the pursuit of social welfare and social change. Social work as a field includes research and practice to improve the quality of life and the development of the potential of each individual, group and community of a society. Social workers perform interventions through direct practice in helping the individual, organizations, community organizing, research, policy, and teaching. Research is often focused on areas such as human development, social policy, public administration, program evaluation and international and community development (Johnson & Yanca, 2000).

### **Role of the Profession**

As a profession, social work is focused on problem solving and change. As such, social workers are change agents in society and in the lives of the individuals, families, and communities they serve (Mullaly, 1997). Mullaly also describes social work as an interrelated system of values, theory, and practice. Social work draws on theories of human development, behavior, and social systems to examine complex situations and to promote individual, organizational, social, and cultural changes.

Historically, social work grew out of humanitarian and democratic ideals, and its values are based on respect for the equality, worth, and dignity of all people. Since its beginnings over a century ago, social work practice has focused on meeting human needs and developing human potential. Human rights and social justice serve as the motivation and justification for social work action. In solidarity with those who are disadvantaged, the profession strives to alleviate poverty and to liberate vulnerable and oppressed people in order to promote social inclusion (Armitage, 2003; Johnson, 1989). Social work values are

embodied in the profession's national and international codes of ethics (International Federation of Social Workers, 2005).

In practice, social work addresses the barriers, inequities, and injustices that exist in society. It responds to crises and emergencies as well as to everyday personal and social problems. Social work utilizes a variety of skills, techniques, and activities consistent with its holistic focus on persons and their environments. Social work interventions range from the individual to family interventions to involvement in social policy, planning, and development. These include counselling, clinical social work, group work, social pedagogical work, and family treatment and therapy, as well as efforts to help people obtain services and resources in the community. Interventions also include agency administration, community organization, and engaging in social and political action to impact social policy and economic development. The holistic focus of social work is universal, but the priorities of social work practice will vary from country to country and from time to time depending on cultural, historical, and socio-economic conditions (Armitage, 2003; Turner & Turner, 1986; Johnson & Yanca, 2000).

### **The Child Welfare System**

“Child welfare” or “child protection” are terms used to describe a set of government and private services designed to protect the safety and well-being of children. The main aim of these services is to safeguard children from parental/caregiver abuse and neglect. Child welfare agencies will typically investigate allegations of abuse and neglect (this action is typically called “child protection services”), act as legal guardians for children in care, supervise foster homes, and arrange adoptions. They also offer services aimed to support families so that they can stay intact and raise children successfully (Armitage, 2003; Johnson & Yanca, 2000; Turner & Turner, 1986; British Columbia Ministry of Children and Family Development, 2010).

Canada's provinces and territories all have child welfare agencies that can be contacted by the public 24 hours a day. These agencies ensure the safety of children who, for a variety of reasons, may not be safe in their homes. These agencies, grouped together, cover the entire country and are collectively known as the Canadian child welfare system. Although circumstances do vary greatly, most families first become involved with the child welfare system due to a report of suspected child abuse or neglect.

In British Columbia, the Ministry of Children and Family Development (MCFD) oversees the delivery and quality of child protection services. The Child, Family and Community Services Act, 1996 (CFCSA) is the legislative authority for the Ministry of Children and Family Development's Child Protection Services. Under the Act, the Minister designates the Director of Child Protection, who in turn delegates the provision of child protection services across the province to child protection workers.

The CFCS Act requires that anyone who has reason to believe that a child may be abused, neglected, or is for any other reason in need of protection, must report it to the Director or a delegated social worker. These reports are investigated by child protection workers, who take the most appropriate action that is least disruptive for the child. These actions may include:

1. Providing or arranging the provision of support services to the family;
2. Supervising the child's care in the home; or
3. Protecting the child through removal from the family and placement with relatives, a foster family or specialized residential resources.

Child protection workers also have the delegated authority of the Director to approve foster homes for children who come into the care of the Ministry. Resources such as group homes, specialized residential facilities, assessment resources, and respite resources are developed to serve children and youth in care.

Child protection services across the province are provided through 429 Ministry offices in five regions and a number of delegated Aboriginal agencies. (British Columbia Ministry of Children and Family Development, 2010)

### **The Child Protection Worker: A Job Overview**

MCFD's job opportunity web site (<http://employment.gov.bc.ca/index.php>) details the responsibilities, qualifications, and knowledge required to work as a child protection worker with the Ministry. The child protection worker provides child protection services to children and families in a given community. According to the British Columbia Ministry of Children and Family Development (2010), this role involves the following "accountabilities" and job requirements:

#### **Accountabilities:**

1. Investigates complaints of child abuse and neglect by interviewing clients, observing and involving appropriate agencies in the investigation, evaluating risk indicators, validating the complaint, and determining a plan of action.
2. Develops and implements a child protection plan by identifying client needs, establishing long- and short-term goals, and developing a contract with clients and other resources.
3. Ensures the ongoing management of cases by monitoring progress towards goals, coordinating services, consulting with other service providers, examining the terms of the contract, and making referrals to other agencies.
4. Prepares documentation for court, files documents, and ensures legislative requirements are addressed and timelines for serving notice follow the Rules of the Court.

5. Prepares clients for court by explaining the purpose, ensuring client has access to legal counsel, informing the clients of other witnesses, and explaining expected court behavior and appearance.
6. Prepares and presents evidence for Family Court, determines admissible evidence, instructs legal counsel regarding the type of court order sought, prepares for hearing, negotiates times and witnesses for hearing, and presents testimony.
7. Acts as the legal guardian by providing statutory services to feed, clothe, and house the child; provides opportunity for the social, developmental, intellectual, and moral development of the child and identifies specific needs.
8. Develops Life Plans with the purpose of reuniting the child with the family, placing the child for adoption, or placing the child into a permanent family setting.
9. Provides services to the family such as assistance with parenting skills or preparing parents for adoption placement.
10. Authorizes expenditures for support services to families.

### **Job Requirements**

- Bachelor's of Social Work or Master's in Social Work, or Bachelor's of Arts in Child and Youth Care, or Master's in Educational Counselling/Master's in Clinical Psychology, or equivalent.
- Work experience through the completion of a practicum in family and child welfare.
- May be required to work evening/weekends.
- Exposure to regular travel in remote locations.

- May be required to use own vehicle on an expense account basis.
- Subject to satisfactory reference check and criminal records review and police record checks.

### **Overview of the Research**

Taking responsibility in ways that will have decisive consequences for children and families evokes anxiety and conflict within workers. It would be remarkable if this were not the case given the pressures, crises, and interventions that can fundamentally affect the lives of children and families. It is these anxieties and conflicts that cause workers to “protect” themselves so they can survive within the emotionally charged environment. Not all of a worker’s ways of “surviving” these situations are constructive and some coping strategies are unproductive and negatively affect good practice (Horwitz, 2006).

Various studies into this aspect of child protection work have shown that it can be more important for workers to protect themselves than to protect children (Dwyer, 2007). In an effort to protect oneself against trauma, the most effective strategy is to minimize one’s exposure. Horwitz (2006) found that child protection workers, in trying to reduce the number of negative workplace experiences to which they are exposed, report avoiding face-to-face client interactions. In this same vein, Regehr et al. (2004) found that workers who feel they do not have the resources or support to face adverse client situations report increased symptoms of depression, avoidance, traumatic stress, and burnout.

Similarly, Stanley, Manthorpe, and White (2007) found that there is the potential for child protection workers at all levels to experience work-related depression. Depression by its very nature tends to lead to the undermining of people’s abilities to assert their needs and ensures that these go unmet, so any organizational barriers and/or stigma related to depression can significantly impair a worker’s road to recovery and contribute to higher turnover rates, further undermining the profession.

Drake and Yadama (1996) found that child protection workers continually report more feelings of depersonalization, role ambiguity, chronic stress and conflict and that these negative working experiences leave child protection services in a continuing retention crisis – a finding confirmed by Hansung and Stoner (2008).

One can conclude from these studies that it can be painful to face the anxiety, the powerlessness, emptiness, grief, anger, and sadness that accompanies dealing with neglectful and abusive families. According to Figley (1995) all child protection workers are at risk of compassion fatigue both because of what they witness first-hand and from the cumulative effects of vicarious experiences of trauma. The low pay relative to responsibility, the long hours of potentially hazardous work, the inadequate services of community agencies, the threat of personal liability from each family on one's caseload, and the contradictions between supportive versus investigative roles, all add to a worker's overall job stresses. Bride (2007) concluded that front line child protection workers engaged in direct practice with clients are highly likely to be exposed to secondary traumatic events and because of these events many workers are likely to experience a number of secondary traumatic stress symptoms. Similarly, Conrad and Kellar-Guenther (2006) found that among Colorado County child protection staff approximately 50% suffered from high or very high levels of compassion fatigue.

A preliminary study by Regehr et al. (2000) found that staff of Ontario's Children's Aid Societies are feeling the burden of increased demands for accountability and documentation in case practice. These authors also found that workers are exposed to traumatic events routinely in their daily practice, frequently resulting in symptoms of secondary traumatic stress. Finally, Regehr and colleagues concluded that even if workers feel well supported in their personal and professional lives, when they encounter a traumatic event, they still experience high levels of traumatic stress.

Anderson's (2000) study of coping strategies and burnout among veteran child protection workers showed that nearly two-thirds of workers sampled scored in the high range for emotional exhaustion. In his study, Anderson set out to examine the relationship between veteran child protection workers' use of coping strategies and their levels of emotional exhaustion, depersonalization, and sense of reduced personal accomplishment. The study confirmed that neither the use of active nor avoidant coping strategies saved these workers from some form of emotional exhaustion. However, when workers indicated that they were using active coping strategies like focused problem solving and use of social supports, more often, they reported reduced feelings of depersonalization and an increased sense of personal accomplishment.

Many members of the public see child protection workers as "baby snatchers" and view them with suspicion and mistrust. Consequently, child protective action is frequently viewed as "too little too late" and simultaneously as "too intrusive." No matter what the approach taken, a worker will be in conflict with the expectations of some segment of the public or some community professionals, consequently "damned if they do or damned if they don't" (Carniol, 2005).

The public in general seems to have "zero tolerance" for negative outcomes once a client has become involved with child protection services. When unintended or inevitable adverse consequences do result, blame and a demand for more regulations, standards, and controls on practice usually follow. While in some instances changes in practice are required, the "zero tolerance" response leads to overregulation of practice. When this occurs, professional judgment is replaced by "bureaucratic" practice and an emphasis on checklists and procedures (Carniol, 2005). According to Hansung and Stoner (2008), the more bureaucratic the working environment the more narrowly defined workers become in their knowledge and how they approach their tasks. These highly bureaucratic work settings resulted in high levels of job stress and reduced levels of holistic thinking and approaches to one's work (Hansung & Stoner, 2008).

Critical events in child welfare practice can tax the coping skills of any child welfare worker. However, Regehr et al. (2004) found that the organizational environment was the strongest predictor in producing post-traumatic distress among child protection workers, as it was the one aspect that was out of the workers' control and was ongoing and chronic.

The work setting, particularly the organizational structure and management of the child welfare agency, also contributes to the workers' stress levels. For instance, upper management will widely concede that with the large caseloads and the corresponding administrative expectations, mandated deadlines for paper work and investigations easily consume the majority of workers' time (Regehr et al., 2004.)

Collings and Murray (1996) in their study of British child protection workers concluded that the most powerful predictor of overall stress was related to the pressure involved in planning and meeting administrative caseload expectations. Also, there is a current societal expectation that child protection workers should be able to assess risk and manage human behavior in such a way that clients are either "cured" or adequately "controlled" and when this is not the case, blame falls to the child protection workers (Collings & Murray, 1996).

Sandra Dwyer (2007) explored the emotional demands of child protection work, particularly how anxiety and fear play into a worker's practice when it comes to working in partnerships between child protection workers and other professionals. She found that collaboration and partnership in itself raised anxiety levels and fear in workers and that more needs to be done to support, acknowledge, and openly discuss these feelings.

The Child Welfare League of America (2008) reported that the kinds of chronic stressors described here contributed to an extraordinarily high staff turnover rate between January 1, 2002 and January 1, 2003, among child protection workers in United States private agencies. This turnover rate amounted to 45% for casework and case management positions, 57% for residential and youth care positions, and 44% for supervisors. Similarly, staff

turnover rates among child protection staff at the Children's Aid Society of Toronto more than doubled between 1997 and 1999 and Children's Aid Societies across Ontario have struggled to recruit and retain staff (Regehr et al., 2000).

Currently in British Columbia, numerous MCFD offices throughout the province, especially those in rural and remote areas are experiencing critical staffing shortages (BC Government Service Employees' Union, 2011).

Dan Perrin's background document (Perrin, 2006) for the Ted Hughes report (Hughes, 2006) found that the turnover rate among MCFD child protection workers was quite significant, with over 10% leaving front-line child protection practice in each of the four years from 2002 to 2006. Perrin also found that there was a shortfall between the number of actual child protection workers in the field and the number of needed workers.

For example in 2005/06 the actual Full Time Equivalents (FTEs) of child protection worker were about 11% or 100 FTEs below the funded number. To provide further context, over the period 2002/03 to 2004/05 the number of new child protection workers joining the Ministry averaged about 100 individuals per year. During this same period of time MCFD saw an average of 142 child protection worker's per year leave their child protection positions. So at this rate of attrition, the current intake levels of about 100 individuals will not adequately maintain required social worker FTE levels (Perrin, 2006).

This suggests that to bring the number of actual child protection worker FTEs up to the number needed to maintain the current turnover rate would require that recruitment of child protection workers increase substantially (Perrin, 2006). The alarming loss of staff in this demanding and highly specialized area of practice raises concerns about the supports for staff, the implications for service delivery and, ultimately, the safety and well-being of children.

In her inquiry into the role of child protection agencies in the retention of child protection caseworkers, Rycraft (1994) found that these agencies play a significant part. Through focused interviews with 23 caseworkers, Rycraft found four factors that are important to retention:

1. Mission, that is, a protection worker's sense of mission can be enhanced during a worker's time with the agency;
2. Goodness of fit, that is, the deployment of staff is within an employer's control and the right job assignment can ensure the ongoing health of a worker;
3. Supervision, that is, the provision of good supervision is in the agency's control and strong supervision has a significant role in improving morale; and
4. Investment in positive staff working conditions, manageable caseloads, decent compensation and benefits are an integral component of worker retention.

In their meta-analysis of 25 articles about the retention of protection workers that examined the relationship between demographic variables, personal perceptions, and organizational conditions on the one hand, and turnover and/or intention to leave on the other, Barak, Nissly, and Levin (2001) found that burnout, job dissatisfaction, availability of employment alternatives, low organizational and professional commitment, stress, and lack of social supports are the strongest predictors of turnover and/or intention to leave. However, given that the majority of these predictors were neither personal nor related to the balance of family and work, but are rather organizational or job related, these authors were optimistic that an agency, management, and policy-makers can do a lot to prevent high rates of turnover.

Similarly, Jenaro, Flores, and Benito (2007) in their study of Spanish human service practitioners who engaged in child protection work found that coping strategies alone do not preclude burnout but did help with staff turnover. High job and salary satisfaction along with active coping strategies played the most important role in promoting personal accomplishment thus reducing burnout and emotional exhaustion. Also, child protection workers who feel included in decision-making and experience supervisory and organizational support are more likely to engage as active employees and are less inclined to leave the agency (Travis & Barak, 2010).

The research surveyed here provides us with some interesting emerging data. First, child protection workers feel the burden of increased demands for

information, of excessive documentation, and of greater accountability in practice (Collings & Murray, 1996; Regehr et al., 2004). These kinds of work demands have resulted from amendments to child welfare legislation and policy (Canadian Association of Social Workers, 2004). For example, here in British Columbia MCFD has certainly been greatly impacted by the Gove Inquiry (Gove, 1995) and the Hughes Report (Hughes, 2006) and the resulting reorganizations. Especially notable was the spike in the number of children coming into Ministry care after the Gove Inquiry and resulting practice shifts for Ministry staff (BC Association of Social Workers, 2007). With the Hughes report in 2006, the MCFD has been in a state of transformation for five years, with minimal changes (BC Association of Social Workers, 2007).

Secondly, child protection workers are routinely exposed to traumatic events such as threats, assaults, violence against children, and client deaths, frequently resulting in symptoms of traumatic stress (Bride, 2007). Thirdly, workers continue to “survive” in this field and provide good casework.

Finally, even when workers have established strong supports in their personal lives and feel well supported by their organization, they continue to experience high levels of traumatic stress when they encounter a traumatic event (Anderson, 2000; Collings & Murray, 1996; Regehr et al., 2000).

### **Review of Terms**

An overview of the literature suggests that a variety of terms and factors are used in a number of studies to describe the various impacts on child protection workers. Predominately, the research focuses on two streams: (a) burnout or the external pressures facing workers, and (b) the internal struggles impacting on a worker’s ability to cope (Canadian Association of Social Workers, 2004; Horwitz, 2006; Regehr et al., 2000).

For conceptual clarity I will provide general definitions of the more popular terms in the literature.

## **Definitions of Terms**

**Burnout.** This term frequently appears in the literature about workplace conditions within the social services sector (Canadian Association of Social Workers, 2004). Burnout is commonly viewed by many as simply job stress faced by workers. Pines and Aronson (1988) define burnout as “a state of physical, emotional and mental exhaustion caused by long term involvement in emotionally demanding situations” (p. 9). Common warning signs include experiencing more illnesses and headaches, having less energy, feeling depressed or more irritable, and feeling detached from clients.

The literature on burnout identifies common symptoms experienced by workers working with difficult clients. These symptoms include diminished self-concept, irritability, loss of compassion, and feelings of discouragement. Physical symptoms such as recurring headaches, colds, and other stress-related illnesses can be experienced with severe burnout (Anderson, 2000). Anderson also found that nearly two-thirds of child protection workers are suffering from emotional exhaustion, the essence of burnout.

**Job dissatisfaction.** This is another area of study that is often reviewed in the literature pertaining to child protection workers. Job dissatisfaction is reported as a major factor leading to burnout (Hansung & Stoner, 2008; Winefield & Barlow, 1995). It is noteworthy that the research indicates that the factors related to job dissatisfaction appear to reflect the working conditions described by the child protection workers, indicating that job satisfaction is due to the working conditions themselves (Acker, 1999; Canadian Association of Social Workers, 2004).

**Counter transference.** Although there seemed to be a paucity of research on child protection workers, a review of the literature on counsellors who work with other traumatized client groups revealed a considerable body of research. Three main conceptual frameworks have been employed in this area: counter

transference, vicarious traumatization, and secondary trauma (Figley, 1995; McCann & Pearlman, 1990).

Counter transference is one that is connected with psychodynamic therapy. Counter transference can be described simply as a therapist's conscious and unconscious response to a patient's trauma, especially if the trauma is connected with the therapist's past experiences (Freud, 1959). More recently, Corey (1991) defined counter transference as the process of seeing oneself in the client, over-identifying with the client, and/or of meeting needs through the client.

**Vicarious Traumatization (VT).** Given the nature of child protection, working with children and families who often are experiencing or have gone through traumatic events, workers are themselves at risk of experiencing vicarious traumatization in relation to their work (Canadian Association of Social Workers, 2004; Carniol, 2005).

McCann and Pearlman (1990) first proposed this concept of VT to describe the disruption in a therapist's internal experiences and perspective of their world as a result of repeatedly hearing the "traumatic material" or stories of clients (McCann & Pearlman, 1990; Raingruber & Kent, 2003; Stanley et al., 2007).

McCann and Pearlman (1990) also argued that VT is an unavoidable result of trauma practice. They found that counsellors who had significant caseloads of trauma work experienced VT or similar symptoms to his or her traumatized clients such as nightmares, fearful thoughts, and intrusive images. Counsellors who had smaller numbers of traumatized clients were found to have fewer VT symptoms. The researchers concluded that although health professionals have the qualifications and training for trauma practice, they are not immune to the effects of hearing about people's traumatic experiences. VT included short-term symptoms of post-traumatic stress disorder, as well as some

permanent changes to counsellors' beliefs, assumptions, and expectations about themselves and others (McCann & Pearlman, 1990).

McCann and Pearlman (1990) also explored the impact of vicarious trauma on a counsellor's memory system. Changes occurred when the counsellor experienced a client's traumatic imagery in the form of flashbacks, dreams, or intrusive thoughts, or when the counsellor suppressed various components of a client's traumatic memories. Although these experiences are mostly temporary, there is a danger they can become permanent. Permanent changes were more likely to occur when counsellors heard material that was relevant to their own individual psychological needs and when counsellors did not have the opportunity to debrief or talk about their own experience of vicarious trauma (McCann & Pearlman, 1990).

Researchers such as McCann and Pearlman (1990) argue that just as trauma symptoms are a normal response to being victimized, vicarious trauma may well be a normal response to trauma practice. The symptoms experienced in vicarious traumatization – anxiety, headaches, nausea, sleeplessness, and distressing imagery – are similar in nature to post-traumatic stress disorder (Adams, Matto, & Harrington, 2001). Similar to burnout, VT is viewed as the interaction of a worker's personal history and relations with the individual characteristics, life circumstances, and trauma experiences that his or her clients present (Cunningham, 2003).

However, vicarious traumatization is seen as being quite distinct and separate from burnout, as shown by various studies in which clinicians working with victims of sexual assault scored low on burnout measures yet showed high numbers of VT symptoms (Cunningham, 2003). Burnout is described as a combination of emotional exhaustion, feelings of depersonalization toward clients, and having a sense of low personal accomplishment in one's work. Burnout is related to the job site, whereas vicarious traumatization focuses on the intrapsychic and interpersonal factors related to the individual experiencing stress.

Cunningham (2003) suggests that the difference between VT and burnout is that VT is the direct result of counsellors hearing emotionally charged, emotionally shocking material from their clients, whereas burnout can result from working with any difficult client group.

**Secondary Traumatic Stress (STS).** Charles Figley (1995) has coined the term “secondary victimization” to describe the damaging effects on family members exposed to a traumatized member. He discusses secondary traumatic stress in terms of “compassion stress” and “compassion fatigue.” All these terms are part of the same phenomena associated with those who work with traumatized clients. The numerous terms describe aspects of and similar features to STS.

Secondary traumatic stress has been defined as the natural consequence of emotions and behaviors that result from knowing about traumatic experiences or events of another person or "the stress resulting from helping or wanting to help a traumatized or suffering person." (Figley, 1995, p. 7)

The symptoms of STS are nearly identical to post-traumatic stress disorder (PTSD). The primary difference is that the exposure to the knowledge about the traumatic event(s) is associated with the set of STS symptoms, and PTSD symptoms are connected to the person directly exposed to the traumatic event (American Psychiatric Association, 1994). (See Appendix A for distinctions between STS and PTSD).

However it is STS that offers a framework of common symptoms that can greatly increase the awareness and provide a basis for research into this phenomenon. Personally, I noticed that the only term that seems to garner any significant attention from management is VT, which again is linked to a more clinical setting than that of child protection. Burnout seems to be ignored (i.e., “Why are staff complaining? Caseloads have gone down since I started.”). I believe that by using STS and labeling experiences for what they are, work-related PTSD child protection workers might be able to argue just how serious an issue this is. If STS continues to be ignored, and no attempts are made to

address the root causes and resulting symptomatic experiences, MCFD and child protection agencies as a whole will always experience unmanageable turnover rates, while continuing to blame burnout and misunderstand the reason for the high rates of turnover.

### **What Is Secondary Traumatic Stress**

Figley (1995) defines secondary traumatic stress as a disorder and its definition is found within the description of PTSD in the DSM-IV (American Psychiatric Association, 1994). Figley highlights portions of the PTSD description to show how an individual may become traumatized without actually being physically harmed or even threatened with harm. Criterion A1, in the DSM-IV specifies that the essential feature of the disorder is the development of characteristic symptoms following:

exposure to or witnessing of an event that involves death, injury, or a threat to the physical integrity of self or others; or learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associates (American Psychiatric Association, 1994, p. 209).

According to Figley (1995), the fundamental difference between the two disorders seems to be the position of the stressor: In Post-Traumatic Stress Disorder, the stressor may directly harm or threaten people (primary stressor), and in Secondary Traumatic Stress Disorder, the stressor is the traumatized individual who has been exposed to harm (secondary traumatic stressor). Just as post-traumatic stress is a natural consequence to a distressing event, secondary traumatic stress can be viewed as a natural consequence resulting from knowing about or witnessing a traumatizing event that has been experienced by a significant other. The significant other in the case of the child protection worker is the client.

Although there is mention of a secondary traumatic stress reaction in the DSM-IV (American Psychiatric Association, 1994), no elaboration is given to the implications. It is interesting to note that there is very little literature on the topic.

Figley (1995) has suggested that the incidence of PTSD may be “grossly underestimated” because these figures do not take into account those who emotionally support trauma victims. He states, “It is time to consider the least studied and least understood aspect of traumatic stress: secondary traumatic stress” (p. 7).

### **Research on Secondary Trauma**

Although there is a comprehensive body of literature on the effects of traumatic experiences on individuals and groups, little attention has been given to child protection workers who deal with traumatic events daily in their practice. The majority of research on secondary trauma was developed from the emergency services literature in the 1970s. Post-traumatic stress disorder (PTSD) symptoms were noticed in rescue workers attending to victims of trauma, and group debriefings were implemented as the primary prevention strategy (Beaton & Murphy, 1995). Emergency services personnel were identified as “hidden victims” by Shepherd and Hodgkinson's (1990) research, but child protection workers, who provide protective services for abused and neglected children, may also be hidden victims (Regehr et al., 2004).

Avary and Uhlemann (1996) defined primary victims of trauma as those individuals who have directly experienced the trauma and secondary victims as those who in some way support the primary victim. In this context, child protection workers can be referred to as secondary victims, and the term secondary trauma has been used to describe the process of a counsellor experiencing similar trauma symptoms to the primary victim (McCann & Pearlman, 1990).

According to Figley (1995), secondary traumatization also results from knowledge of a traumatizing event experienced by a significant other; the stress results from helping or wanting to help a traumatized person:

Secondary Traumatic Stress Disorder (STSD) is a syndrome of symptoms nearly identical to PTSD (APA, DSM-IV, 1994), except that exposure to knowledge about a traumatizing event experienced by a significant other is associated with the set of STSD symptoms, and PTSD symptoms directly connected to the sufferer, the person experiencing primary traumatic stress. (p. 8)

The difference between secondary traumatization and vicarious traumatization is that the former is classified under the diagnostic criteria in the DSM-IV and the latter is a construct based on McCann and Pearlman's (1990) constructivist self-development theory.

In order to counter the impact of STS, it is crucial to understand the toll it takes on the workers from their own perspective. I feel that much can be learned from examining the point of view of those whose lives have been adversely affected by their work with abused and/or neglected children.

A review of the child welfare literature reveals a clear gap in qualitative understandings of secondary traumatic stress. To date, a phenomenological study focusing on the descriptive experiences of child protection workers struggling with secondary traumatic stress has not been published. It is my belief that a phenomenological research study of STS experienced by child protection workers will add to the understanding of secondary trauma research. It would stand to reason that in gaining an understanding of the child protection workers' experiences we will begin to learn more about how workers maintain effective case practice.

My belief is that child protection workers are struggling with repeatedly painful and even horrific experiences that are disruptive to their everyday ideas of how the world should be. I anticipate that child protection workers grapple with the difficult task of integrating these disruptions into previously held core beliefs (i.e., good vs. evil; hope vs. despair; safety vs. vulnerability; anger vs. compassion) and also struggle with the physical, psychological, and social

effects associated with stress and trauma. Given my own experiences as a children protection worker dealing with the emotions, the anxiety, the frustrations, the anger, the hurt and powerlessness of day-to-day case practice, I believe there is an ethical and moral reason for chronicling the costs of caring.

The ethical imperative pertains to an obligation that child protection workers have to provide appropriate and effective care to some of society's most vulnerable people. If child protection workers as professionals do not recognize the emotional and personal impact on their work, they run the risk of failing to recognize the effects of secondary trauma and thereby jeopardizing the care they provide (Horwitz, 2006). The moral necessity lies in the obligation to provide vital, effective, and excellent service to society's most vulnerable.

## Chapter Three

### Research Approach and Methodology

#### **Research question**

How does the emotional impact of working with child abuse and neglect cases affect the child protection worker? Specifically, how is this secondary trauma incorporated into shifting core beliefs and the ways in which workers reconstitute their lives in order to be psychologically and physically healthy?

#### **Purpose**

My interest in studying the impact of working in child protection on those practitioners in the field comes from my own background as a child protection worker. This study has been designed to focus on individual experiences of secondary trauma through the real life experiences that child protection workers construct as they make meaning of their struggles with this phenomenon.

In my view, this inquiry is an attempt at intervention. It is an attempt to intercede with child protection workers to examine how they perceive their work. It is an attempt to alter the status quo and change the way MCFD “cares” for its employees. It is an attempt to contribute to a rewriting of our understanding of the health of child protection workers. Child protection work, like other helping professions, is interested in trying to understand the clients’ points of view and their experiences in order to provide the best intervention. Just as understanding the experiences of clients facilitates a greater understanding of the effectiveness of an intervention, it would stand to reason that gaining an understanding of the experiences of child protection workers will permit a deeper knowledge of how workers best maintain effective case practice.

## **Objectives**

Through a descriptive interview process, this researcher developed a collaborative research relationship with the participants for the purpose of understanding the multiple experiences of child protection workers struggling with secondary trauma. Given how little is known about secondary trauma experienced by child protection workers and given that such an experience is a personal one requiring personal interpretation, a qualitative approach seems best suited to building an initial understanding of the experience.

Because there is so little research with this participant group, an exploratory study using qualitative methodology based on phenomenological philosophy seems appropriate. Specifically, the objectives were as follows: (a) to explore the child protection workers' perceptions of their sense of self, their world view, and any behavioral, cognitive, physical, and emotional experiences that they may attribute to their child protection work; (b) to clarify the impact of child abuse and neglect on the child protection workers' psychological needs such as intimacy, esteem, trust, and safety; (c) to describe issues of particular concern to child protection workers; and (d) to identify the coping resources and strategies child protection workers use to either prevent or manage any adverse effects of child protection work.

## **Methodology**

There are many approaches within the qualitative tradition. Choosing among them depends upon the nature and purposes of your research. To speak of a methodology is to refer to the philosophical framework and basic assumptions that underlie that particular tradition. It "includes the general orientation to life, the view of knowledge, and sense of what it means to be human" (Van Manen, 1990, p. 25).

Phenomenology allows us to look at "how phenomena present themselves in lived experience" (Van Manen, 1990, p. 184) and is concerned with that lived experience which one experiences for oneself (Garfat, 1998). An objective of this

study is to explore the child protection workers' perceptions of their sense of self, their worldview, and any behavioral, cognitive, physical, and emotional experiences that they may attribute to their child protection work.

It was in reading Van Manen's (1990) *Researching Lived Experience: Human Science for an Action Sensitive Pedagogy*, that I realized that there was a research methodology that fit my own values, by emphasizing "one's lived experiences" and "making means of." I saw a methodology that was right for the questions I was wrestling with. In conducting a phenomenological study, I hope to gain insight into how child abuse and neglect impacts on the lives of child protection workers. In using this paradigm I am trying to understand the phenomenon of secondary trauma from my own lived experience as well as from the experiences of my research participants.

I chose a phenomenological research design for several reasons. First, as mentioned above, with its emphasis on "lived experiences" it allows me to study secondary trauma and its impacts on child protection workers.

Second, the interview process used for a phenomenological design is wide-ranging and capable of describing many aspects of the experience (Van Manen, 1990). Child protection workers are familiar with the process of investigating meaning through client interviews and the processes of assessing individual and family experiences. Child protection workers become involved in the lives of their clients and engaging in a relationship is seen as a core value of practice. Child protection workers investigate experiences of trauma in order to gain a greater understanding into the nature of the work and it would seem logical that one might need to investigate the experiences of the work on the worker. Again, phenomenological research design seems the most appropriate methodological orientation to accomplish this investigation.

Third, writing is the way that phenomenology is practiced. Child protection practice constantly involves the process of relating the workers' experiences of their clients, either verbally through conversations with the family, case consultation, and court testimony, or through writing case notes and file reviews.

Due to the nature of child protection, the workers with their file recordings need to remain as attentive as possible to the ways they record their experiences with their clients and need to be open and objective in their explanations of those experiences.

Phenomenological writing is the act of making contact with the things in our world (Van Manen, 1990). Phenomenological inquiry writing is also based on the notion that no text is ever perfect, no interpretation ever complete, no explication of meaning ever final, no insight is beyond challenge. It demands that researchers remain as attentive as possible to the ways they experience the world and the infinite variety of possible human experiences and possible explications of those experiences (Creswell, 1998). Because child protection work is relationship-based, phenomenological inquiry writing seems most appropriate for this study.

Finally, the procedures of phenomenological research are relatively straightforward and will allow the researcher to focus upon a critical reflection of this phenomenon, the impact of secondary trauma on the lives of child protection workers.

### **Selecting Participants**

Although I ultimately employed a phenomenological based approach to conduct my interviews and my analysis, in order to find my participants I used Charles Figley's (1995) "Compassion Fatigue Self-test" as the screening tool to choose my four participants. This is a 40-item questionnaire in which participants rate themselves on a scale of one to five (see Appendix B for Compassion Fatigue Self-test). This one to five rating scale determines how often a participant is experiencing various symptoms of fatigue and stressors, such as feeling hopelessness, in dealing with a client.

This instrument has two subscales, one that measures compassion fatigue and the other burnout. Twenty-three questions measure compassion fatigue. Compassion fatigue is defined as the symptoms of work-related PTSD.

Sample questions include, “I feel estranged from others” and “I have difficulty falling or staying asleep.” Seventeen questions measure burnout. Burnout is defined as “feeling hopeless and unwilling to deal with work.” Sample questions include, “I find it difficult separating my personal life from my work life” and “I have concluded that I work too hard for my own good.”

Respondents were placed into categories of extremely low risk (sum score of 0-26), low risk (27-30), medium risk (31-35), high risk (36-40), and extremely high risk (41-115) of compassion fatigue. For burnout, respondents were placed into categories of extremely low risk (sum score of 0-36), moderate risk (37-50), high risk (51-75) and extremely high risk (76-85).

Of the 25 experienced (2+ years) child protection workers who completed the initial screening tool, 20% were male and 80% were female. All are working in child protection offices providing direct client service dealing exclusively with child protection caseloads. On average, participants had been working with the MCFD for 7.88 years. The years of experience with MCFD ranged from a low of 2 years to a high of 25 years.

By using the “self-test” this researcher hoped to gain a preliminary understanding of the levels of stress and trauma child protection workers are experiencing. After the tests were scored, I then asked each supervisor of the various local offices to identify those child protection workers using effective coping resources and strategies to either prevent or manage any adverse effects of secondary trauma in their day-to-day case practice. Based on the Compassion Fatigue Self-test and the supervisors’ recommendations, I then selected the four participants who are coping despite experiencing compassion fatigue.

It was my hope that combining the “self-test” with the supervisor identification of those workers best coping with stress in their daily practice would clarify why some workers struggle with the effects of secondary trauma and how some workers cope. The primary method of investigation for this study was one long interview with each of the four participants. This allowed the researcher to gain a comprehensive description of each participant’s experiences of the

phenomenon. The qualitative data included; detailed description, direct quotes, any correspondence, and my personal notes. The interviews consisted of open-ended, unstructured, and semi-structured questions. I prepared a list of question that guided me through each of the interviews. This list of specific questions was to ensure that certain topics were being covered. Given the nature of the research question, I asked several big open-ended questions such as “do you experience difficult cases on a daily basis?” and “ how would you describe these difficult cases?”. I then asked a number of probing questions based on the participants’ responses. All the interviews were audio taped and then transcribed for thematic analysis.

### **Participant Recruitment**

As a practicing child protection worker with the MCFD, I began this study by approaching the local area manager with my research proposal. He agreed to bring my study request forward to the regional manager’s table. It was at this table that my proposal was accepted and I was given the permission by the management team to recruit participants for my research project from the various child protection offices in the Vancouver Island region. I then followed up with each community services manger on Vancouver Island asking permission to connect with each of the region’s team leaders and offices to begin my research. Supervisors of each interested office were given and asked to sign the supervisor consent form (See Appendix C for supervisor consent form)

With permission given, the researcher arranged with each of the team leaders from the various offices to present the research topic to his/her respective teams either at a regular team meeting or a meeting specifically set up for this purpose of presentation. At these initial meetings participants were informed about the overall purpose of the investigation and the main features of the design, as well as to any possible risks and benefits from participation in the research project. I then invited all child protection workers in each of the selected area offices to an orientation meeting to provide a detailed description of the

study, the methodology, the goals, and objectives. Also outlined, were the procedures to ensure the protection of participants from risk. These procedures involved (a) selecting participants equitably, (b) obtaining informed consent, (c) maintaining privacy and confidentiality, (d) assessing the risk-benefit, (e) assuring the right to withdraw from the study at anytime, and (f) offering the opportunity to access their Employee Assistance Program (EAP) if required.

This second meeting in all cases followed each of the team's staff meetings or the specific orientation meeting. At the end on this second meeting, all workers within the selected office were provided with a copy of the "self-test" and the consent form. This was to help provide some additional level of anonymity. Those individuals interested in participating in the study were asked to fill out the "self-test," sign the consent form (See Appendix D for participant consent form) and then place both the self-test and consent forms in a self-addressed envelope provided for return to the researcher. The envelopes provided were marked private and confidential and had no return address on them. All workers who chose to participate were selected.

All participants were asked their willingness to be among the four selected for in-depth interviews and all participants were told that they were to be rated by their supervisors. After the tests were scored, I then asked the supervisors of the various local offices to identify those child protection workers who were using effective coping resources and strategies to either prevent or manage any adverse effects of secondary trauma in their day-to-day case practice. Based on the Compassion Fatigue Self-test and the supervisors' recommendations, I then selected four workers who were experiencing compassion fatigue, yet were coping with it.

## **Participants**

The participants of this research study were child protection workers currently working with the Ministry for Children and Family Development (MCFD) and practicing in the field of child protection. All MCFD child protection workers

within each of the selected cities were asked to participate in the study and were invited to take part in the screening process. Ninety-four of the Compassion Fatigue Self-tests were disturbed.

A total of Twenty five (25) workers from the fourteen (14) MCFD Child Protection offices completed and returned the “Compassion Fatigue Self-test.” From this larger screening group I then selected four of these front-line child protection workers with three or more years of experience for in-depth interviews. The four subjects were chosen purposefully, without regard to gender or age, for their capacity to inform me about the emotional impact they have experienced. I specifically looked for child protection workers who are experiencing compassion fatigue and yet are coping with the daily demands of the job.

### **Ethical Considerations**

In preparing this research design, several ethical issues arose. First of all, what is the purpose of the research project? According to Kvale (1996) “an interview study should, beyond the scientific value of the knowledge sought, also be considered with regard to improvement of the human situation investigated” (p. 111). One of the goals of this project is just this, to improve child protection workers’ working conditions. The study hopes to do this by providing insight into the toll that secondary traumatic stress has on workers, based on their own perspective of the issue.

I believe that much can be learned from a worker’s point of view. It is this understanding that I hope will translate into action on the part of the MCFD in order to support front line staff. For if the emotional and personal impact of child protection work is not recognized, its effects on case work and the level of care workers provide to clients will remain ignored. I also believe that without some sort of action the alarming loss of staff in this demanding and highly specialized area of practice will continue, thus raising concerns about the implications for service delivery and, ultimately, the safety and well-being of children.

Secondly, this study followed the legal requirements for protecting human subjects. I followed the five procedures to ensure the protection of participants from risk outlined in the section on Participant Recruitment. Individual participants were informed about the overall purpose of the investigation and the main features of the design, as well as any possible risks and benefits from participation in the research project. A participant's informed consent involves obtaining their voluntary participation and giving them the right to withdraw from the study at any point while taking their data with them, thus avoiding the potential of undue influence and coercion.

Given the research subject, ethical issues may arise with regard to participants disclosing information, possibly rendering them vulnerable with respect to how their supervisors and/or managers might view this information. For example, talking about how their work may negatively affect them may cast employees in an unflattering light with their employer. So anonymity became extremely important. While all possible safeguards were used to assure participants' anonymity, the methodology of the study prevented complete anonymity during the initial phase of the research as consent and the "self-test" were distributed in a group setting. By participating in this group process, the researcher cannot guarantee complete anonymity.

The self-test is a measure designed to look at whether child protection workers are experiencing the effects of compassion fatigue or secondary trauma. In an effort to understand which workers are best coping with the stresses of the workplace, the researcher asked each team's supervisor to rate how individual workers cope with their day-to-day practice. While supervisors were asked to rate their workers, they were not provided access to the self-test scores or the names of workers participating. Supervisors were asked to score all workers, whether in the screen-in group or not, thus helping to provide some anonymity.

With the small number of interviewees ( $n = 4$ ), anonymity was maintained by selecting participants from a number of different locations, attaching no identities to the data, and by mixing of identities.

During the interview situation, the confidentiality of participants was accomplished by changing their names and any identifying features. Participants were told at the outset of the study who would have access to the data, that only the researcher would know the identity of participants.

Given the sensitive nature of the topic – a worker’s experience of trauma – the researcher needed to pay particular attention to ensuring that each participant was fully supported and felt comfortable throughout the interview process. I also needed to ensure that no unnecessary harm came to the research participants. Sufficient debriefing time was made available to participants after each interview and follow-up communication with participants occurred to permit additional debriefing. Also available to each participant were counselling sessions through the Ministry’s Employee Assistance Program (EAP). Each research participant was provided with the EAP brochure and this researcher provided details of the program.

### **The Interview Context and Data Analysis**

As the researcher was a child protection worker currently practicing, the relationship between this researcher and the participants was, I believe, one of a professional collegiality, mutual respect, and shared understanding for the phenomena under study.

The interviews for this inquiry were conducted in a place and at a time chosen in agreement between the researcher and each child protection worker participant. The locations were chosen for convenience of access and comfort. The participants were asked to schedule 2.5 hours for the interview. The interview recording equipment was placed in the open and left in continuous view. Participants were told that these recordings were to be transcribed and copies returned to each participant as part of the process of the study. The relationship of control and power was taken into account, especially since this inquiry hopes to achieve a free flow of dialogue between the interviewer and interviewee. While no formal relationship existed between the researcher and the

participants, attention was paid to giving as much power as possible to participants. All participation was voluntary. Participants were given the right to stop the interview process at any time. Interviewees were also assured that they could withdraw from the inquiry at any time without repercussions of any kind.

Although these steps may not eliminate the vestiges of a power relationship, they were intentional steps designed to ensure that the interviewees felt as empowered as possible throughout the process of the study. The researcher viewed the interview as a dialogue in which both interviewer and interviewee jointly construct the content. This dialogue allowed the study participants to give meaning to, and express their understanding of themselves, their experiences, and their world. The researcher felt this approach gave the participants as much responsibility as the interviewer in directing the flow of the conversation (Garfat, 1998).

I interviewed four child protection workers. The in-depth and lengthy interviews provided an extensive and valuable store of data. After each interview I walked away with a new and richer understanding, experience, and feeling in relation to my research topic. In each interview, the respective participant provided new connections and discoveries; their spontaneous interpretations and descriptions allowed me begin to see emerging patterns and themes prior to reading the transcribed interviews themselves.

Each of the participants' audio taped interviews was transcribed verbatim. Care was given to listening to the various aspects of each participant's speech, such as laughter, pauses, silences, hedging, crying, tone of voice. Any inaudible speech was also noted.

After the transcription stage this researcher provided a copy of each participant's transcribed text. Each participant was then asked to review his or her own text for content, to ensure authenticity and to respond to the research question. Participants were also provided with general instructions to make changes if they felt the text needed to be clearer or expanded upon. Participants were also asked to make sense of their experiences, to expand upon what was

implied or not said, to interpret contradictions, and to explain any use of metaphors. The researcher discussed any changes and edits to the text with each individual participant.

Once the resulting transcripts were returned to the researcher, each participant text or “lived story” was examined using a phenomenological philosophy approach and a thematic analysis method. I used a multi-stage process to find patterns and themes in the participants’ interviews (Kirby & McKenna, 1989; Kvale, 1996).

I first began by reading the individual transcripts several times in an attempt to immerse myself in the details and descriptions of the interview while trying get an overall sense of the interview as a whole. I then started with a preliminary review of the data. This process involved a cursory look at each participant’s interview noting in the margins and throughout the text of the transcripts any emerging and possible themes and patterns at both an individual participant and group level. I then reviewed the participant’s responses to each question individually and collectively looking for any overall common patterns and themes.

Kirby and McKenna’s (1989) data analysis method involves breaking the data into small pieces of data (“bibbits” – free standing piece of data that makes sense on its own), arranging these bibbits into groups and then linking the groups together into themes or categories. For example: “did I make the right decision,” “I need constant supervision” and “could I have done more,” all spoke the self doubt around a workers case practice which linked in with other themes under the meta theme of professional issues. I reviewed each participant’s interviews and color-coded and grouped each bit of data with other similar bits of data. I started by setting out possible themes from the data into columns.

After I completed an overview I allowed myself some time and space to reflect and consider all possible themes before moving on to the next stage of my data review. I next reflected on the larger patterns and themes and just how they presented themselves with respect to the various themes and categories. From

my notes and preliminary review of the data I was able to create a sort of matrix that I could sort, filter, and refine.

I then repeated this process several times over several weeks, further refining my groupings. Each successive review of the participants' texts or "lived stories" was a further attempt to reveal the "essence" of the phenomenon. Next, a conceptual picture of the phenomenon was constructed by describing the themes and showing how they are interconnected. Once satisfied with the categories that resulted from the data, I began to seek meaning from what they described. Five categories emerged from this process: cognitive, emotional, behavioral, spiritual, and physical.

Continuing with Kirby and McKenna's (1989) approach, I started to link the categories together to develop themes and combine these themes to generate a response to the researchers questions based upon the data gathered. To create my theories, I compared and contrasted each category. I looked for relationships among and across the data. I then began to infer possible meanings from these relationships.

I attempted to identify some of the complexities of the data. For example, how was the data diverse? Was the data congruent or incongruent? Were there inconsistencies? What assumptions were present in the data. I then used these questions to create an understanding of how the participants interpret the impact of child protection on their lives.

At this point and upon further reflection, my five categories – cognitive, emotional, behavioral, spiritual, and physical – started to lose some of their meaning and no longer seemed to speak to the "essence" of the impacts that the participants were describing. I then returned again to the entirety of the participants' whole text, and upon more in-depth examination and reflection it appeared that participants were all describing three main impacts of secondary trauma in their lives. The five original categories quickly merged and evolved into three "meta themes" or main dimensions. These were: Professional Issues, Personal Impacts, and Behavioral/Physical Changes. These three categories

spoke emphatically to the impacts as a whole of secondary trauma on child protection workers.

Although I used a multi-stages process to analyze the data, this was not a linear process, which seemed appropriate given the convoluted nature of the research topic. There were times when I seemed to jump ahead a stage only to step back and start again with the whole process. Upon completion of the research I had an opportunity to discuss some of the finding with the participants. While they did not alter or change the overall results, these brief discussions did help to clarify various interview points and refine my overall conclusions.

### **Strengths and Limitations**

One of the strengths of this methodology is the participants themselves shaped it. The participants, through their own personal stories, helped guide the interview process and shape the research itself. Each worker was able to take ownership of the process and had no hesitation in leading the interview by relating his/her own personal experiences and letting me know the direction and the important items to take note of. Each participant helped lead the questions by relating his/her own personal lived experiences.

I believe that the methodology honored each participant and was adaptable to any individual needs. I believe the fact that I was a practicing child protection worker was important, as I could very much relate to the lived experiences of the participants. I believe this allowed participants to feel more at ease and thus “open up” more freely to myself.

Participation in the “screening in” self-test tool included a broad cross-section of staff from across Vancouver Island. A total 14 offices participated, ranging from urban offices such as Victoria and Nanaimo to a number of smaller rural offices such as Sooke and Port Alberni. There were 94 potential participants, so the 25 completed self-tests represented a sample of 26.6% which, is relatively representative of the breakdown of MCFD employees in the region and as a whole, with the exception of the administrative staff.

However, this study could also be limited by a response rate of only 26.6%. This small response rate could be a limiting factor in the generalizability of the findings. Another limitation could be that in using team leaders as part of the “screening-in” process, a bias may have been introduced into the study and so reflected in the findings.

I concluded my interviews in the fall of 2004. These were done in the context of a new Liberal government coming to power in the summer of 2001 and conducting a “core review” of all government services including child protection. Budget cuts followed this core review across government and the Ministry’s child protection services were significantly affected. While MCFD’s cuts were to be “back ended,” meaning that the more significant cuts would come later rather than early on, by 2004 MCFD had just seen a 12% budgetary reduction in child protective services. By the fall of 2004, MCFD saw over 600 actual FTE’s across the Ministry cut in staffing (Perrin, 2006) and the Ministry and staff were facing yet another round of cutbacks in the coming year. Since my interviews, in 2004 MCFD has seen another major injury due to a death of a child known to the Ministry. The Hughes report, 2006 again brought about change, new direction and major program shifts referred to as “service transformation.”

Finally when looking at trauma experienced by child protection workers, this study included only those practitioners still working in the field. It did not seek out and include former child protection workers who had left the MCFD. Given the high turnover rates in the child welfare field, this could be a sizeable group (Perrin, 2006). Thus, one could conclude that this study provides a distorted picture, namely one that features those workers who “survive” and possibly even flourish in this type of stressful environment.

## Chapter Four

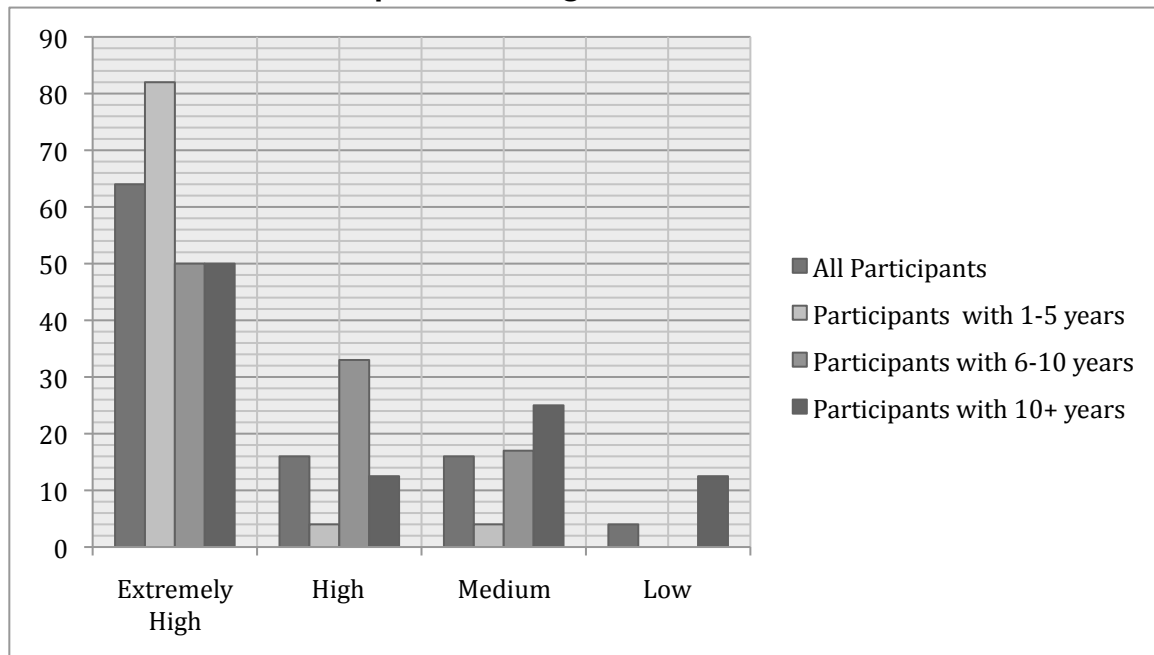
### Findings

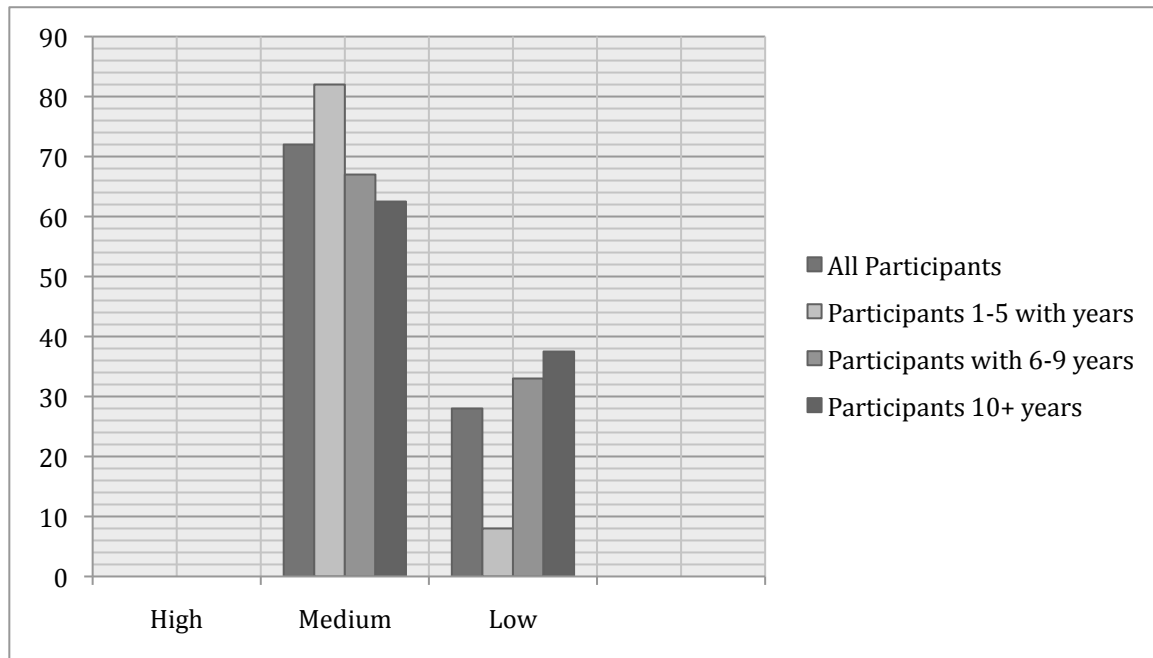
#### Findings

The Compassion Fatigue Self-test showed that participants in this study tended to rate “extremely high” for compassion fatigue while burnout was medium to low

Of the 25 participants, 64% rated as being at extremely high risk for compassion fatigue, 16% as being at high risk, 16% for being at moderate risk, and only 4% for being at low risk. An additional 72% of the participants were rated as being at medium risk for burnout, with 28% as being at low risk for burnout. Table 1 shows the complete breakdown for compassion fatigue and Table 2 for burnout.

**Table 1 - At risk for Compassion Fatigue**



**Table 2 - At risk for Burn Out**

Perhaps one of the most unexpected and concerning findings was that 80% of child protection workers who returned the “self-test” were at “high” or “extremely high” risk of compassion fatigue and that 72% of child protection workers were at medium risk for burnout. These are certainly concerning figures for a Ministry and a field that is struggling with the retention of staff.

Another unexpected finding was such a significant difference, 32% greater risk for being rated at extremely high risk for compassion fatigue, between new child protection workers (0-5 years in the field) and more veteran workers (6+ years). Also of note was that child protection workers with less than 6 years experience were also showing greater risk for burnout.

Child protection workers with 6-9 years experience showed an 83% risk of “high” and “extremely high” risk of compassion fatigue, while workers with 10+ years were at 62.5 % risk of “high” and “extremely high” risk of compassion fatigue. Looking more closely at senior child protection workers, it appears that

those workers with 6-9 years experience share that same risk, 50%, for scoring extremely high for compassion fatigue as their more veteran colleagues with 10+ years of experience. However, the more senior child protection workers, 6-9 years and 10+ years, show similar risks for burnout, 67% and 62.5% respectively. So it would appear that the more years of experience in the field a child protection worker has, the lower the risk for compassion fatigue and burnout.

This researcher conducted a series of interviews with the four participants in August and September of 2004. Specifically, Participant #1 was interviewed on September 21, 2004. Participant #2 was interviewed on August 21, 2004. Participant #3 was interviewed on September 29, 2004 and Participant #4 was interviewed on August 23, 2004. During this next phase of my study, when participants were given the opportunity in an interview to discuss their roles as child protection workers and the potential effects of the job on their lives, it became clear that there are significant impacts.

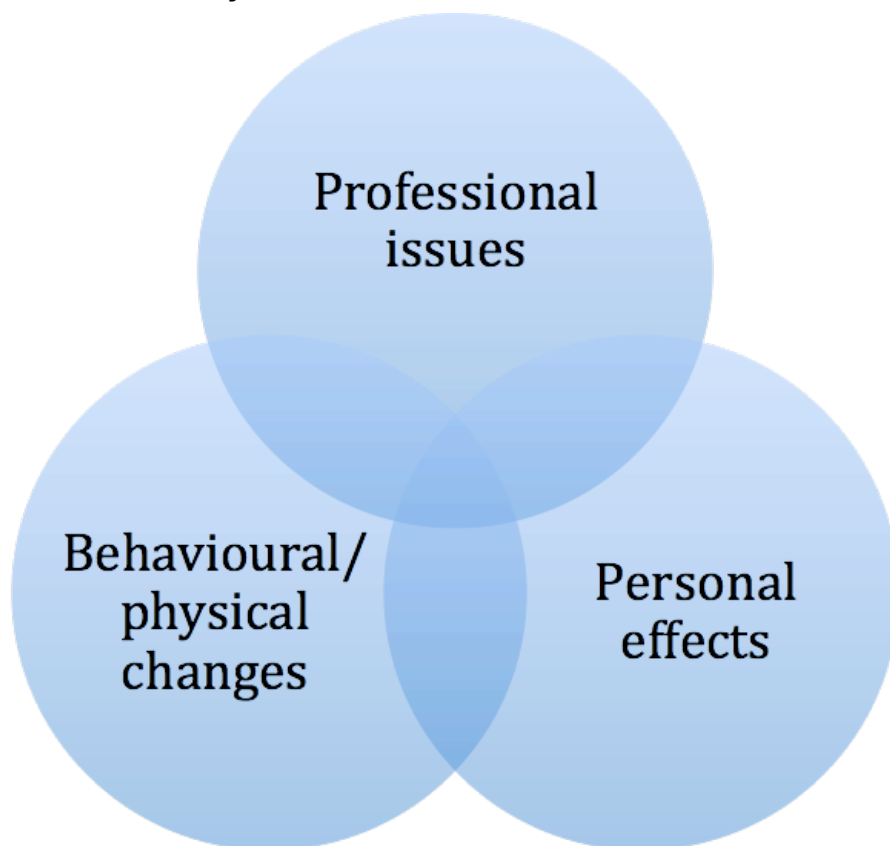
As touched upon briefly in the previous chapter, detailed analytical examination of the responses led to a final set of categories emerging. These were: Professional Issues, Personal Impacts, and Behavioral/Physical Changes (See Table 3).

It is these categories that spoke to the impacts of secondary trauma on child protection workers as a whole. The three overarching categories all had a several clear sub-themes (see Table 4 and a number of these sub-themes seemed to overlap or slip into one another. This overlapping will be explored further in discussing each of the categories.

I also included numerous quotes so a reader may actively participate in determining the validity of the data presented. As Kvale (1996) commented, the reader plays an active role in reviewing and interpreting the work to determine if what is presented by the author is familiar enough to “ring true.” As Lincoln and Guba (1985) explained, descriptions of the human experience are considered credible and reliable.

My goal in presenting numerous direct quotes from the participants is to allow readers to experience the participants' words and insights directly and to thereby assist them in understanding the all too often "taken for granted" meanings of words. The hope is that readers will recognize the experiences described by the participants and take away an expanded understanding of their own.

**Table 3 – Impacts of Secondary Trauma**



**Table 4 – Three Main Dimension and Sub-themes**

Profession Issues	Personal Impacts	Behavioral/Physical changes
<ul style="list-style-type: none"> <li>•Diminished concentration</li> <li>•Confusion</li> <li>•Whirling thoughts</li> <li>•Loss of meaning</li> <li>•Lack of Confidence/ Decreased self-esteem</li> <li>•Self-doubt</li> <li>•Preoccupation with trauma</li> <li>•Trauma imagery</li> <li>•Preoccupation with work/ inability to let work go</li> <li>•Apathy</li> <li>•Rigidity/reactionary</li> <li>•Minimization</li> <li>•Perfectionism</li> <li>•Question the meaning of our role</li> <li>•Loss of purpose/meaning</li> <li>•Lack of self-satisfaction/lack of satisfaction with job</li> </ul>	<ul style="list-style-type: none"> <li>•Withdrawn</li> <li>•Loneliness</li> <li>•Isolation from friends, family and other supports</li> <li>•Impact on parenting</li> <li>•Intolerance</li> <li>•Conflict with spouse</li> <li>•Decreased interest in intimacy or sex</li> <li>•Mistrust</li> <li>•Spirituality</li> <li>•Conflict with co-workers</li> <li>•Safety concerns around family</li> <li>•vulnerability in the community</li> </ul>	<ul style="list-style-type: none"> <li>•Rapid heartbeat</li> <li>•Breathing difficulties</li> <li>•Somatic reactions</li> <li>•Aches and pains</li> <li>•Headaches</li> <li>•Sleep disturbances</li> <li>•Tension</li> <li>•Physical exhaustion</li> <li>•Rush of adrenaline/Fight or flight response</li> <li>•Over stimulated</li> </ul>

### Professional Issues

All participants identified a number of professional issues that can be directly attributed to the high stress and traumatic events of child protection work.

The participants described a number of cognitive impacts. Most participants expressed feeling a sense of **confusion**, **whirling thoughts**, and at times a sense of **diminished concentration**:

I start to think about what I have to do and my head starts to spin. (#2, 2004, p. 26)

I could barely concentrate, it got so bad that I could not even find 10 minutes to just shut down. (#2, 2004, p. 26)

I kept getting my days mixed up. (#1, 2004, p. 9)

sometimes I am not able to concentration and focus and I am in the middle of a meeting, it's scary kind of... (#1, 2004, p. 9)

All participants identified feeling a **loss of confidence, lowered self-worth**, and **self-doubt** in their abilities. These highly skilled and veteran social workers were constantly second-guessing their own judgments. **Fear of failure** and the implications and consequences of failure appears to be one reason why senior workers continually have doubts around their own decisions and actions. A continued questioning of their own case decisions seems to come from the immense importance of some of the case decisions required by child protection workers. Various participants described this constant questioning of their decisions as trying to alleviate their self-doubt. Ironically, however, participants indicated that this led to an even greater questioning and an ever greater undermining of self-confidence resulting in diminished self-esteem.

Specifically, participants would express a lack of confidence in what their supervisor was asking of them. Doubts over whether or not one was “pulling their own weight” was another persistent theme. A number of participants talked of how a difficult case could become all-consuming and how “doubts around whether they were pulling their weight” would arise when colleagues would help out with some of the workload. Another participant expressed these same feelings in saying “no” to taking on additional work when he/she tried to establish some “healthier” boundaries around work once he/she returned from a sick leave.

Another strong theme expressed by all participants were the self-doubts around the granting of a continuing custody order: that they could have done more; or if they could have tried this strategy, then perhaps there might have been a different outcome. There was a strong sense that not only did the system fail this child, but also they did as well, “that maybe I could have done more.”

This theme of self-doubt has led all participants at one point in their career with MCFD to question their “fit” as a child protection worker. This questioning ultimately leads to significant numbers of senior child protection workers moving

out of child protection into other roles within the MCFD or leaving the Ministry altogether. Evidence of this can be seen in the high turnover and attrition rates in child protection. Along with “reflecting” on their “fit” with MCFD, all participants reported a loss in meaning around their role as a child protection worker, a questioning as to “what are we doing, is a removal less traumatic than just leaving the child in the situation?” (#2, 2004, p. 12)

I did not feel I had the confidence to do the things that my Team Leader was asking. (#1, 2004, p. 13)

I should have done more, what else could I have done? (#3, 2004, p. 9)

...have I made the right decision? (#1, 2004, p. 18) (#2, 2004, p. 16) (#3, 2004, p. 14) (#4, 2004, p. 6)

I am in the right job, maybe a different position would be a better fit. (#4, 2004, p. 6)

I need a lot of supervision because I feel like I don't have the confidence. (#2, 2004, p. 16)

I still, emotionally, feel that I am not pulling my weight. (#1, 2004, p. 22)

All these doubts, I could have done more. (#3, 2004, p. 8)

...are co-workers going to think I am not getting my work done? I'm thinking I might look disorganized. (#4, 2004, p. 15)

All participants reported a questioning of their own role within the MCFD. A **loss of purpose** as to just what they are doing as a child protection worker stood out as a strong theme among participants. “What are we doing here with this family” was a common question, or perhaps more accurately, an assertion. This questioning also extended to the Ministry as a whole. Most participants reported an ongoing “**internal war**” regarding MCFD’s overall role around prevention, support, and intervention versus protection. How much of a support type of

intervention does the Ministry provide, before “we say enough is enough” and it moves to a protective intervention? Participants expressed this internal conflict as a general questioning of the system and a reflection of the lack of clarity around clear Ministry vision, purpose, and goals:

Why are we waiting, we say the child should not go back home, so we use a family placement, then say we are not going to pick a side. I don't get it. What are we doing, should we support this family? (#3, 2004, p. 16)

We do a Voluntary Care Agreement (VCA) for a year, then a Temporary Custody Order (TCO) for a year, then court is delayed and adjourned for another year, what is it all for? (#3, 2004, p. 15)

...if we have a sense right off the bat, like have 5 other kids we got long term on and here's an infant. Do we think this parent can make it? Why would I wait 5 years before going long term...is that good for the kids? (#3, 2004, p. 15)

We have a child who has grown up in this neglect, their needs are not being fully met, but what do we (MCFD) have to offer this child? We are taking them from their parent, from a situation that they grew up in, and I am offering them a stranger home, occasional visits, all with the promise that “things will get better and then there is a good possibility that they will just be return back home in a short time.” (#2, 2004, p. 16)

...all this family needs is some support, it will be long term, but it is needed and I have to say NO because it's not in the budget. (#2, 2004, p. 10)

...just what are we doing? Because sometimes I don't know and it's frustrating! (#1, 2004, p. 18)

...are we using family to save money? Or are we using them because it's best for the kid, then let's support them and help. (#3, 2004, p. 41)

Several participants expressed that self-doubt also leads to feelings of **guilt** that played an active role in their decision-making. Other participants described feelings of **blame** in regard to their decision-making with families.

These participants indicated that there have been times, when working with a family, they would feel they were to blame for a child coming into care, or that they were responsible for “a client being evicted.”

Do I want to remove this child because if I do, it will mean a lot of extra work. I mean personally I don't want to have to deal with the fallout, I feel guilty just thinking of all the court stuff and fighting with the parents... (#2, 2004, p. 12)

Most participants also expressed a sense of responsibility and guilt when it comes to their colleagues. Participants indicated that they have a “shared responsibility” to support each other and so felt that they “could not say no” when it came to helping a co-worker. One participant indicated that he/she came back early from a sick leave out of feelings of guilt due to the extra burden his/her co-workers were assuming in their absence. “The only thing that brought me back after 3 weeks, well ...I kind of had a guilt feeling...” (#1, 2004, p. 22)

Another participant described having to deal with a file that took a great deal of his/her time. They were constantly out of the office in meetings and had to spend number of days with a child in care at the children's hospital in Vancouver. While the emotions involved with this file were overwhelming, this participant indicated feelings of guilt regarding his/her co-workers who took on some of his/her workload. Other participants indicated that they could not say “no” to a colleague. They feel that they need to help, that they need to support their co-worker usually to their own detriment:

I sometimes think maybe I pushed and pushed and that is why they (co-worker) agreed. (#1, 2004, p. 23)

Several participants described a **grieving** process that they go through with the ups and downs of a continuing custody order (CCO) trial. One participant talked of a strange **sadness** once a child becomes a CCO, “It feels like the system has failed that child.” Participants also indicated that they need some

clinical support in dealing with the stressful events of a trial, as workers go through this “emotional rollercoaster” and then, while the trial concludes, this does not bring closure for the worker or the families because “there is still the aftermath to deal with.”

All participants declared that, once the trial is over, they are the people who have to deal with the aftermath, explaining to the child, the family, the community, and other professions; that in this “aftermath” a worker’s explanations can be taken with support and agreement or with a questioning of that worker’s reasoning and judgment, sometimes to the extreme of outright hostility. All the while, participants are describing feelings of grief and loss and recovering from the emotional rollercoaster of the trial. In regard to issues of **grief and loss**, most participants felt that there wasn’t the needed emotional support and understanding from the Ministry.

Another participant talked of the experience of grieving the loss of the team that once was and feeling alone on the team because of all the instability with the turnover of permanent staff. Another critical factor was the lack of a stable permanent team leader. This participant indicated there had been five acting team leaders in the last year, and noted, finally, that with the instability the team was becoming a group of individuals, thus leaving this participant feeling alone, grieving the team of the past:

need to know and feel like we did everything that we could do. Go through this long emotion process of the CCO trial and at the end of it we transfer the file to a different worker and team, does not feel right, we have a relationship here and an emotional connection. (#3, 2004, p. 38)

I think that I need to hear and know that it is okay if tears happen. (#3, 2004, p. 40)

I sat through the whole trial...and basically reheard a summary of the past 3 years I’ve worked with this family. And the ups and downs...all the attempts to get this child home, to see everyone involved who wholeheartedly tried. (#3, 2004, p. 39)

We aren't dealing with nice families anymore...where you go into court with consents...nothing getting resolve. So we are spending huge amounts of time in court. (#3, 2004, p. 45)

Most participants describe experiencing types of **visual imagery** and thoughts of the trauma that they have heard described. Other participants relate how this **preoccupation with trauma** is a way in which “the trauma” with “its constant ability to remain with them” slowly “erodes” them emotionally. All participants described a sort of **preoccupation with work** and an **inability to let work go** that often kept them “stuck” back at the office:

Still can see the girl's face in the rearview mirror, she was screaming and crying there in the car. (#1, 2004, p. 17)

I can remember that the little girl was just sitting there in the middle of the empty room staring at the TV with a blank look, not moving, while the mom just swearing and yelling at me. (#1, 2004, p. 17)

I'm sometimes at home feeling like I left children at risk. (#4, 2004, p. 15)

It was my first removal...I think for the longest time I could remember all the circumstances around it, I could remember the child and the conversations I had. (#1, 2004, p 16)

It never goes away and living and working in the community one... never really leaves work. (#3, 2004, p 9)

Still remember every detail of this report and going over it with the SCAN team. (#3, 2004, p. 34)

There are times when I feel like everyone is nuts and the world is doomed. (#2, 2004, p. 45)

often find myself waking up in the middle of the night thinking should have done this or need to do that. (#4, 2004, p. 39)

it never goes away, so you never really leave work. (#3, 2004, p. 9)

I was on holidays, but I came back in for this trial, think I needed closure; I should have just stayed away. (#3, 2004, p. 17)

All participants expressed getting to a point where their caseloads overwhelmed them and they indicated that their empathy for their clients gets lost in the chaos and unyielding nature of the child protection process. They also noted themselves becoming **rigid** and **reactionary** in their thinking. Most participants described themselves as having little patience and being **intolerant** of inter-team struggles and disagreements, which would often blow up into full-scale conflict because of everybody's bluntness and lack of patience:

I have seen some workers become very black and white in their thinking, they go into a family's home, tell them how things are going to go. At first I could not understand this but now after being with MCFD 10-plus years I have found myself being just that, very black and white with some families. (#3, 2004, p. 17)

those files that just do not go away, we keep trying and nothing changes, I just get to a point where I do not care anymore and I think there is nothing left to do but go CCO. (#3, 2004, p. 14)

I get to a place where everything is blowing up and then one more thing to deal with, I start getting to do this and do that. I lose my ability to hear what is occurring and I feel like I am just chasing my tail. (#3, 2004, p. 8)

Still other participants reported, "as workers we can" have a tendency to **minimize** risk factors, especially when dealing with long term and multi-generation families:

I think that sometimes we are minimizing. (#2, 2004, p. 45)

All participants described a sense of **perfectionism**, of holding themselves to a higher than standard level. Participants also indicated that in addition to a worker's own sense of perfectionism there are also the MCFD's set of expectations, as well as another set of expectations, the public's need for accountability. In addition to the

MCFD's and the public's expectations, all participants mentioned how all these expectations can change, and that along with the "ever changing expectations" are the "ever new expectations" leaving workers ever "dazed and confused."

Participants also described how feelings of **anxiety** and pressure caused by these high expectations from multiple sources hold a real risk to workers, in that to meet their own high standards and all the expectations that are out there, they start to become overwhelmed. Finally, most participants indicated that it was draining to have these expectations placed on them but to not be able to meet any of them:

My expectations of myself are huge. (#3, 2004, p. 8)

I want to do good work...and I am not getting the work done, I can't do the work I want to do. (#3, 2004, p. 7)

One thing is that I think there are very high expectations. So there are high expectations for everybody within the system that you have to. And there are all kinds of checks and balances to make sure that everybody's doing this very high level of work. (#2, 2004, p. 6)

There's lots of people in the community, they are very powerful people in the courts and the RCMP and psychiatrists and people that we deal with all the time that we are having to, as well, meet their high expectations of what we are doing. Because they are challenging us all the time. The psychiatrists are challenging – oh, this isn't a good idea and you shouldn't be removing these kids and the kids should be together – and the court system is doing the same thing and the RCMP might be questioning those kinds of things too. So I think there is this huge – It's not just from within the Ministry – this expectation and pressure from everybody. And I'm constantly, every day, try as I might not to, I'm always saying to myself, "Oh, today I didn't do this very well or didn't do that very well; this person in the community is not happy with me because I didn't respond quickly enough or I didn't get the right information" and so that is the kind of, I think that is one huge, you know, huge for me stressor; just living up to all these expectations. (#2, 2004, p. 7)

What I've found since I've started in '96 is that the more things keep getting piled on but nothing gets taken away. So there are always new

expectations but not like okay, now you have to do this but you don't have to do this anymore. No. It's like you have to do this AND you have to do that. And I think the expectations keep getting greater and greater. And I think there is a real risk of, like for me myself I'm trying to hold myself to those expectations and there is a perfectionism that evolves from that.... I don't know if it's the job itself that attracts perfectionists, because of the high expectations, but it seems to me that it is not just me. Like, I look around and most of the people try to meet this very high standard. And I think that is a huge stress for me personally.... I'm always trying very hard to do, to meet all the practice standards, to meet the policy requirements, to... but that is just one piece of it. You still have your client's actual well-being and the safety of the kids... (#2, 2004, p. 6)

All participants described feelings of **frustration** with the amount of work expected of them. One participant indicated that his/her caseload went from 18 to 34, "...at 18 I could manage the workload, but at 34 I case manage the crises. I have to prioritize the chaos, deal with the immediate situation(s) at hand and hope I get back to the non-emergencies and hope they just do not blow up into an urgent situation, or if they do it is on an another day." (#3, 2004, p. 8)

Another participant described being told to just "manage your caseload, why are you complaining" (#3, 2004, p.22). All participants felt caseloads were busier, with more paperwork, and less time for their clients. "There's more and more work and then there are the bureaucratic changes, I think sometimes there is too much change. It is very frustrating and demoralizing" (#1, 2004, p. 20).

Participants spoke of their frustration in being asked to deal with additional programs, such as the "Kith and Kin" program (now the Extended Family Program) while being given no additional resources to carry this out. Moreover, due to the number of vacancies and cuts, participants indicated that there are fewer people to cope with ever increasing workload demands. All participants expressed frustration about the limited resources, court delays, and being "stuck" in the middle between clients, procedures, policy, standards, and legislation. A number of participants described themselves as becoming "**jaded**" when they make repeated attempts to accomplish things and things do not change:

I think you get jaded when you try and try and nothing ever changes.  
(#3, 2004, p. 14)

In a kind of purgatory with the families we work with. (#2, 2004, p. 4)

Like to yell, scream and then cry to get out my frustration. (#2, 2004, p. 10)

The support wasn't there. (#1, 2004, p. 7)

...and there are days where I am feeling like I am banging my head against a wall. (#2, 2004, p. 39)

The stress of constant change, lack of resources, and cutbacks were issues that led to all participants feeling a sense of **powerlessness**. Several participants indicated that their caseloads increased “overnight” because there was no backfill for workers who are off on sick leave while vacancies went unfilled. Participants indicated that they are expected to “step into the breach” and deal with the immediate situation(s) at hand and then left to try and manage the “crises and chaos.”

Most participants indicated that when they have expressed their frustrations around staffing, they have been told to just “manage your caseload,” and asked, “why are you complaining?” Or, they say, that is how it felt. All participants expressed a general feeling around a **lack of support** from management when it comes to staffing issues. All participants describe that at times they felt powerless to effect any change with the families they work with directly because of the lack of resources and the overwhelming nature of the workload.

All participants expressed feeling “there is just too much stuff that has to be done.” They stated that management does not understand this fact and does not seem to understand what the frontline workers are facing and the details of what is required of them day in and day out. These feelings on the part of staff seem to lead to a greater disconnect between the frontline and management and

a growing sense of powerlessness.

Participants also talked of the need to be listened too and really heard. In line with these feelings of not being heard, a number of participants were concerned about a perceived lack of sensitivity to the frontline and their needs. These feelings come to the forefront when workers are advocating for their families regarding the need for supportive services. Because of budget situations, it is the workers who generally have to say “NO” more and more to their clients. One worker felt that his/her judgment was being “ignored” and that these cuts showed a real lack of sensitivity to the families who are in crisis and needing help. Moreover, these “tough” political decisions are in reality carried out by the frontline, while the people making these decisions seem to have little understanding or sensitivity around this fact.

Participants also described team instability, exemplified by the lack of permanent staff on the team or, more importantly, a stable team leader as leading to a sense of powerlessness:

...at (a caseload of) 18 I could do the work, but at 34 I can't. (#3, 2004, p. 8)

I can't do the work that needs to be done...what am I supposed to say to my child in care...as...I won't see her for 6 months? (#3, 2004, p. 24)

It should be the top supporting us, listening to what is needed and supporting the frontline. (#1, 2004, p. 5)

There was no sensitivity to the worker. (#1, 2004, p. 6)

...the government doesn't want to pay for your darn kid to be in care, we sort of have to say, “oh well, the direction that we are going now is around community supporting family. (#2, 2004, p. 10)

Like they cut 30% of our staff, they cut 30% of our budget, and then they are making out that everything is wonderful and we are the ones that have people coming to us all upset and crying and whatever...if people were sort of willingly in all this stuff and we'll say, well, this isn't right or this should be changed and the answer we get from our

supervisor or I'll get from mine is, "well this is just the way it is. You just have to live with it because it's not going to change." But this is reality. (#3, 2004, p. 24)

...all the stress comes down and then we're here and the stress from management comes down because they're not listening to the supervisors, supervisors are frustrated and they're not doing what we need for support then everything is put on us. Like, we can't go to the supervisors if we don't feel like we're supportive, we're not allowed to talk to our other co-workers 'cause we're feeling stressed out and we might get in trouble or something and we're not being able to debrief, we hold it in. If we're not, if we're building and we're building and building and not getting the work done, the clients are getting madder and the stress, it's like being caught between two rocks that are compressing the worker. (#3, 2004, p. 22)

All participants described feelings of **anxiety** and stress on a daily basis. They all indicated that these feelings are especially heightened on a Monday morning after the weekend. Participants also stated that the anxieties are especially acute when getting back from a holiday and "knowing that you will have to deal with a full voice mailbox, and have 45 people needing a call and countless e-mails to answer and 'all' of my families needing/wanting my immediate attention." (#3, 2004, p. 17 )

That first day back is like being hit by a brick wall, you go from a nice calm day to the middle of a hurricane as soon as you enter the office. Sometimes wonder if the time off is worth it, as one gets backfill and so yours and everyone else's caseload just sits while the worker is away. It is like a guessing game as to which files on your caseload fell apart (#2, 2004, p. 26).

All participants indicated that a worker over time gets **desensitized** and **numb**, that "one has to or this job will overwhelm them." Several participants also described the impact of being a child protection worker to being akin to a rock on a beach, the waves keep rolling in, pounding on you, "you are slowly being eroded away."

You have to just hold it at arm's length and try not to think about it. (#2,

2004, p. 21)

Waves lapping at the shore, wave after wave, they keep coming, and we are standing there until then comes a tidal wave, you are too exhausted to move. (#2, 2004, p. 22)

Felt like the waves kept coming and coming and after a while...you're stuck there and you can't leave and you got to erode...slowly away...that is what the impact is for me. (#3, 2004, p. 28)

...you do get kind of desensitized, you kind of have to. Because if you didn't then I guess you couldn't do it, you'd have to leave. (#2, 2004, p. 21)

All participants related how in their role as a child protection worker there is the reality – if not daily, certainly weekly – that you are making very critical decisions regarding children and families. The participants all talked of a **fear** that goes into making a major decision in a family's life. Participants indicated a fear around the decision of whether or not to remove a child, the critical impact that single moment would make in the child's life and then all the following decisions that stem from that original decision. Many participants described this feeling of fear as overwhelming, contemplating whether or not they were making the right decision.

Wrapped into this fear was the fact that none of these decisions were made lightly, that there was a considerable amount of “emotional time” that was part of each decision. All participants talked of meeting after meeting in which professionals and the community looked to them to make these decisions: whether to remove or not, a critical medical decision, a placement choice, or which school a child should attend. Participants indicated their fear of being asked to make “the right” decision, to be “accountable” for the choices made and to “not get it wrong.” Compounding this fear was the fact that each of these decisions had potentially critical impacts for the child in question.

Participants described this fear of making the right choice as being quite prominent when they first started in child protection. Some participants expressed

how, at first, the thought of an investigation was “too frightening;” questions arose such as, “how can I go into someone’s home and judge them,” and “what if I get it all wrong?” Another participant talked of feeling scared and fearful the first time they had to screen calls. Others indicated that they remember the “fear” experienced when going out on their first protection call, “I was scared in what I could encounter.” (#1, 2004, p. 15)

Finally, one participant was clear that the decisions that a child protection worker make do have “lifelong impacts and consequences” for children and families and that is a fear that workers hold on to each time they are asked to make a decision.

All participants described concerns around personal safety and having to deal with threats. Most participants told of receiving direct threats from a client(s) resulting in a real sense of fear, whether at the office or at home. Participants indicated involving the RCMP in these situations leading to fear around any continued work with the police, to possibly “angering” this client again, and “what would/could happen then.” Participants reported not only being fearful for their own safety but also being fearful for their families’ safety. All participants indicated that their individual offices had protocols in place for dealing with “health and safety” issues, but that their fears extended beyond the office to their off-hours in public. Participants reported being worried while being out in the community doing some daily activity such as shopping.

Participants all described a fear of “going into the unknown” with another common safety concern expressed as “sometimes you never know what to expect” when knocking on a client’s door for the first time. Participants indicated that what a caller may tell the MCFD or what the file may say does not always match up when you get to a family’s home:

We aren’t dealing with nice families anymore who need a bit of support, there are some very scary people who we deal with. (#3, 2004, p. 23)

I felt safe to go home and safe around town, I just tended to look over my shoulder occasionally because sometimes you do have to worry... because we work with some unpredictable clients so not sure what to expect. (#1, 2004, p. 7)

If you ever come near my house again I'm going to fucking kill you. (#1, 2004, p. 8)

you are going into an unknown situation, you do not have a lot of information...it's a really safety fearful stress. (#4, 2004, p. 14)

I am very cautious of where I sit in a room. (#3, 2004, p. 36)

when it's safety, I'm not willing to take a risk. (#3, 2004, p. 36)

Another theme described by participants was this feeling that they needed to be "doing something," that when at work they were ready to "spring into action, it's like I am just waiting for the next crisis or phone call and then I go..." (#2, 2004, p. 27).

I think at work I'm ready, my mind is open and I'm ready...I'm ready for phone calls, for meetings, for people coming in. (#2, 2004, p. 27)

All participants referred to feeling **overwhelmed** by the pressure to meet Ministry expectations. "I know various workers who fit the bill, who are just burning themselves out" because of their own internal expectation of themselves to meet the Ministry's standards. Participants indicated that "you know you're overwhelmed as you feel like you're running all the time, you're your double booking, trying to do five things when you can only do two well." One participant described having "so much on my plate and then it just hit me all of a sudden. I could not do any more." (#1, 2004, p. 22).

Another participant's talked about how child protection workers go into a survival mode because of the pressures and caseload expectation. "I don't want to deal with anything more right now, I can't cope with any more." (#3, 2004, p. 26).

All participants feel the pressure that “they need to do to it all”, that there is the expectation that child protection workers will “see all their kids”, “get all their plans of care done”, “complete all their risk assessments”, and that “it does not stop,” that the workload and expectations just keep coming.

Participants all expressed the feeling that their files are changing, becoming “more and more difficult.” Supportive files are gone and workers are left with “more and more of the ugly protection cases” (#3, 2004, p. 46). All participants declared that these feelings around dealing with more difficult files added to their sense of being overwhelmed.

Participants all described the overwhelming nature of a removal, the raised level of anxiety, the emotional stress of the situation, and then the actual removal itself. Once a removal occurs participants described the paperwork, the court documentation, the new expectations regarding the child on the part of the parents, the extended family, and the community as “pure and simply, completely overwhelming,” “not to mention that I just ignored my other 15 families during this chaotic time” (#4, 2004, p. 15). All participants indicated that the stress builds and builds as, “I just can’t do and see everyone in a day that I need to” (#4, 2004, p. 15).

We have to do everything, we have already taken on everything that we can take on...we are all exhausted. (#2, 2004, p. 15)

It was just go-go-go. Felt like they (management) just wait for us to give up. Just wanted some help, just wanted this one file to go away. (#1, 2004, pp. 22-23)

It became a survival thing, I’m not going to do anything more right now. I can’t cope anymore. (#3, 2004, p. 26)

...you have demands on this side, you have demands on that side and you’re trying to be your own practice because everything you do is up to you. So it’s an amazing amount of stress because they don’t realize that it’s coming, but it needs to sort of slow this way a little bit, like there has to be like a circle, like ummm...there is pressure put on us from our supervisors ’cause we need to do our job and that’s the end

of it, but they also need a little air vent at the bottom so that we can release the pressure so as more comes in the top we have a way to release it so that it's a healthy cycle, if you will. (#3, 2004, p. 22-23)

All participants talked about the “**emotional drain**” that child protection has on its employees. They all describe an emotional attachment that they develop with the children and families on their caseloads. It is these attachments with their emotional ups and downs that participants describe as leaving them “totally drained,” and “not wanting to deal with anything else” by the day’s end. One participant felt there was is no consideration for the impacts of working with families on the worker, as “there are files that ‘literally’ suck the life out of you” (#3, 2004, p. 47). Participants indicated that the “emotional trauma” does not go away quickly, “it sort of seeps out away and in doing so you never really fully recover” and “so we slowly emotionally get worn down.”

A number of participants indicated that the more adversarial the relationship with the family and the greater the resulting conflict, the more extreme the feeling of personal depletion and “kind of **depression**.” During any given work day participants described the possibility of having clients yelling at them, calling them names, and using threats to intimidate, all leaving them feeling drained and “emotionally vacant.” All participants mentioned that there are times when they just want to yell back or tell that client “what you think”, but they do not, because “we are professionals” and “I understand where the parent may be coming from.” But at the end of the day “it leaves you with nothing left to give, I’m physically and emotionally beat” (#3, 2004, p. 28).

I find it draining when the parent is very angry with me. (#2, 2004, p. 10)

Draining elements are the families that we are working with, the emotional attachments. When we are on a family service team, we do not get rid of files. (#3, 2004, p. 8)

By the end of the day I am drained, totally drained. (#3, 2004, p. 28)

## Personal Impacts

The participants all described “taking work home” and having their job as a child protection worker affect and impact their personal life. **Isolation** was a strong theme noted by all participants, the need to “just be alone and get away from everything.” Participants indicated that once home, they “just do not want to see anybody, I feel I have nothing left to give so I avoid seeing anyone” (#2, 2004, p. 11).

Most participants described being “protective” and “cautious” in whom they socialize with. Some participants talked about not wanting to socialize with co-workers, because “all we do is talk about work and I just can’t do that.” Another participant felt that they “just could not have certain types of friends” as these “attachments or friendships can leave me feeling quite vulnerable as you are putting yourself out there” (#2, 2004, p. 19). This participant was talking about “those friendships” where he/she spend more time “social working” this person rather than just being friends. Participants also indicated that this “**isolation**” or “**withdrawal**” from social activities extends to limiting contact not only with close friends but with family as well. Several participants described “needing space” from their partners and saying “no” to a family barbeque. Other participants told of ignoring phone calls and not connecting with others, in an effort to “just be alone.”

Several participants indicated that there are days in the office where they “just shut” their door in an effort to avoid dealing with any extra issues that are going on in the office. One participant described having friends who “need to do things on a daily basis” as something that would be too overwhelming for him/her. Another participant related that spending hours on the Internet is a way to isolate oneself, to take on different personas and be “someone else” and “not worry about work or anything” (#1, 2004, p. 26).

Interestingly, all participants indicated how they avoid describing and/or discussing their job as a child protection worker with people. “I usually say I work for the government and leave it at that; if I am pushed I say I work with kids” (#1,

2004, p. 12).

All participants mentioned that the concern around talking with others about the job is that people will then suddenly want to “open up” and seek advice about a personal crisis. Moreover, often there is a negative reaction: “How can you do that, take children from parents?” In both cases participants felt they did not have the energy for either discussion. Several participants felt that friends, family, and even the public does not understand how child protection workers take the traumas of work home, that child protection workers spend countless extra hours working evenings and weekends because of some situation that just cannot wait:

I don't invite friends over, I'll do lunch or something when I have the energy and that way I can stay for as long or as little time as I want. (#2, 2004, p. 17)

...like, how are you supposed to have relationships with friends or do stuff with friends during the week and not have that become a stressful thing? Like, you leave work say 5:30, 6:00 p.m., and then exercise for an hour then it's already 7:00 p.m., and you haven't eaten dinner, so the whole week is stressful because you just can't pack the stuff in. (#2, 2004, p. 29)

...there are days I close my door and say all I need to do today is my work. I can't deal with anything else around me. (#3, 2004, p. 13)

I really feel I need to isolate myself. (#3, 2004, p. 29)

constant sort of struggle...am I really up for it today, to socialize? (#2, 2004, p. 28)

I go into a cocooning mode...I won't make commitments with people for Saturday or Sunday...I save the weekends for myself just to recharge. And I do not find it recharging necessarily to interact with friends. (#2, 2004, p. 28)

The married participants talked about an added level of **conflict with their spouses** because of their role as a child protection worker, from a disconnect in not having their spouse understand their needs (e.g., desire for space and need

to be alone), to direct conflicts due to added workplace stress that is taken out on the loved one.

Most participants described this need for isolation as leading to conflict and a lack of understanding with their partner. “We function differently, he needs a lot people around all the time and I don’t, it’s too overwhelming for me” (#2, 2004, p. 18).

One participant felt that “isolation” was a “huge theme” in his/her life. He/she felt that he/she isolated him/her self socially because he/she was “not interested in being around people.” This same participant indicated that this led to a “constant struggle” with his/her spouse because the decisions around socializing were often left up to the participant and if they were “really up for it” that day. Another participant talked about how he/she would feel tired, emotionally drained, and wanting space after work or on a weekend, that there would be a disconnect with their spouse who could not “conceptualize” this: “He would feel that something was wrong and be hurt.”

All participants described, “**being short**” and “**irritable**” with their spouse. One participant talks about when her partner would call her at work and the response would be quite direct and short and “all the time I am thinking I do not care, find it yourself, nice of you to call, but I do not have time for this, bye” (#4, 2004, p. 16-17). She also related being quite blunt and shutting down those she cares for. “I then feel bad, so this stress becomes a feeling of guilt” (#4, 2004, p. 17).

With an increase in conflict and feelings of exhaustion, most participants also described a **decrease in intimacy** with their spouses:

It’s put our relationship into conflict. (#2, 2004, p. 17)

I find that my patience with my family is a little shorter, I don’t give them the time they need. (#4, 2004, p. 16)

I am more direct and blunt with my husband and he gets hurt by this. (#4, 2004, p. 17)

I'm tired and I'm going home and I don't have the intimacy with my husband. (#4, 2004, p. 32)

Several participants talked about a general **mistrust** that can arise when, in your role as a child protection worker, you are provided with a great deal of information regarding various people in the community. One's view of the community becomes "tainted" in a negative way. With this increased negative view of the community, many participants described avoiding community events where clients may attend. One participant talked about how his/her family would spend lots of time doing things outside his/her home community in an effort to avoid situations where he/she could run into a client:

It is difficult as you have all this info about people in the community and while we interact with only a small percentage, it is amazing how visible they are. (#3, 2004, p. 19)

I admit that we spend a lot of our time as a family doing things where we time things to avoid situations where clients may be. (#3, 2004, p. 20)

I am questioning my caregivers, my neighbors and I am certainly aware of what is going. (#3, 2004, p. 18-19)

All participants described feelings of intolerance with friends, family, and co-workers. They related how the daily exhaustion, frustration, and trauma of work had **impacts on parenting**. Several participants described times coming home from work and not being able to do one more thing, so family activities did not happen that day. One participant then told of feeling **guilty** because he/she was "too tired" and "too drained" to take his/her daughter to a soccer practice. Another participant described being "so sick and tired of meeting his/her clients' needs all week, that he/she either wished to think about nor deal with anyone else wanting and needing something, whether they were a co-worker, friend, or my family."

there are times when I come home and I just can't do it, I can't do a friend sleeping over or soccer. (#3, 2004, p. 29)

I find I can shut down those I care for and I don't like that. (#4, 2004, p. 17)

Participants reported feeling fear and anxiety at home around the phone ringing, that it could be after hours and that they would be pulled away from their family and any plans they had:

the phone rings and I need quiet and I am telling my children that they need to be quiet and they are just wanting my attention. (#3, 2004, p. 43)

I hate the phone, it's something that we have from talking on the phone all the time at work, I don't want to call people, I don't want to talk. (#2, 2004, p. 18)

Several participants felt that their friends, families, and even the public do not understand how child protection workers take the traumas of work home, that child protection workers spend countless extra hours working evenings and weekends because some situation just can not wait. Several participants describe often having to re-explain to their spouses about why the "work" cannot "just wait until the next day" or why they will be late because they need to finish speaking with a family or a child on their caseload:

I had holidays this summer but I came in two days for this trial because it was closure. (#3, 2004, p. 17)

Spiritual beliefs played an integral role for two participants in particular. Their **spirituality** was described as reinforcing their sense of the meaning of the work. There was a great sense of comfort in believing there was a higher power to provide support and direction. Praying or meditation was described as a way of reducing stress and helping them find "some peace" after a difficult day.

One participant in particular described a strong belief in God as a guiding light in his/her life and as a child protection worker. For this participant, his/her belief in God “fills them up emotionally.” It helped kept them balanced in his/her life and helped reduce their stress load. “I have a higher power of support” (#4, 2004, p. 35). This participant also reflected that with the numerous difficult cases and traumatic situations that he/she may encounter, his/her faith and belief that “God does have a plan for me” allowed them to reflect on the situation confronting him/her and helped them to better understand what all this is about:

If I am suddenly getting overwhelmed, I always tell myself, does God ever give me anything I can't handle – no – and I instantly feel better and then I can go and do the best I can. (#4, 2004, pp. 33-34)

...if I miss church or I miss a bible study, I miss something that gives back to me, then I feel it at work all week. I have a basket of apples and I give out all my apples. I go back to church that's what fills my basket for me. (#4, 2004, p. 35)

I can turn to my faith and I feel okay, I can do this. (#4, 2004, p. 31)

My faith allows me to separate work from home. (#4, 2004, p. 35)

### **Behavioral and Physical Changes**

All participants described a number of behavioral and physical changes that have manifested over their time as child protection workers. All participants described similar forms of sleep disturbances, from a restless night “just laying in bed,” to “tossing and turning,” to waking in “the middle of the night.”

I sometimes would wake up in the middle of the night and go for a run on my treadmill just to work out the stress I was feeling. (#3, 2004, p. 9)

there are nights when I just lay there thinking about work. (#2, 2004, p. 26)

when things got stressful at work I would toss and turn all night and

each day I would get more and more exhausted because I wasn't sleeping. (#4, 2004, p. 31)

Several participants described a need to "spend time being cared for" so they could "go face the week." Another participant talked about reconnecting with old friends, as "I did not have to defend myself to them as they know me."

sometimes I just need my mom to take care of me, so it is nice to go over to their place for a Sunday dinner and just be pampered. (#2, 2004, p. 11)

It's kind of a nurturing thing, reconnecting with several old friends, they know me and I feel like I do not have to defend myself with them. (#2, 2004, p. 41)

All participants mentioned a form of **hyper vigilance** in which they felt "overly aware" of what was going on in the community. They indicated this was either because of knowledge from their own caseload, or through their team's files, or by what other community agencies were passing on to them. However, this "awareness" left participants feeling they were never very far from work. Participants talked of times when they were out in the community and "click" they suddenly went into a "work mode" because they "heard a parent yelling or a couple arguing".

at what point does a social worker become a reporter, because if I see something, ...I step in. (#1, 2004, p. 27)

...it would be real nice to go out as a family and not have to be worried what everyone else is doing...but when you have that knowledge...it's not like I can go home and say, okay, I'm no longer a social worker as of 4:30 p.m....you are always a social worker. (#3, 2004, p. 19-20)

Several participants discussed having a need for control. They described it in relation to helping protect themselves, "I need to control what is around me so I do not feel so vulnerable" (#2, 2004, p. 27).

Like, I don't want to be accommodating at all when I am at home...so when at home I am controlling because I am trying to protect myself. (#2, 2004, p. 27)

when I am at home I am a control freak, I have to control everything, it's probably because I have so little control at work. (#2, 2004, p. 27)

A number of participants indicated that they drink as a form of stress relief; some saw this as just a matter of fact, that after a stressful day at the office one would go out for a drink. However one participant expressed some concern around the use of his/her own drinking as a "de-stressor" as well as referring to concerns for past co-workers' levels of drinking to cope with stress. Several participants describe "reaching" for food when they felt stress at work. They indicated they would respond when things were not going well or when they did not feel good about work by eating. All participants were also quick to point out that there usually is an ample amount of "junk food like donuts, candies and cookies" in their offices, which "does not help."

there are lots of people in my office who say that is how they relieve stress – they drink. (#2, 2004, p. 43)

I find at times I drink too much and I think it is a problem a lot of people have at work. (#1, 2004, p. 31)

However most participants described using a number of positive coping strategies. Several reported that while they may be "reaching for that donut" they were also actively going to the gym or running as a form of stress relief and positive self-care. Other participants talked of using the Employee Assistance Program (EAP) to support them through some difficult times at work and to help deal with the multitude of stressors in their lives.

Participants experienced some real physical effects. **Headaches** including **migraines**, **breathing difficulties**, **rapid heartbeat**, feelings of **tension**, and

miscellaneous **aches and pains** were all described by each participant. Another strong theme that ran throughout all the participant interviews was the feeling of being **physical exhausted** by day's end. Participants related how these tension pains, headaches, not eating, and poor sleeping patterns would accumulate and leave them "physically exhausted."

Sometimes I go down to my car, turn on the stereo and have a 30-minute catnap. (#1, 2004, p. 10)

I ended up with an instant headache at work. I probably had them about 20 out of the 30 days in a month when they were at their worst. (#2, 2004, p. 38)

my doctor diagnosed it as tension headaches, sounds weird...sort of like headaches that I would get all the time and mainly it's because of stress...from work. (#2, 2004, p. 24)

I was sitting in this one meeting...having to make a decision...I felt pressure on my chest...a real constriction, I had to leave. (#1, 2004, p. 21)

my blood pressure was 137 over 110, so I was being physically affected by work. I took time off to re-evaluate. (#1, 2004, p. 21)

I could feel everything tense up. (#2, 2004, p. 38)

I feel the stress, like a weight on me, like a backpack. (#1, 2004, 29)

I feel tense just talking about work. (#2, 2004, p. 44)

I breathe to get organized, so I don't feel teary and don't panic. (#4, 2004, p. 16)

I was tired, I was exhausted, I wasn't sleeping well...I was getting headaches because I wasn't eating...I felt like, I felt I was in this *Arrrgghh*... (#4, 2004, p. 31).

## Chapter Five

### Analysis, Discussion, and Recommendations

#### **Analysis**

The literature indicates that child protection workers are at risk of compassion fatigue, both from what they witness first-hand and from the cumulative effects of secondary traumatic stress (Anderson, 2000; Bride, 2007; Conrad & Kellar-Guenther, 2006; Figley, 1995; Horwitz, 2006).

The finding that the MCFD child protection workers who participated in this study were at significant risk for STS was not surprising. In view of the findings from the “self-test” showing that 64% of child protection workers are at extremely high risk of compassion fatigue, a level that rises to 80% when extremely high risk and high risk are combined, we should be concerned for the well-being of Ministry child protection workers and the Ministry as a whole. It was surprising, however, that, while all participants did express various symptoms of burnout, such as strong levels of frustration with the Ministry, feelings of depersonalization, and a sense of being overwhelmed due to caseload sizes and workload, this did not translate into a high risk for burnout on the self-test.

One possible explanation for the lower burnout rates in this study may be that a number of workers DID get burnout, recognized this, and moved into other non-protection positions within the Ministry or left the job altogether. With an annual turnover rate of about 11% (Perrin, 2006) for child protection workers, this could be a compelling explanation. This appears to be a limitation of the study: Since it only included practitioners still working in the field and did not include any former child protection workers, the study cannot be an accurate source of data on burnout. Rather, it is a study that informs us primarily about the cumulative effects of secondary traumatic stress experienced by front line child protection workers.

During the interviews participants reflected on the numerous details of child protection work. They described the day-to-day pressures of managing a caseload and dealing with traumatic events or traumatized people. From their responses, three major categories emerged: **Professional issues** relating to case practice and effectiveness; the **Personal impacts** of child protection work on the way workers function, both on the job and in their private lives; and **Behavioral or Physical changes** experienced by child protection workers. It is these categories that best illustrate the dramatic way secondary trauma affects child protection workers as a whole.

Regarding **professional issues**, cognitively participants described a sense of diminished concentration and feelings of confusion and whirling thoughts. They also reported a sense of apathy, rigidity, and a tendency to minimize issues. However, participants mostly reported feelings around a reduction in their own self-confidence and a loss of purpose and meaning in their role as child protection workers. This self-doubt has workers continually questioning their decisions and actions leading to a further undermining of their confidence and even greater questioning of their role and fit with the Ministry.

Perfectionism, along with the MCFD's high standards and accountability, leave many workers feeling overwhelmed. In other words, it is their own perfectionism and high expectations, coupled with the high expectations that the MCFD has of its staff, that hold a real risk for the workers. In order to meet these standards, they try to meet all the expectations – however unrealistic – that are out there and so start to become overwhelmed.

This sense of being overwhelmed equates to feelings of frustration, physical exhaustion, being emotionally drained and not able to “cope with anything else.” These feelings can lead to isolation and conflict with co-workers and loved ones, presenting still further stressors. Again, extra stress leading to a sense of being overwhelmed and feelings of powerlessness can result in worker apathy and reactionary practice. Participants expressed this internal conflict as a general questioning of the system and reflecting on the lack of clarity around

Ministry vision, purpose, and goals.

It is evident that trauma experienced by child protection workers stays with them. Participants described how the traumatic events of the day can remain with them and slowly erodes them emotionally. All participants told of preoccupation with work and an inability to let work go, often keeping them stuck back at the office.

Fears and anxiety were another strong theme raised. Of concern is how these fears and anxieties can overwhelm workers, affecting their ability to make decisions and so directly impacting the children and families they are trying to service.

Overall, the participating professionals described various impacts on their sense of self-esteem and sense of control, such as:

- Difficulty in maintaining a sense of self-esteem.
- Feelings of self-doubt and a lack of confidence.
- A sense of cynicism, doubt, and self-protection.
- Feelings of being overwhelmed and a sense of being powerless.
- Feeling less in control of various aspects of ones own life.
- Feelings of being overwhelmed by the system and workload.
- Feelings of guilt that one could do more in a given situation.
- The need to be more controlling in one's own life to compensate for a perceived lack of control in the workplace.

Regarding **personal issues**, the most often reported were feelings of loneliness and isolation from friends and family, intolerance, irritability, mistrust, and guilt. Withdrawing from social activities, avoiding phones, and “needing space” all exemplify the theme of workers isolating themselves and manifesting a form of disconnection from the community and the supports around them. Themes around increased conflict with a spouse and co-workers were evident in the interviews.

Participants also described various impacts on their sense of intimacy, such as:

- Feelings of difficulty in spending time alone or with others.
- Feeling the need to fill time with distractions, such as superficial relationships, self-medication with food and drink, engaging in compulsive behaviors such as exercise.
- Withdrawing from others and only wanting to associate with co-workers; or just the opposite, not wanting to spend time with colleagues as “all we do is talk about work.”
- Decreased interest in intimacy or sex.

Related impacts on participants’ sense of trust and sense of safety were also described, such as:

- Feelings that no one can be trusted and that the world is doomed.
- Disruptions in trust of others, difficulty developing trusting relationships. (“We lose the ability to trust others – clients, friends, and family.”)
- Feeling jaded and cynical.
- Doubting one’s own judgment.
- Feeling of increased vulnerability in the community.
- Excessive concerns around personal safety.
- Increased fears for their own children or spouse.

Of interest was the fact that several participants expressed a strong sense of spirituality. This theme seemed to provide those workers with a strong sense of support and purpose.

All participants described multiple **behavioral and physical changes**, such as:

- Rapid heartbeats, the rush of adrenaline and a fight or flight response, breathing difficulties, headaches and migraines.
- Feelings of being over stimulated.

- Feelings of tension and physical exhaustion.
- Aches and pains.
- Sleep disturbances.

So, it seems clear that the high levels of stress experienced by child protection workers impacts them on a concrete physical level. It appears these symptoms are warning signs that should be heeded by the workers and the MCFD. Left untreated, these symptoms can hasten the deterioration of the body leading to a far greater number of more serious impacts related to STS.

Beyond the professional, personal, and physical impacts of STS, a number of other issues emerged from the study. The design of the child protection system itself contributes to heightened stress levels, particularly the combination of high demand, low support, and little control over decisions and the flow of work. Consequently, those in government and management need to be mindful of the unusually challenging environment where child protection workers practice. As the identified literature clearly indicates, the work setting, specifically the organizational structure and management of the child welfare agency, greatly contributes to the workers' stress levels (Collings & Murray, 1996; Hansung & Stoner, 2008; Regehr et al., 2004)

The interviews revealed that practitioners were stressed by the lack of resources needed to provide basic, let alone high quality services. They felt that inadequate resources limited a child protection worker's capacity and effectiveness in achieving his/her main mission, that of ensuring the safety and well-being of children.

## **Discussion**

The themes raised in the interviews and the data in the literature are telling us that the risks of experiencing symptoms of STS are almost a certainty for a child protection worker. Child protection workers engaged in direct practice will be exposed directly and indirectly to traumatic events through their work with

children and families. If secondary traumatic stress is not addressed, it will continue to adversely affect child protection workers in the MCFD eroding their ability to provide effective casework.

One can conclude from the research that it can be painful to face the anxiety, the powerlessness, the emptiness, the grief, the anger, and the sadness that accompanies dealing with neglectful and abusive families (Dwyer, 2007; Regehr et al., 2004; Stanley et al., 2007)

The stresses and the impacts of STS faced by child protection workers can be viewed as akin to a giant whirlpool in the sea of child protection. The workers are all in the proverbial deep end treading water to cope with the pressures, stresses, and trauma of their daily role. Workers are left circling this whirlpool, waiting for that one last rogue wave that can be the push that sucks the worker into the vortex. This wave can be almost anything, from a traumatic event, an intimidating threat, a critical incident, a conflict with a co-worker, a demand for excessive documentation, a life event, or a personal situation such as a serious illness.

## **Conclusion**

There can be no doubt that child protection workers are affected by secondary traumatic stress and that the quality and ability to provide services is affected by STS. We may therefore conclude that understanding the impact of secondary traumatic stress on child protection workers is critical on a variety of levels. Understanding this on a personal level can highlight educational needs, assist us with building on individual strengths, lead to the development of personal strategies to help child protection workers manage within their workplaces, and facilitate the provision of ethical and effective services. Additionally, this knowledge can be used to assist in advocating for social and institutional changes that can help workers maintain their well-being and ensure effective, ethical case practice.

While this study did not examine whether STS was the reason why child protection agencies experience such high turnover rates, I believe given the high personal, professional, and physical costs associated with STS, one could safely conclude this is a major factor. These multiple costs and the consequent staff turnover combine to adversely affect the child welfare system as a whole, undermining the morale of remaining staff. I also believe that associated with the high turnover rates are the pressing issues of the identified short-term and long-term emotional and physical disorders, strains on interpersonal relationships, professional impacts and costs of not attending to the insidious way STS affects child protection workers. If it is not recognized and responded to, STS may derail the primary mission of the child welfare system – assuring the safety and well-being of children.

Child protection workers are especially skilled at dealing with difficult issues. However, the impact of STS on child protection practice seems to be overlooked by both workers and employers. Although many workers seem quite aware of the negative effects of STS on their practice, I believe more needs to be done by all levels – the workers, supervisors, managers, policy-makers, and the Ministry – in order to counteract these deleterious effects.

Finally I believe there is a triad of responsibility: first, that of the individual (knowledge provides understanding that can result in more adaptive coping skills); second is that of the agency or organization (knowledge again provides understanding so the organization can be more supportive in its response to workers and thus help mitigate STS); and, finally, that of government and policy-makers (again, understanding to provide knowledge so policy and new programs can take STS into account).

**Recommendations:****1. Increase understanding and knowledge of STS across the province.**

In order to confront the realities and impacts of STS, MCFD administrators will need to recognize and deal with STS in a systemic way. This begins with increasing knowledge, understanding, and responsibility for STS throughout the Ministry. My hope would be that comprehensive and continued understanding of STS and its potentially harmful effects will lead to acceptance and normalization of workers' needs and rights to seek out supports for their own professional, personal, and physical well-being.

**2. Create a provincial prevention program and support regular use and encouragement of the Employee Assistance Program (EAP).**

In order to mitigate the negative affects of STS, policies that are consistent with current research and knowledge of the risks and prevention of STS must be put in place. Any prevention program should be mandatory and ongoing after any critical incident, such as the regular use of the EAP to meet with staff members on a regular basis (individually, team meeting, retreat day). The program should not be limited to child protection workers alone, but should include all staff in an office (administrative, support staff, supervisors, etc.). In addition, regular use of the EAP to provide supports, insights, and understanding on STS should be encouraged.

**3. Initiate frequent and regular clinical supervision for front line staff as well as for their supervisors.**

Clinical supervision can be a powerful support in preventing STS (Dill, 2007). Allowing child protection workers the opportunities for supervision encourages them to reflect on their decision-making, practice, client relationships, and their reactions to difficult families. It, moreover, allows workers the time and space that they need to gain insight into their case practice and interactions with their clients. The team leader is a pivotal position in MCFD, they

are in the best position to understand the demands made on workers and can advocate for both workers and clients. A strong clinical supervision model will support and strengthen professional decision-making and help to maintain ethical case practice. Team leaders are themselves front line workers and should also be offered direct clinical supervision. As well, organizational support for clinical supervision will require ongoing education and support and should be part of a comprehensive clinical supervision program.

#### **4. Provide adequate financial incentives and rewards for child protection workers to remain on the front line.**

The fact that pay levels that do not accurately reflect the high demands and stresses of child protection leads to a significant disincentive for experienced workers to remain in their role as front line child protection workers, especially when they have options within the Ministry to move to alternative positions with lower stress and the same pay. For the majority of workers, front line child protection is the entry-level position within the Ministry. The MCFD seems structured to offer the more experienced practitioner careers opportunities “out” of front line child protection practice. So organizationally, the career structures appear to encourage workers to move away from direct practice. In order to encourage experienced front line child protection workers remain in their roles, MCFD needs to promote front line child protection and increase compensation and opportunities. Otherwise child protection teams throughout the province will continue to struggle with novice and inexperienced workers in front line positions, thus raising concerns about the supports for staff, the implications for service delivery and, ultimately, the safety and well-being of children. MCFD should strongly consider developing “senior” practitioner positions to promote child protection remaining in a frontline role. These senior practitioner positions should be promotional opportunities in that they offer workers a high wage scale, provide opportunities such as mentoring, community development etc... These senior practitioner roles would allow MCFD to invest and ensure that skill senior workers

remain doing frontline child protection. Highly skilled frontline child protection workers are valuable and strong assets for the Ministry and should be prized as such. These senior practitioners can be invaluable supports to new hires, providing mentorship, take on the more difficult case files and provide leadership and support to their colleagues. The BC government and service employees' union could also be a strong advocate in promoting a "senior" practitioner role again this would support that child protection is a highly skilled job and incentives and promotional opportunities are needed to see its' members remain in these critical roles.

#### **5. Build worker capacity and worker retention.**

If the MCFD wants to improve worker retention and build capacity within child protection, it must design career options for the novice child protection worker to become an advanced/senior practitioner while still remaining on the front line. As the research shows, the chronic stressors of STS contribute to an extraordinarily high average two-year staff turnover rate (Drake & Yadama, 1996; Perrin, 2006; Regehr et al., 2000). Consequently, salaries, job classifications, and working conditions in child protection should fully recognize the value, demands, and stresses of the job. MCFD should further develop its job classification structures and link to appropriate salary scales to provide multiple career advancements within front line practice. It should also recognize that child protection work is a highly specialized field requiring significant levels of knowledge found in allied scientific, technical, and medical fields. MCFD, by investing in developing frontline skills, could promote and support its staff and thereby ensure the longevity of their MCFD involvement. MCFD needs to provide child protection workers with the incentive to further their knowledge and broaden their expertise by allowing workers to upgrade their qualifications so they can advance to the next level. It should provide opportunities for workers to further develop specialized skills in particular aspects of working with children and families (e.g., forensic interviewing, collaboration, advanced decision-making,

practice supervision, etc). I believe these measures would give child protection workers the opportunity and desire to build skilled career capacity would encourage long term personnel retention in the recommended role of advanced/senior practitioners.

#### **6. Communicate a strong vision, purpose, and clear goals.**

The MCFD needs to provide the front line with a clear overriding vision and purpose that workers can “rally around” to gain a sense of grounding when those times of intense questioning arise. Vision and purpose need to be strongly emphasized and linked to service delivery and practice so novice and senior workers alike can clearly see their “fit” within the Ministry. Creating a succinct, clear policy framework can combat role ambiguity and promote greater worker contentment with the organization. Without role clarity and a clear sense of “fit” for a worker, feelings of depersonalization, role ambiguity, chronic stress, and conflict will persist and these negative working experiences will leave child protection services in a continuing retention crisis (Drake & Yadama, 1996)

#### **7. Provide strong support for new hires.**

MCFD needs to be mindful of the particularly challenging environment that newly hired workers enter and cognizant of recruitment and retention problems. In this study participants often remarked that they observed that new workers were often unprepared for the emotional intensity of the role and were consequently vulnerable to the negative impacts of STS. New hires should start with the clear expectation that they will be mentored by a senior practitioner and work with their mentor in a case support role for a period of no less than six months. During this period of time, they should receive core MCFD training and gradually build up to a full child protection caseload.

**8. Recognition of the negative impacts of STS on office culture.**

The MCFD as a whole needs to recognize fundamentally that STS has negative impacts on child protection workers and has potentially negative influences on office culture. One cannot presume that an office or the system as a whole can engage in an intelligent process of working through anxieties about differences in culture and priorities will necessarily occur given the negative symptoms and anxieties associated with STS. So, in order to effectively address a negative office culture one also will need to address STS and its impacts on the office

**9. Increase a sense of support and safety around change.**

Government and managers need to recognize that at least until the “dust settles” from any organizational changes, child protection workers are left in restless or unsettled environments. Any major inquiry can often be accompanied by negative media coverage of child protection workers. According to the participants in this study, this can lead to a “climate of fear,” “blame,” and mistrust which seems to have reached epidemic proportions within the MCFD. The “culture of blame” is a force that is ever-present in a child protection worker’s mind and currently holds a powerful place within the collective memory of the MCFD. To date, there have been several recent inquiries (Gove, 1995; Hughes, 2006) into the Ministry’s “failures.”

Such inquiries play a mixed role. On the one hand, openness and public accountability are paramount in a government child protection system. It can improve practice quality by addressing systemic causes of poor outcomes and support a client-focused practice. However on the other, increased scrutiny can also undermine the quality of practice by focusing on faultfinding, or sudden policy shifts that prove unworkable and unachievable, not forgetting the often-negative media coverage of child protection workers. MCFD needs to help prevent systemic “pendulum swings” by focusing on sustainable practice rather than extreme swings from a family-focused to a child-focused practice model. A

practice model should be developed that works with the strengths of families but does not forget the legal mandate to protect children from harm. MCFD needs to avoid these swings by constantly reviewing its practice and allowing it to evolve based upon best practice and strong research.

**10. Increase understanding at the university level.**

The university programs that offer child protection and child welfare education and training, need to develop courses that assist students to understand the realities of the work that they will be undertaking and help them to understand the health and wellness risks and the impacts of STS on child protection workers. The role of the child protection worker is unique and comes with high emotional and mental demands. Students should be educated about the demands of this work and about the specifics of self-care that speak directly to the demands of this job. Knowledge about STS and the prevention of the fallout of STS should be integrated into child protection practicum training.

**11. Increase the BC Government Service and Employees' Union's advocacy role to include lobbying for specific assistance for workers with STS**

MCFD child protection workers are part of the BC government and service employees' union. The BCGEU has always advocated for its members and has a role in supporting frontline child protection workers in helping to prevent and mitigate the effects of STS. The BCGEU, through an education campaign could work with the employer to increase knowledge, understanding and awareness of STS and its impacts on frontline workers. The BCGEU, through collective bargaining, could advance the knowledge of the impacts of STS and advocate for increased wages, senior practitioner positions, educational opportunities and other support benefits.

**12. Provide support for STS by working on these issues at a systemic level from a social justice perspective.**

MCFD needs to recognize that the design of the child protection system itself contributes to heightened stress levels. The combination of high demand, low support, and little control over decisions and the flow of work create systems based stresses. Consequently, administration and management personnel need to be mindful of the unusually challenging environment within which child protection workers practice. Workers and clients face many of the same barriers, inequities and injustices and neither group should be blamed for the social conditions and structural inequities that are the context and often a part of the cause of their suffering. Policy makers and politicians, those who create the laws and structures that regulate child protection practice, need to recognize that workers were inordinately stressed and their clients inordinately disadvantaged by the lack of resources needed to provide basic, let alone high quality services and that inadequate resources limit child protection workers' capacities and effectiveness in achieving their main mission, that of ensuring the safety and well-being of children.

**Personal reflection**

I see myself as a competent and accomplished senior child protection worker, yet I still experience numerous feelings, anxieties, and conflicts that constantly interfere with my own effective case practice: anxieties about dealing with difficult or angry clients, my own denial or inhibition of anger, my own fear of difficult decisions, my sense of a lack of support, my feelings of incompetence, denial or projection of responsibility, my difficulties separating personal from professional responsibility, my feelings of being a victim, my feelings of total responsibility for the families on my caseload, my ambivalent or angry feelings towards clients and about one's professional role and the need to be in control.

I know many competent workers who seem to be circling the "big black whirlpool" each day, and are just waiting for the one element that will send them

spiraling down. Their dedication to the children and families they serve is admirable. Unfortunately, many seem to be “just hanging in.” Emotionally and physically they are fragile. Although many workers seem quite aware of the negative effects of STS on their practice, I believe more needs to be done by all levels to reduce its negative impacts on workers, practice, and clients through the triad of responsibility – individual, organizational, governmental – discussed previously.

Finally, I recall sitting in the staff room one coffee break. A veteran worker and staff comedian was telling a humorous story about a client. This “black humor” is not uncommon in many offices and social service agencies, but on this particular day we began to talk about this thing called black humor. This individual then made a comment that has long since stayed with me. He said, “you either joke about it or you cry about it.” This comment contains a simple truth about the stresses of child protection: A worker either finds a way to cope with the constant traumatic stories or the trauma overwhelms them.

Therefore, it is imperative that the child welfare system gains a greater understanding of STS and its potentially devastating impacts on front line workers so it can begin to combat the risks and support workers in their efforts to remain healthy. The literature reveals a clear gap in qualitative understandings of secondary traumatic stress. To date, a phenomenological study focusing on the descriptive experiences of child protection workers struggling with secondary traumatic stress has not been published. It is my belief that a phenomenological research study of STS experienced by child protection workers will add to the understanding of secondary trauma research. It would stand to reason that in gaining an understanding of the child protection workers’ experiences we would begin to learn more about how workers maintain effective case practice.

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## APPENDIX A – DISTINCTIONS BETWEEN STS AND PTSD

### Suggested Distinctions Between the Diagnostic Criteria for Primary and Secondary Traumatic Stress Disorder

Primary	Secondary
<p><b>A. Stressor</b> Experienced an event outside the range of usual human experiences that would be markedly distressing to almost anyone; an event such as:</p> <ol style="list-style-type: none"> <li>1. Serious threat to self</li> <li>2. Sudden destruction of one's environs</li> </ol> <p><b>B. Reexperiencing Trauma Event</b></p> <ol style="list-style-type: none"> <li>1. Recollections of event</li> <li>2. Dreams of event</li> <li>3. Sudden reexperiencing of event</li> <li>4. Distress of reminders of event</li> </ol> <p><b>C. Avoidance/Numbing of Reminders</b></p> <ol style="list-style-type: none"> <li>1. Efforts to avoid thoughts/feelings</li> <li>2. Efforts to avoid activities/situations</li> <li>3. Psychogenic amnesia</li> <li>4. Diminished interest in activities</li> <li>5. Detachment/estrangements from others.</li> <li>6. Diminished affect</li> <li>7. Sense of foreshortened future</li> </ol> <p><b>D. Persistent Arousal</b></p> <ol style="list-style-type: none"> <li>1. Difficulty falling/staying asleep</li> <li>2. Irritability or outbursts of anger</li> <li>3. Difficulty concentrating</li> <li>4. Hypervigilance for self</li> <li>5. exaggerated startle response</li> <li>6. Physiologic reactivity to cues</li> </ol>	<p><b>A. Stressor</b> Experienced an event outside the range of usual human experiences that would be markedly distressing to almost anyone; an event such as:</p> <ol style="list-style-type: none"> <li>1. Serious threat to traumatized person (TP)</li> <li>2. sudden destruction of TP's environs</li> </ol> <p><b>B. Reexperiencing Trauma Event</b></p> <ol style="list-style-type: none"> <li>1. Recollections of event/TP</li> <li>2. Dreams of event/TP</li> <li>3. Sudden reexperiencing of event/TP</li> <li>4. Reminders of TP/event distressing</li> </ol> <p><b>C. Avoidance/Numbing of Reminders of Even</b></p> <ol style="list-style-type: none"> <li>1. Efforts to avoid thoughts/feelings</li> <li>2. Efforts to avoid activities/situations</li> <li>3. Psychogenic amnesia</li> <li>4. Diminished interest in activities</li> <li>5. Detachment/estrangements from others.</li> <li>6. Diminished affect</li> <li>7. Sense of foreshortened future</li> </ol> <p><b>D. Persistent Arousal</b></p> <ol style="list-style-type: none"> <li>1. Difficulty falling/staying asleep</li> <li>2. Irritability or outbursts of anger</li> <li>3. Difficulty concentrating</li> <li>4. Hypervigilance for TP</li> <li>5. exaggerated startle response</li> <li>6. Physiologic reactivity to cues</li> </ol>

## APPENDIX B – COMPASSION FATIGUE SELF TEST

### Compassion Fatigue Self Test for Social Workers

Name \_\_\_\_\_ Office \_\_\_\_\_ Date \_\_\_\_\_

Please describe yourself: \_\_\_ Male \_\_\_ female; \_\_\_ years as practitioner. Consider each of the following characteristic about you and your current situation. Write in the number for the best response. Use one of the following answers:

**1=Rarely/Never 2=At Times 3=Not Sure 4=Often 5= Very Often**

Answer all items, even if not applicable. Then read the instructions to get your score.

Items About You:

1. \_\_\_ I force myself to avoid certain thoughts or feelings that remind me of a frightening experience.
2. \_\_\_ I find myself avoiding certain activities or situations because they remind me of a frightening experience.
3. \_\_\_ I have gaps in my memory about frightening events.
4. \_\_\_ I feel estranged from others.
5. \_\_\_ I have difficulty falling or staying asleep.
6. \_\_\_ I have outbursts of anger or irritability with little provocation.
7. \_\_\_ I startle easily.
8. \_\_\_ While working with a victim I thought about violence against the perpetrator.
9. \_\_\_ I am a sensitive person.
10. \_\_\_ I have had flashbacks connected to my clients.
11. \_\_\_ I have had firsthand experience with traumatic events in my adult life.
12. \_\_\_ I have had firsthand experience with traumatic events in my childhood.
13. \_\_\_ I have thought that I need to "work through" a traumatic experience in my life.

14. \_\_\_ I have thought that I need more close friends.
15. \_\_\_ I have thought that there is no one to talk with about highly stressful experiences.
16. \_\_\_ I have concluded that I work too hard for my own good.
17. \_\_\_ I am frightened of things a client has said or done to me.
18. \_\_\_ I experience troubling dreams similar to those of a client of mine.
19. \_\_\_ I have experienced intrusive thoughts of sessions with especially difficult clients.
20. \_\_\_ I have suddenly and involuntarily recalled a frightening experience while working with a client.
21. \_\_\_ I am preoccupied with more than one client.
22. \_\_\_ I am losing sleep over a client's traumatic experiences.
23. \_\_\_ I have thought that I might have been "infected" by the traumatic stress of my clients.
24. \_\_\_ I remind myself to be less concerned about the well-being of my clients.
25. \_\_\_ I have felt trapped by my work as a Social Worker.
26. \_\_\_ I have felt a sense of hopelessness associated with working with clients.
27. \_\_\_ I have felt "on edge" about various things and I attribute this to working with certain clients.
28. \_\_\_ I have wished that I could avoid working with some therapy clients.
29. \_\_\_ I have been in danger working with therapy clients.
30. \_\_\_ I have felt that my clients dislike me personally.

**Items About Being a Social Worker and Your Work Environment:**

31. \_\_\_ I have felt weak, tired, rundown as a result of my work as a Social Worker.
32. \_\_\_ I have felt depressed as a result of my work as a Social Worker.
33. \_\_\_ I am unsuccessful at separating work from personal life.
34. \_\_\_ I feel little compassion toward most of my coworkers.
35. \_\_\_ I feel I am working more for the money than for personal fulfillment.

36. \_\_\_ I find it difficult separating my personal life from my work life.
37. \_\_\_ I have a sense of worthlessness/disillusionment/resentment associated with my work.
38. \_\_\_ I have thoughts that I am a "failure" as a Social Worker.
39. \_\_\_ I have thoughts that I am not succeeding at achieving my life goals.
40. \_\_\_ I have to deal with bureaucratic, unimportant tasks in my work life.

**Scoring Instructions:**

(a) Be certain you responded to all items, (b) Circle the following 23 items: 1-8,10-13, 17-26, and 29. (c) Add the numbers you wrote next to the items, (d) Note your risk of Compassion fatigue:

26 or less = Extremely low risk; 27 to 30 = Low risk; 31 to 35 = Moderate risk; 36 to 40= High risk; 41 or more = Extremely high risk.

Then, (e) Add the numbers you write next to the items not circled, (f) note your risk of burnout:

17-36 or less = Extremely low risk; 37-50 = Moderate risk; 51-75 = High risk; 76-85 = Extremely high risk.

Scores for this instrument emerged using a sample of 142 psychotherapy practitioners attending workshops on the topic during 1992 and 1993. Psychometric properties of the scale are reported by Stamm and Vara (1993).

Alpha reliability scores ranged from .94 to .86; structural analysis yielded at least one stable factor which is characterized by depressed mood in relationship to work accompanied by feelings of fatigue, disillusionment, and worthlessness. Structural Reliability (stability) of this factor, as indicated by Tucker's Coefficient of Congruence (ec), is .91.

## APPENDIX C – PARTICIPANT CONSENT FORM

**University of Victoria**

***Office of the Vice-President, Research  
Form Human Research Ethics Committee***

***Participant Consent***

**The Other side of Child Protection, “The lived experiences of front line Child Protection Workers.”**

You are being invited to participate in a study entitled "The Other side of Child Protection: The lived experiences of front line child protection workers," that is being conducted by Michael Gough. I am a Graduate student in the department of Child and Youth Care at the University of Victoria and I also currently work for the Ministry of Children and Family development as a Intake/Investigations Child protection worker. As a Graduate student, I am required to conduct research as part of the requirements for a Masters degree in Child and Youth Care.

The purpose of this research topic is to examine the "lived experiences" of emotional trauma experienced by Child Protection Workers and how this trauma is incorporated to shifting core beliefs. I am curious whether and how workers reconstitute their lives in order to be psychologically and physically healthy while experiencing some level of compassion fatigue. I anticipate that Child Protection Workers may be grappling with the difficult task of integrating these experiences into previously held core beliefs (i.e. good vs. evil; hope vs. despair; safety vs. vulnerability; anger vs. compassion) and may be struggling with physical, psychological, and social effects as well.

Specifically, the research objectives are as follows: (a) to explore the Child Protection Workers' perceptions of their sense of self, their world view, and any behavioral, cognitive, physical, and emotional experiences that they may attribute to their Child Protection Work, (b) to describe issues of particular concern to Child Protection Workers, and (c) to identify the coping resources and strategies child protection workers use to either prevent or manage any adverse effects of Child Protection Work.

I am only seeking volunteers for my study in the selected area of Child Protection and I am hoping that you will be consider being one of those volunteers.

If you agree to voluntarily participate in this research, your participation will include:

- 1) completing the "Compassion Fatigue Self Test" questionnaire in which participants rate themselves on a scale of one to five to best fit each question on how work experiences affects them personally.
- 2) Agreeing to have your work supervisor rate the coping of your work experiences.
- 3) You may be one of five participants selected to be part of several in depth interviews.
- 4) The five participants will then be asked to collaboratively interpret their interviews and review the findings with the researcher.

Participation in this study may cause some inconvenience to you, including time requirements and dealing with a sensitive subject.

There are some potential risks to you by participating in this research and they include being asked to describe difficult work experiences and the possibility of feeling "vulnerable" and how this information might affect you in the work place.

To prevent or to deal with these risks the following steps will be taken. Sufficient debriefing time will be made available to participants after each interview. Follow - up communication with participants will occur to allow for additional debriefing if need be. Also available to each participant will be counseling sessions through the ministries Employee Assistance Program (EAP). Each research participant will be provided with the Ministry's EAP brochure and details of the program will be provided by the researcher.

The potential benefits of your participation in this research include adding to the understanding of secondary trauma research and in order to counter the impact of secondary traumatic stress in Child Protection.

Your participation in this research must be completely voluntary. If you do decide to participate, you may withdraw at any time without any consequences or any explanation. If you do withdraw from the study your data will not be used in the study and destroyed upon withdrawal.

Your confidentiality and anonymity will be protected. This will be done by changing all participants' names to numbers. Participants' names and numbers will be on a list kept in a locked box until the completion of the study. Supervisors will complete ratings on all of their staff and will not know who is participating and who is not. The protection of participants' privacy will be accomplished by changing any identifying features. Only I will know the identity of participants. Any assistants who help in the data collection and analysis will not be given the participant's identity. Any information that is obtained in connection with this study and that can be identified with you will remain confidential and will only be disclosed with your permission. All data will be kept in a secure place and no unauthorized person(s) shall have access. Once the study is complete, all data

will be destroyed. The qualitative data will include: interview transcripts, detailed descriptions, direct quotes, any correspondence and the researchers notes.

It is anticipated that the results of this study will be shared with others in the following ways; shared directly to participants, published article, thesis oral defense and a summary report back to MCFD with the offer of workshops.

If you have any questions, please feel free to contact me, Michael Gough, (250) 248-9468 or my thesis supervisor, Dr. Frances Ricks, (250) 721- 7211. In addition to being able to contact the researcher and supervisor at the above phone numbers, you may verify the ethical approval of this study, or raise any concerns you might have, by contacting the Associate Vice-President Research at the University of Victoria, Dr Howard Brunt, (250) 472-4362.

Your signature below indicates that you understand the above conditions of participation in this study and that you have had the opportunity to have your questions answered by the researcher.

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*Name of Participant*

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*Signature*

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*Date*

***A copy of this consent will be left with you, and a copy will be taken by the researcher.***

## APPENDIX D – SUPERVISORS CONSENT FORM

University of Victoria  
 Office of the Vice-President, Research  
 Form Human Research Ethics Committee

*Supervisors Consent*

**The Other side of Child Protection, “The lived experiences of front line Child Protection Workers.”**

You are being invited to participate in a study entitled "The Other side of Child Protection: The lived experiences of front line child protection workers," that is being conducted by Michael Gough. I am a Graduate student in the department of Child and Youth Care at the University of Victoria and I also currently work for the Ministry of Children and Family development as a Intake/Investigations Child protection worker. As a Graduate student, I am required to conduct research as part of the requirements for a Masters degree in Child and Youth Care.

The purpose of this research topic is to examine the "lived experiences" of emotional trauma experienced by Child Protection Workers and how this trauma is incorporated to shifting core beliefs. I am curious whether and how workers reconstitute their lives in order to be psychologically and physically healthy while experiencing some level of compassion fatigue. I anticipate that Child Protection Workers may be grappling with the difficult task of integrating these experiences into previously held core beliefs (i.e. good vs. evil; hope vs. despair; safety vs. vulnerability; anger vs. compassion) and may be struggling with physical, psychological, and social effects as well.

Specifically, the research objectives are as follows: (a) to explore the Child Protection Workers' perceptions of their sense of self, their world view, and any behavioral, cognitive, physical, and emotional experiences that they may attribute to their Child Protection Work, (b) to describe issues of particular concern to Child Protection Workers, and (c) to identify the coping resources and strategies child protection workers use to either prevent or manage any adverse effects of Child Protection Work.

As part of the screening in process the research is asking each of the participating offices Child Protection Supervisors to consent to rate all individual workers on how they are coping with their day to day practice. Each Supervisor will be asked to rate **all** Child protection workers on a one to five scale, five being best ability to cope with the day to day demands of the job and one being not effectively coping. All participants who complete the screening in tool will be told their Supervisors rating. In order to ensure participants anonymity you will not

have access to who participated in the study nor entitled to any of the data other than the final summary that will be presented to each participating offices.

Participation in this study may cause some inconvenience to you, including time requirements and dealing with rating a workers ability to cope with their daily practice.

There may be some potential risks to you by participating in this research and they include being asked to rate a workers ability to cope in their day to day practice and having that worker informed of your rating

The potential benefits of your participation in this research include adding to the understanding of secondary trauma research and in order to counter the impact of secondary traumatic stress in Child Protection.

Your participation in this research must be completely voluntary. Your confidentiality and anonymity can not be protected, as participants are informed that their Supervisors will complete ratings on all of their staff and made aware of those ratings.

It is anticipated that the results of this study will be shared with others in the following ways; shared directly to participants, published article, thesis oral defense and a summary report back to MCFD with the offer of workshops.

If you have any questions, please feel free to contract me, Michael Gough, (250) 248-9468 or my thesis supervisor, Dr. Frances Ricks, (250) 721- 7211. In addition to being able to contact the researcher and supervisor at the above phone numbers, you may verify the ethical approval of this study, or raise any concerns you might have, by contacting the Associate Vice-President Research at the University of Victoria, Dr Howard Brunt, (250) 472-4362.

Your signature below indicates that you understand the above conditions of participation in this study and that you have had the opportunity to have your questions answered by the researcher.

\_\_\_\_\_  
*Name of Participant*

\_\_\_\_\_  
*Signature*

\_\_\_\_\_  
*Date*

***A copy of this consent will be left with you, and a copy will be taken by the researcher.***