Stress, Trauma, and Support in Child Welfare Practice

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Introduction

A growing body of literature spanning three decades identifies the emotional impact of providing social work services. This process, defined as burnout, is viewed to encompass a variety of symptoms, including emotional exhaustion, loss of a sense of personal and professional accomplishment, diminished capacity to meet the needs of clients, and ultimately, job departure (Brunet, 1998; Cherniss, 1980; Maslach, 1982; Um & Harrison, 1998). Child welfare practice has frequently been identified as a particularly stressful field of practice with high risk of burnout (Anderson, 2000; Jayaratne, Chess, & Kunkel, 1986). Stressful aspects of the job include excessive work demands caused by unwieldy caseloads, court appearances, and overwhelming paperwork; poor working conditions; negative public perceptions; and low salary (Bradley & Sutherland, 1990; Collings & Murray, 1996; Gutterman & Jayaratne, 1994; Vinokur-Kaplan, 1991). Added to these administrative challenges are the difficulties associated with productively engaging involuntary clients and the awesome responsibility of protecting society's most vulnerable citizens (Munro, 1996; Lindsey & Regehr, 1993). Finally, child welfare practice is fraught with social and political pressures, including conflicting pressures of the best interest of the child, concerns for the parents, and shifting public policies (Guterman & Jayaratne, 1994). Child welfare workers are charged with balancing society's wish to protect children from abuse while maintaining the family as the bastion of liberty (Munro, 1996).

In addition to ongoing workload demands and sociopolitical pressures, child welfare workers are often confronted by traumatic events as a result of working in high-risk situations. These traumatic events can include threats or injury toward themselves and the injury or death of a child for whom the worker has responsibility. In recent years, there has been a growing recognition that exposure to tragic events results in traumatic responses in emergency service workers responding to the event (McFarlane, 1988; Solomon & Horn, 1986; Regehr, Hill, & Glancy, 2000). Symptoms described include recurrent dreams; feelings of detachment, guilt, anger, and irritability; depression; memory or concentration impairment; somatic disturbances; alcohol and substance use; and reexperiencing of symptoms when exposed to trauma stimuli (Gersons, 1989; Gibbs, Drummond, & Lachenmeyer, 1993; Solomon & Horn, 1986). Several of these authors have concluded that severe emotional reactions are normal responses to exposure to traumatic events in the line of duty.

Despite the attention to individual responses to traumatic events in emergency organizations (e.g., policing, fire, and ambulance), relatively little research has focused on trauma responses in child welfare workers. Interestingly, child welfare documentation, such as case records and abuse evidence photographs, have been considered so disturbing that one study discussed the traumatic responses encountered by researchers surveying charts of child maltreatment cases (Kinard, 1996). As a result, steps were taken to protect researchers from exposure to traumatic stimuli by limiting the amount of time spent reading the material. Further, when conducting follow-up interviews with some of the families, one of the researchers was threatened because the family member assumed that she was a child welfare worker. Clearly, the exposure for children's aid workers to both disturbing material and threats of violence is likely to be substantially higher.

A recent study investigating traumatic exposure in child welfare workers determined that vicarious events (i.e., stemming from proximity to clients' lives) were more highly associated with traumatic effects than were those stemming from verbal abuse and threats directed toward the worker (Horwitz, 1999). Several factors place child welfare workers at high risk of secondary or vicarious trauma. For example, the prolonged relationship that child welfare workers often have with the victims and perpetrators. A traumatic event, in the form of violence against a child, spouse, or the workers themselves, can thus be experienced as both a betrayal and a failure. In addition, child welfare workers are particularly vulnerable due to their capacity for empathic engagement. While empathy is a major resource in assessing and intervening with clients, research suggests that it also increases the risk of experiencing symptoms that parallel those of the victim (Figley, 1995; Kilpatrick, 1998). Further, police, fire, and other emergency workers report that they are most vulnerable to traumatic impact when the incident involves children (Beaton & Murphy, 1995; Regehr, Hill, & Glancy, 2000). Finally, child welfare staff members are at greater risk than other mental health and social work practitioners because they work primarily in people's homes, exposing them directly to violence and traumatic material without the physical and psychological safety of the office environment.

Several studies have pointed to the importance of social support as a mediator of workplace stress and burnout. In general, high levels of perceived social support have been found to be associated with lower levels of stress as well as higher levels of perceived personal accomplishment and self-esteem (Davis-Sacks, Jayaratne, & Chess, 1985; Um & Harrison, 1998). However, it appears that job support may not moderate the relationship between critical incidents encountered in the workplace events and the experience of trauma (Horwitz, 1999).

The present study explores stress and traumatic events in a child welfare setting. The purpose of the research is to develop a better understanding of the ongoing stressors, critical incident stressors, and traumatic events encountered by child welfare workers; to examine the consequences on individual workers of exposure to stress and trauma; and to discuss the impact of social supports on the experience of trauma.

Methodology

This research was conducted at the Children's Aid Society of Toronto, one of the largest board-operated child welfare organizations in North America. Data collection involved both qualitative and quantitative methods. The quantitative survey was distributed to all staff following meetings describing the nature of the study. Front line, clerical, and management staff returned a total of 175 questionnaires (described in this article). This represents approximately a

30% response rate from the entire agency. However, a higher response rate came for some areas. For instance, the response rate of intake social workers was closer to 50%. This is particularly high considering that a number of workers in this area had only recently been hired and did not complete questionnaires. Lower response rates were obtained for support staff members who provided fewer services directly to clients. Actual response rates are difficult to determine as data collection occurred over a 4-month period, during which there were varying numbers of vacancies and newly hired individuals.

Thirty-eight of the respondents were men and 135 were women (for 2 questionnaires, gender data were missing). Twenty-nine percent of the respondents were single, 58.6% were married or living common-law, and 12.4% were separated, divorced, or widowed. With regard to education, 26.5% had BSWs, 32.9% had MSWs, 12.4% had other university degrees, and 20.6% had college diplomas. The mean age of respondents was 40.8 years (SD 10.3) with an age range of 23 to 63. The mean number of years in child welfare was 12.7 (SD 9.3); however, there was tremendous variation in the number of years worked in child welfare by position. As indicated in Table 1, the median number of years worked in child welfare in intake positions was 1 while the median number of years worked in other social work positions was 12, and in management the median was 19.

Table 1: Years in Child Welfare

Position	Mean Number Years	Median Number Years
Intake social worker	2.3	1
Family service social worker	6.8	3
Other social worker	14.9	12
Child and youth worker	13	13
Clerical	13	15
Management	19.3	19
Other	13.7	13

Workers who participated in the quantitative portion of the study were asked if they would be willing to participate in a one-hour interview to further discuss their experiences. A subsample of 20 workers was selected for personal interviews. These interviews explored dimensions of ongoing stressors, traumatic stressors, and support systems. At the completion of the study, group meetings were held with members of three constituencies—management, volunteer front-line workers, and union executives—at which time the initial data were presented and reactions were obtained.

Quantitative Measures

Demographic data. Demographic data were collected using a questionnaire that covered items including age, sex, marital status, education, ongoing stressors, and exposure to traumatic incidents.

Posttraumatic reactions. This variable was measured by three scales: the Beck Depression Inventory, the Impact of Events Scale, and the Stress-Related Growth Scale. The Beck Depression Inventory is a self-report scale that assesses the presence and severity of affective, cognitive, motivational, vegetative, and psychomotor components of depression (Beck & Beamesderfer, 1974). Initially standardized on 606 psychiatric inpatients and outpatients, the reported reliability coefficient was .86. Test-retest reliabilities were .48 for psychiatric patients after 3 weeks and .74 for undergraduate students after 3 months. The BDI is now one of the most widely used measures of depression in both clinical practice and with nonclinical research populations.

The Impact of Events Scale (Zilberg, Weiss, & Horowitz, 1982) assesses the experience of posttraumatic stress for any specific life event. It taps dimensions that parallel the defining characteristics of Posttraumatic Stress Disorder (PTSD) in DSM-IV, that is, signs and symptoms of intrusive cognitions and affect, concurrently or oscillating with periods of avoidance and denial or blocking of thoughts and images. Cluster analysis has shown the two subscales to have high internal consistency with Cronbach's alphas of .78 and .82. Test-retest reliability is set at .87. A score of 26 or more is considered consistent with a diagnosis of PTSD (McFarlane, 1988; Lavie et al., 1998).

The Stress-Related Growth Scale measures positive outcomes of stressful events (Park, Cohen, & Murch, 1996; Cohen, Hettler, & Pane, 1998). The SRGS was tested on 922 students in the United States and a sample of adult church members. Reported alphas were .94 and .96, respectively. Test-retest reliability after 2 weeks was .81.

Social support. A situation-specific support measure was designed by the researchers. This addressed perceived support of family, friends, coworkers, supervisors, and managers. Participants were asked to rate the level of support they received from people in their personal lives and from colleagues in their organizations on a scale of 0-5, with zero representing no support and 5 being very supportive.

The Social Provisions Scale (SPS) is a brief (24 item) multidimensional self-report instrument that offers the possibility of discriminating among six distinct types of social support, and which also assesses global support (Cutrona & Russell, 1987). The measure was tested on a total of 1792 respondents, including psychology students, nurses, and teachers. The reported alpha level for the total scale was .91. Extensive validity testing was reported by the developers (Cutrona & Russell, 1987).

cont'd on page 14

Results

Ongoing Stressors

Participants were provided with a list of potential ongoing stressors in their jobs and were asked to indicate whether or not each of the items represented a stressor for them. The highest-ranked ongoing stressor was the quantity of work, which was rated as a stressor by 75% of respondents. Other highly endorsed items were documentation requirements (59.9%), dealing with difficult or disruptive clients (55.2%), and organizational change (50.6%). In addition, approximately one third of participants indicated that job stressors included conflicts with staff, supervisors, or managers; changing policies and standards; risk of civil or legal liability; court-related activities; public or media scrutiny; and/or lack of community resources. These are reported in Table 2.

Table 2: Ongoing Stressors

Type of Stressor	% Reporting
Amount of work	75.0%
Documentation	59.9
Difficult or disruptive clients	55.2
Organizational change	50.6
Conflicts with staff, supervisors, managers	39.5
Changing policies / standards	36.6
Risk of civil or legal liability	33.7
Court-related activities	33.1
Public or media scrutiny	32.2
Lack of community resources	31.6
Mandatory training	26.9
Travel	18.0
Conflict with community individuals	14.6

Qualitative information collected during interviews and consultation group meetings reinforced this data. It was noted that in response to recent increases in workload and accountability requirements, workers were expected to simultaneously and immediately attend to a large number of competing demands. As a result, respondents reported second guessing their decisions, exhibited concerns that clients' needs had not been met, and felt no sense of accomplishment in their work. In addition, some workers reported feeling disempowered by the requirements of the system and the pressures under which they worked. Respondents reported frequently working overtime to meet the excessive demands. This had negative implications for their personal health and for their family life. Many reported concern about not adequately meeting their responsibilities to their own children.

Other ongoing stressors reported by workers included negative and scathing publicity by the media about the agency, or about particular workers, or both. Workers also expressed frustration about the lack of time available to work directly with families, and expressed concern that their work was focused more on meeting the needs and requirements of legislation rather than providing service to clients. Further, concerns were expressed about the high turnover, the addition of many new workers, and the agency's inability to properly train personnel. Supervisors experienced the increased responsibility of reviewing each step of every case for new workers. New workers expressed concerns that they did not possess the knowledge to manage all situations.

Critical Incident Stressors

Table 3 presents a list of events that respondents may have encountered during their work in child welfare. Respondents were asked to indicate whether they had encountered any of the listed events and whether they experienced emotional distress as a result of exposure to these event(s). A total of 145 or 82.7% of respondents indicated that they had been exposed to at least one critical incident at work, including the death of a child, the death of an adult client, and/or assaults and threats against themselves. Of the 145 CAS staff who reported exposure to these events, 101 or 70% indicated that they had experienced distress as a result of their exposure. This represents 58% of the total sample of 175.

Table 3: Traumatic Incident Stressors

Type of Incident	% Who Report Experiencing Item	% Who Report Distress
Death of a child in service due to accident	31.2%	21.5%
Death of a child in service due to abuse	*	77.8
Death of a child for whom you had service responsibility	24.9	62.8
Death of an adult client	20.8	50.0
Assault against self	23.7	26.8
Threats of violence against self	52.6	63.7
Threats or injury to other staff	46.8	50.6
Other serious event	22.5	78.2
Any traumatic event	82.7	70.0

***Researchers assumed that all employees had experienced a death of a child within the agency.**

The types of traumatic events encountered by respondents did not vary greatly by position. Approximately 20% of staff in all job categories had been victims of assault on the job at one time during their career. The exception was child and youth workers, of whom 70% reported having been assaulted on the job. In addition, almost 50% of staff throughout the agency (and 60% of child and youth workers) had experienced verbal threats against themselves at some time in their career. The mean number of months since the most recent traumatic event was 8.5 for intake workers, 7.75 for clerical staff, 18.6 for family service social workers, 16.7 for management staff, 24.0 for child and youth workers, and 27.6 for other social workers. This is summarized in Table 4.

Table 4: Frequency of Critical Events

Job Category	Most Recent Event (Mean Number of Months)	Mean Number of Incidents in Past Year
Intake	8.59	1.19
Family service social worker	18.61	1.20
Other social worker	27.63	1.25
Child and youth	24.00	1.00
Clerical	7.75	2.00
Management / supervisor	16.68	1.55
Other	33.94	1.56

During the feedback sessions with the consultation groups, workers were not surprised by the rates of assault and joked that if you hadn't been hit, you hadn't been at the agency long enough. They identified risks that resulted from working alone in dangerous neighborhoods. Several noted that police had said they would never go to those neighborhoods alone. Further, workers identified that the threats of violence had a powerful effect because these raised safety fears for both workers and their families. Finally, workers noted that removal of children from their family had not been included in the study as a specific critical event, even though this was a highly stressful traumatic event. In most cases, removing children from their families is very traumatic for the family, often precipitating threats and violence.

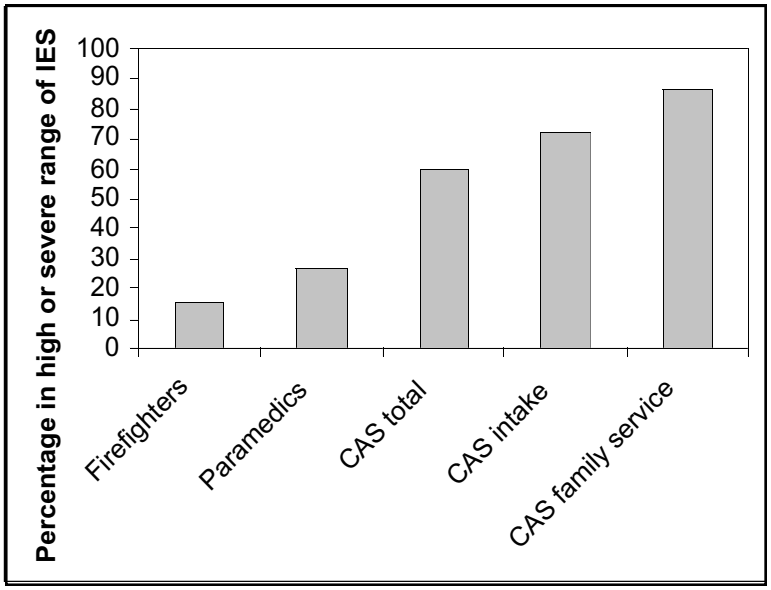
Relative Ranking of Stressors

Participants were asked to rank four categories of stressors: workload, traumatic events, working environment, and reviews/accountability. Using this system, 68% of workers rated workload as the most stressful part of their job, 14% rated traumatic events, 11.5% rated the working environment, and 11.5% rated reviews and accountability. Thus, while workers do experience high rates of posttraumatic distress, it is important to recognize that stress is experienced most often as a result of high workloads and multiple, often competing, demands.

Signs and Symptoms of Traumatic Stress

Scores on the Impact of Event Scale indicated that staff members experience high degrees of traumatic stress reactions. The IES is divided into categories indicating low, moderate, high, or severe levels of distress. The severe distress category relates to a symptom score that is associated with a diagnosis of Posttraumatic Stress Disorder (PTSD) according to other researchers (McFarlane, 1988; Lavie, et al., 1998). In this sample, 46.4% of respondents reported symptoms scoring in the severe category. These high levels of posttraumatic stress symptoms are particularly striking when the respondents were sorted by job categories. Among intake social workers, 52.0% scored in the severe range, and an additional 20% scored in the high range; 64% of family service social workers were in the severe range, and an additional 12% were in the high range; and 75% of children's services social workers were in the severe range, with an additional 12.5% in the high range. To better identify the significance of these levels of traumatic response, the levels of distress are compared with a sample of firefighters and paramedics (Regehr, Hill, & Glancy, 2000; Regehr, Goldberg & Hughes, 2002). Figure 1 reports the number of respondents in the high or severe range of symptoms on the IES.

Figure 1: Comparing Traumatic Stress With Others



While workers identified high levels of posttraumatic stress symptoms, they did not report symptoms of depression. Ninety-four percent of respondents scored in the none to mild depression range on the Beck Depression Inventory, according to guidelines set by the developers (Beck, Steer, & Garbin, 1988). No respondents scored in the severe range.

cont'd on page 16

The Stress-Related Growth Scale does not have established means of high growth and low growth. However, there was a mildly positive correlation between reports of postraumatic growth and level of posttraumatic symptoms as measured by the IES (r=0.19, p=0.05).

To assess the association between ongoing stressors and traumatic response, a variable was created which was a sum of the number of different ongoing stressors that individuals reported. Therefore, each respondent could obtain a cumulative workload stressors score of 0 to 14. A correlational analysis then revealed a moderately strong association between the cumulative workload stressors and both the IES (r= 0.30, p=.001) and the BDI (r=0.23, p=.001).

Support Systems

Participants were asked to rate the level of support that they received from people in their personal lives and from others in the organization on a scale of 0-5 (0 being not at all supportive, and 5 being very supportive). Approximately two thirds of those who were in a significant relationship felt that their spouses/partners were supportive at a level of 4 or 5. Sixty-five percent rated friends and over half rated family as highly supportive (4 or 5 ratings).

Respondents also reported high levels of support from colleagues (74% at level 4 or 5) and from managers (53% at the level of 4 or 5). Ratings for the Employee Assistance Programs and union were lower, in large part because respondents did not feel they were appropriate sources of support for job-related distress. The mean score on the social provision scale was 80.43 (SD 8.3). This is not significantly different from norms established for samples of university students, teachers and nurses of 82.45 (SD 9.9) (Cutrona & Russell, 1987).

Interestingly, despite high reported levels of support, none of the measures of social support was significantly associated with scores on the Impact of Event Scale. That is, while support may be important in many ways, it does not appear to reduce symptoms of traumatic distress. Levels of social support from family (r= -.232, p=.01) and colleagues (r= -.294, p=.01) were, however, moderately related to depression scores. Similarly, scores on the Social Provision Scale were not significantly associated with IES scores, but were associated with scores on the Beck Depression Inventory (r= -.254, P=.01). That is, people with higher levels of perceived support reported lower levels of depression symptoms.

In the qualitative component of the study, several individuals commented on the fact that they loved their jobs and felt committed to the agency. Workers commented on supervisors who nurtured staff, encouraged staff to take breaks, and took an interest in the lives of their staff outside of work. Many workers stated that they had learned to set clear boundaries in their lives so that the work-related stress did not interfere in their personal lives. This included developing leisure time activities and not discussing work issues at home. Nevertheless, most respondents had experienced or continue to experience stress in their personal lives because of their preoccupation with the demands and stressors from work.

Discussion

Consistent with earlier literature on stress and burnout in social workers in general (Bradley & Sutherland, 1995; Collings & Russell, 1996) and child welfare workers in particular (Jayaratne, Chess, & Kunkel, 1986; Kilpatrick, 1998), 68% of respondents in this study identified workload as the primary stressor in their jobs. This included documentation requirements and multiple demands for service resulting from recent legislative changes. Further, new legislative requirements had resulted in organizational changes and concerns regarding liability, which were augmented by scathing media attention. All of these increased the pressures experienced by staff and also increased their vulnerability to posttraumatic stress symptoms. The qualitative component of the study underscored how these ongoing stressors depleted the resources of staff and increased vulnerability in dealing with crisis situations.

Study findings further demonstrate that child welfare staff members are exposed to a significant number of traumatic stimuli. Approximately 20% of staff in all job categories and 60% of child and youth workers had been victims of assault on the job; 50% of all staff and 70% of child and youth workers had been verbally threatened. This is consistent with the findings in another study that suggested 11% of rural child protection workers had been assaulted in the previous year, and 33% had been verbally threatened (Horejsi, Garthwait, & Rolando, 1994). In the present study, one fourth of respondents indicated a child for whom they had service responsibility had died, and one fifth of respondents had experienced the death of an adult client. Other traumatic events reported included riots, and attending coroners' inquests. In addition, several staff members indicated that apprehensions of children were particularly traumatic due to the highly emotional reactions of family members, which often led to verbal or physical assault. These events occurred more recently for intake workers and clerical workers than for other staff members. In total, 82.7% of respondents reported encountering a traumatic event on the job, and 70% of these workers reported significant emotional distress as a result.

The subjective ratings of emotional distress were corroborated by scores on the Impact of Event Scale. Previous researchers have concluded that scores falling in the severe range of the IES are consistent with a diagnosis of posttraumatic stress (McFarlane, 1988; Lavie, et al., 1998). In this study, 46.4% of all individuals in the study, 52% of intake workers, 64% of family service social workers, and 75% of children's services social workers had scores consistent with a diagnosis of PTSD. Clearly, staff members within this large urban child welfare organization in general and social workers in particular are experiencing high levels of posttraumatic distress.

Symptoms associated with posttraumatic stress disorder measured by the IES fall into two categories: 1) avoidance symptoms, which include feelings of detachment, efforts to avoid thoughts or feelings associated with the trauma, and efforts to avoid activities or places that are reminiscent of the trauma; 2) intrusion symptoms, which include intrusive thoughts or memories of the event, distressing dreams, and physiological symptoms. However, while workers identified high levels of posttraumatic stress symptoms, they did not report symptoms of depression. This suggests that the symptoms are event-specific and do not translate into generalized depression.

Workers also reported strong levels of distress, even though workers also report strong support systems within both their personal lives and within the organization. This was consistent in both the quantitative and qualitative components of the study. Therefore, contrary to the general research on stress and burnout (Um & Harrison, 1999; Davis-Sacks, Jayaratne, & Chess, 1985), social support did not appear to mediate posttraumatic stress symptoms in this sample. There was no significant association between scores on the IES and any measure of social support.

Finally, while workers did report traumatic distress, they also reported experiencing rewards and satisfaction with their work. In the qualitative interviews, workers reported feelings of commitment and enjoyment. Other authors have similarly indicated that social workers reported that their jobs were satisfying and meaningful despite high levels of stress (Watson, 1979; Reagh, 1994). In addition, the association between the IES and the SRGS, found in this study, suggests that increased levels of distress are associated with higher reports of personal growth or positive outcome. This conclusion is consistent with other reports that suggest that stress and trauma can be energizing for workers (Jones, 1993).

This study raises some important questions for further research. One is the impact of staff's posttraumatic distress on worker-client interactions and case decision making. For instance, heightened anxiety and hypervigilance may influence decisions regarding case openings, apprehensions, court recommendations and risk ratings. This could potentially increase both workload and hostile reactions of clients, thus perpetuating two of the stressors ranked highly in this study. A second issue relates to the scores on the Impact of Event Scale by management. While lower than those of front-line social workers, they also fell above the range associated with PTSD. The manifestations of these symptom levels on supervision and policy development are as yet undetermined.

Implications for Practice

In summary, workers from a large urban child welfare agency who participated in this study identified that ongoing workload pressures were the most stressful part of their job. Suggestions provided by workers for assisting with these pressures included increased support staff, reduced caseloads, and streamlining of recording procedures. In addition, staff scored the importance of encouraging workers to take lunch breaks and not work excessive amounts of unpaid or unclaimed overtime.

The finding that traumatic stress symptoms are not ameliorated by support is somewhat troubling for administrators of child welfare organizations. While support is clearly important for workers, it does not eliminate or even significantly reduce the symptoms of traumatic stress. As a result, the most effective solution would appear to be reducing workers' exposure to traumatic experiences. In part, this could be accomplished by reduced workloads and improved safety measures to reduce staff's exposure to threats and violence. In addition, child welfare organizations can promote resilience in staff through self-esteem building strategies, such as creating the conditions to allow for task accomplishment, validation, and professional growth (Horwitz, 1998).

Finally, it is important to celebrate the dedication and strengths of workers who continue to work in this difficult area of practice. Their power to reframe traumatic events as learning experiences and to overcome their fears are truly remarkable skills. We must ensure that the efforts of these child welfare are acknowledged. Their accomplishments need to be presented to both legislators and the public to increase the awareness of child welfare workers as valuable resources that we must support and protect.

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cont'd on page 18

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