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A Study of Compassion and Job Satisfaction among Erie County's Child Protective Services Caseworkers: Vicarious Trauma, Coping, Supervisory Style, Bureaucratic Structure, and Safety

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Abstract

When high profile child fatalities with previous Erie County Child Protection Services (CPS) involvement generated considerable negative media commentary questioning the competency of CPS, there was concern over the mental well-being of CPS caseworkers. Furthermore, a key problem to be resolved was the high turnover of CPS caseworkers, which is both a budgetary drain on the County due to the training costs involved with new caseworkers, but also deprives the Department of Social Services of experienced family and child welfare personnel. This study seeks to understand factors negatively affecting the CPS caseworkers. Previous research indicate that human service workers exposed to traumatic events can experience a reduction in compassion satisfaction and an increase in vicarious trauma and burnout. Government human services administration tends to be organized under the traditional public administration model of a rigid hierarchy in authority and decision making with tight supervisory structures and little opportunity (or encouragement) of opinions from front-line workers, which also can reduce CPS worker job satisfaction. Other potentially negative factors identified in the literature include perceptions of safety, the workplace environment, and supervisory styles. This study of Erie County CPS caseworkers utilized a convergent parallel mixed methods research design in order to analyze compassion satisfaction, burnout, and vicarious trauma (ProQOL instrument) and workplace safety and environment, organizational structure, and supervisory styles (focus groups). A single sample t-test conducted on the ProQOL results revealed that Compassion Satisfaction among the respondents was statistically significant (lower than the population mean) while Vicarious Trauma and Burnout were not statistically significant from the population mean. The qualitative phase (focus groups with CPS workers) uncovered significant dissatisfaction among CPS workers with respect to organizational factors, supervisory styles, and safety and environment. This study found that CPS was organized according to the traditional (hierarchical) public administration model in which CPS caseworkers were not empowered to have a voice within their agency and were not invited to participate in the policy-making process. Furthermore, it was found that CPS supervisors and front line staff were not trained in Trauma Informed Care practices. Thus, it was concluded that counterproductive organizational practices within Erie County have produced negative outcomes for the workers and may be a greater source of caseworker turnover than either the nature of the job itself or the recent negative perceptions of Erie County's CPS division.

Acknowledgements

I would like to begin with special thanks to my family for their continued support and patience in the pursuit of my educational endeavors. I would also like to extend my gratitude to all of my Buffalo State professors for sharing their knowledge and expertise, especially my advisor Dr. Laurie Buonanno.

I would like to express my gratitude to Robert Frank and his staff at the Erie County Department of Human Resources and Development. Without his assistance, this research would not have come to fruition.

To the brave women and men of Erie County Child Protective Services: There are no words to express my admiration for you in selflessly putting your lives on the line, each and every day for the children and families Erie County. I know of no other job where you give so much of yourself but receive very little thanks in return. Please know that you have the ability to effect change in children's lives that most people will never experience. You are true professionals.

Preface

In my role as Deputy Commissioner for Erie County Department of Social Services, I am a managerial confidential employee. I serve at the pleasure of the Commissioner and County Executive. This was the last year for Erie County Executive's first term and he was up for re-election. This was a politically charged climate throughout county government.

I was on the job six months when I was given with the responsibility of "fixing" Child Protective Services (CPS) in the midst of a crisis. There were three high profile child fatalities and Erie County CPS was in turmoil. Caseworkers had been terminated as a result of these fatalities. Each day the media cited these deaths to imply CPS was incompetent. The Erie County caseloads had soared to over 5,000 with some caseworkers responsible for 80-100 cases. The workers were overwhelmed and were experiencing high levels of stress. As I walked through the units, I saw the hopeless and desperate look on the caseworkers' faces. One of the caseworkers stopped me in the hall and said "Do you see how horrible it is here? Can you please help us?" I knew then that I had to assist them in whatever way I could.

The next months were filled with meetings with the Erie County Legislature to convince them that more workers were needed. Once they approved the new hires, we hired thirty-five new CPS Caseworkers. I was able to leverage a dual, condensed training schedule for these workers and formed a new training pod for the trainees.

It was all hands on deck as we rolled up our sleeves and worked together. Records were reviewed and approved during nights and weekends. We all knew what had to be done if we were ever going to see the light at the end of the tunnel. In less than one year, we were able to

cut the number of outstanding cases in half, while still continuing to accept new cases at a rate of 700-900 cases per month.

The New York State Office of Children and Family Services recommends that a CPS worker's caseload should not exceed 15 cases. Many of the caseworkers have now met this goal, but some caseworkers still have a caseload exceeding this state recommendation. National averages for turnover in child welfare caseworkers runs around 40 percent, with Erie County now running considerably better with a 20-25 percent turnover rate. The work still continues, but Erie County CPS is now in a much better place compared to those dark days between 2011-2014.

While the case numbers decreased, my concern for the caseworkers' well-being did not. I knew that manageable caseloads would help them, but I also knew that something more needed to be done. The caseworkers had experienced a traumatic event and the agency had not addressed this situation. It was because of what I witnessed that I chose to conduct my research on the factors that are associated with the CPS caseworker's ability to conduct their work; namely, Secondary/Vicarious trauma; compassion satisfaction; burnout; environmental and organizational factors; supervisory style and training; and, coping mechanisms. My hope is that the results of this research will ameliorate these effects among our CPS caseworkers in Erie County

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Chapter I: Introduction

Introduction

Between 2011-2014, the Erie County Child Protective Services (CPS) was the target of considerable negative media attention due to three child deaths (2014, p. 157). The media and other observers implied, if not alleged, that the Erie County CPS Division failed to protect these children[1] (Michel, 2013). With such highly-publicized tragedies, first-term County Executive Mark Poloncarz was taken to task. Throughout 2014, continuing negative commentary suggesting "incompetence" of Erie County CPS caseworkers and supervisors permeated every aspect of their work as well as dogged the Poloncarz Administration (Michel, 2013). The issue resurfaced in the 2015 county executive contest in which Poloncarz sought a second-term when his opponent, Republican NYS Assemblyman Raymond Walter, brought up the CPS issue in a debate (Michel, 2015).[2]

As Maynard-Moody and Muscheno (2003, p. 157) remind us, street-level bureaucrats (a category for which Erie County's CPS caseworkers undoubtedly qualify) "are the coal miners of policy: they do the hard, dirty, and dangerous work of the state." Added to the hard, dirty, and dangerous nature of CPS work was the very high caseload carried by Erie County CPS caseworkers, which averaged between 40 and 45 cases (some caseworkers carried between 50-60

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[1] "Ten-year-old Abdifatah "Abdi" Mohamud's stepfather struck him more than 70 times with a baseball bat. Five-year-old Eain Clayton Brooks suffered massive brain injuries and sexual assault inflicted by his mother's live-in boyfriend. Eight-year-old Jacob T. Noe's mother stabbed him, she said, to save him from going to hell" (Michel 2015).

[2] Mark Poloncarz won by a margin of 2-1 (McCarthy, 2015).

cases) despite the fact that the 2014 Annual Report and Recommendation of the *New York State Citizen Review Panel* was that CPS caseworkers should have a caseload of 12-15 cases.(New York State Office of Children and Family Services, 2014).

Since the tragic deaths of three children whose families were in the CPS system, additional caseworkers have been hired to assist in reducing caseloads to a manageable level (Michalopoulos, 2014); the average caseload per worker had been reduced to 22 as of October 2015 (Michel, 2015). However, it takes an average of 6 to 12 months for caseworker trainees to begin accepting a full caseload of 15 (or more cases). Furthermore, caseload reduction strategies (such as unlimited overtime, including weekends for CPS caseworkers) have been introduced and instituted in Erie County, but such strategies are short-term "fixes" that cannot be sustained in the long run because CPS workers need time to "decompress" from such a stressful work environment.

Caseworker turnover is always a key concern in child welfare agencies because of the many issues with which child welfare workers are regularly confronted—including organizational and supervisory factors (e.g., low salary, lack of supervisory support, unreasonable workloads, lack of opportunity for coworker/mentoring support) to job-related factors (e.g., lack of job satisfaction, feelings of inefficacy, role overload/conflict stress, and burnout). Research conducted by Conrand and Kellar-Guenther (2006), for example, showed that the quality of service delivery in response to child maltreatment was significantly affected by the ability of an organization to recruit and retain competent, committed staff. The situation had become problematic in Erie County: as of late 2014, two-thirds of the CPS caseworkers were

new trainees and as *The Buffalo News* reported only 31 percent of full-time, frontline CPS workers had been employed for five or more years with the county (Michel, 2015).

***

The child welfare system is a network of public and private agencies that identify and respond to children who are being abused and neglected. Many children who have become part of the child welfare system have experienced trauma, loss, shame, and a loss of trust. While the media has tended to focus on easily collected statistics – the ratio of caseworkers to cases – child welfare workers can be personally affected by the nature of their work; i.e., ensuring the safety, permanency and well-being of these children and their families. There are two crucial aspects of the child welfare worker's job related to this point, which I will discuss below.

The first concern, added to the already dangerous, dirty, and hard work of the CPS casework and supervisor, is the "unspoken" fear permeating the Erie County CPS Unit – the double fear that a mistake made on a team's caseload will result in a disciplinary action or termination and the constant worry that a family situation may be imploding. The CPS worker's frame of reference comes from the reality that caseworkers have seen their co-workers (or heard of caseworkers in other jurisdictions) terminated due to alleged casework practice errors (Rog & Kathleen, 2013). Adding to this generalized fear is increased attempts in both criminal and civil courts to hold CPS workers responsible for the abuse and deaths of children. And while some observers have suggested that criminal prosecutions of child protective workers is nothing more than an attempt to find a scapegoat for a child's death or blatant attempts by prosecutors and politicians to gain publicity - see (Kanani, Regehr, & Bernstein, 2002) – the possibility of criminal prosecution and civil penalties weighs heavily on the CPS casework and supervisor.

The second concern particular to the child welfare worker flows from the nature of the work and its impact on the CPS worker. Previous studies have reported compassion fatigue and/or vicarious/secondary trauma among child welfare workers (Whitfield & Kanter, 2014). Secondary trauma arises from hearing emotionally shocking material from traumatized clients with symptoms of intrusive imagery, avoidant behaviors, a heightened arousal state, general distrust of others, and general anxiety (Bride, Jones, & Macmaster, 2007).

Vicarious trauma (VT) (Kanani et al.) has also been referred by researchers as contact victimization, secondary traumatic stress, compassion fatigue, secondary wounding, and event countertransference. VT is defined as a pervasive effect on the identity, world-view, psychological needs, beliefs, and memory systems of a therapist who treat trauma survivors. (Canfield, 2005; Culver, 2011; Lonergan, 2004; Perlman, 1999, p. 57; Sommer, 2008). According to Perlman (1999, p. 52), VT is "neither a reflection of inadequacy on the part of the therapist nor of toxicity or badness on the part of the client."

This study takes the position that New York State and its agent (in this case Erie County) has an obligation to protect all of its citizens, including public employees. Given the considerable stress placed on CPS caseworkers and supervisors, one might wonder to what extent are they "holding" up – are they depressed, burned out, at a "breaking point"? Do they perceive their work environment safe? Are they satisfied with the supervision provided? Do they feel comfortable in their workspace? These are the critical questions informing this study of Erie County CPS workers.

In order to answer these questions, a convergent parallel mixed methods study was conducted of Erie County CPS workers and supervisors (July-August 2015) utilizing a web-administered

questionnaire (quantitative) and multiple focus groups (qualitative) comprised of five-seven CPS caseworkers. The advantage of the convergent parallel design is that two investigative strands can be carried out independently and at the point of interface (data analysis), the researcher can compare, contrast, and synthesize the results of the findings to obtain a more complete understanding of key factors that are affecting the ability of CPS caseworkers to thrive and become more proficient in managing their caseloads, interacting with their clients, and working productively in the organization. This study purposively focuses on those factors that the Department of Social Services has the authority to remedy; and, therefore, a salary analysis is not undertaken as part of this research.

This paper is organized as follows. The remainder of this chapter is devoted to an explanation of the problem, purpose statement, and a discussion of the subject's significance for public administrators. In Chapter 2, I review the relevant literature and identify the key factors previous studies have found that are associated with child welfare worker satisfaction. Chapter 3 begins with a presentation of the study's sample selection, moves on to the research method, and reports and analyzes the data. Chapter 4 is devoted to a discussion of the results by synthesizing the findings of the two strands of data collection. Chapter 5 offers conclusions, recommendations, and implications of the study's findings.

Statement of Problem and Purpose of Study

Child welfare workers are exposed to traumatic events through their contact with the children and families they serve. Child welfare workers' exposure to these traumatic events can result in lower

compassion satisfaction, burnout, and VT. These are serious issues that if not addressed, can negatively impact the quality of the caseworkers' work product and their emotional well-being.

However, this study extends this observation further with respect to the unique stressors associated with the job of the CPS caseworker. This is because the study is being conducted on the heels of an extraordinary series of tragic events: namely, the deaths of three children between 2011 and 2014 whose families were in the CPS system. Thus, this study also provides an opportunity to study a CPS division after a traumatic event has occurred that has far reaching consequences for the public agency and governmental entity. So, for example, Camasso and Jagannathan (2014) recount how a single disturbing case of child maltreatment drove public child welfare reform in one large U.S. northeastern state. Their case analysis demonstrated how horrific CPS cases can set in motion a dynamic that was termed the "social outrage routinization process," and illustrated the key roles played by the media, moral entrepreneurs, the courts, and the CPS workforce in child welfare protection reform. This research found substantial trauma to the CPS workforce. Three stages were identified and recommended in reaction to such a crisis: 1) Re-focus on the fundamentals by prioritizing key first steps, including reductions in caseloads, workforce development, and management by data; 2) Incorporate the best thinking of stakeholders and frontline workers and supervisors (which, in turn, inspires changes in adoption practice, resource family development, services and placements); and 3) Establish accountability-based outcomes for children and families (rather than what had been a crushing checklist of more than two hundred legally enforceable tasks).

Drawing on insights from Carl Jung, Max Weber and Henry Mintzberg, Anderson (2000) argued that not only do such archetypical cases and the attendant moral outrage serve as a means

for legislative and judicial actions, they can also motivate *structural and procedural changes in CPS operations* (emphasis added). The typical response identified, however, was to "manage" outrage through public education or public relations campaigns and to allow the outrage to influence only the more immediate and exceptional decisions following an appalling event. Would Erie County's own experience with moral outrage, too, fail to go beyond the "immediate" or would our County do the hard work of "get into the blackbox" of the CPS division in order to seek out and remedy structural and procedural processes that undermine the good practice of public administration—economy, effectiveness, ethics, equity, and efficiency—to which all public servants should aspire?[3]

Certainly, the first reaction was a "shakeup" of CPS (see above) –but some caseworkers simply chose to "exit" through retirements and moving on to other positions either in other County offices or leaving County employment altogether. The reason for their exit is a matter for speculation, but undoubtedly takes us outside of the central purpose of this study. Our interest is based on ensuring that the CPS division is staffed with an experienced, healthy, and professional workforce. Of concern, however, is that during the period in which this study was

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[3] (See Norman-Major, 2011 for a review of the "Es" of public administration.) With respect to equity, families served by public welfare agencies are more likely to experience the most extensive interventions. Such clients are most often identified as impoverished, minorities, and female single parents and have likely experienced significant disempowerment (Hegar, 1988). Research suggests that when the child welfare workers, themselves, become disempowered, they are less able to empower their clients and *could* actually further disempower their clients. Empowered workers, who believe in their ability to make a difference in their own lives as well as the lives of others, are more likely to empower those with whom they work (Galant, 1999 1999). It can be concluded that empowered child welfare workers are in a better position to help achieve the desired outcome – stable families who can care for their children.

conducted two-thirds of the CPS caseworkers were new trainees.[4] High turnover of CPS workers should be of concern to the County for at least four reasons. First, it puts a larger number of less experienced caseworkers into the field than is the norm. Second, it places an additional burden on those experienced caseworkers whom less experienced caseworkers seek out for mentorship. Third, it takes anywhere between 6-12 months to train a CPS caseworker to assume a full caseload. And, fourth, a high turnover rate involves additional costs to taxpayers. With respect to this last point, Erie County expends approximately $50,000 to train each new caseworker. To put this into perspective, if twenty caseworkers leave their posts during a one-year period, the Erie County budget will need to expend approximately $1,000,000 for CPS caseworker training. Naturally, without an increase in Erie County's taxation base, these funds will need to be redirected from existing programs – and, thus, this increase could potentially negatively affect monies for libraries, parks and recreation, and cultural agencies.

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The purpose of this study, therefore, is to identify those factors that contribute to ensuring that Erie County's CPS caseworkers feel that they are empowered to achieve the tasks laid out for them by the CPS Division and County administrators. Can we identify whether the personal factors associated with careworkers (compassions satisfaction, burnout, VT) are at acceptable or unacceptable levels? Does the County ensure that CPS caseworkers are trained in the coping skills that are necessary in all of the helping professions? And, finally, to what extent do CPS workers feel they are working in a safe and supportive environment?

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[4]Eighty CPS workers were eligible for cases in 2013, while in October 2015 this number had increased to 113 with an average caseload of 22 (Michel 2015).

Significance of Study

As Anderson (2000) reports, child maltreatment reports are steadily increasing not just in the US, but globally. Investigations into the deaths of children receiving child welfare services have occurred throughout North America, Europe and Australia (Regehr, Chau, Leslie, & Howe, 2002). These deaths have attracted considerable media attention and public outrage. Yet a significant barrier to studying the impact of child welfare caseworkers is lack of access. This often insurmountable problem is overcome in this study because the researcher holds the position of First Deputy Commissioner in the Department of Social Services in Erie County. Given the intense scrutiny of Erie County's CPS Division in recent years – this agency offers a rare research opportunity to study child welfare caseworkers who are under considerable stress, and offers a critical lens from which to study and contribute to our knowledge of the stress triggers among child welfare workers. This research also provides a unique opportunity to study the attitudes of CPS caseworkers in the period immediately following a crisis. What are they thinking about their jobs? Their work environment? Their value to the County and to their supervisors?

Chapter II: Review of the Related Literature

Introduction

There are several factors affecting the satisfaction of CPS workers. The first section of the literature review defines and examines research on the effects of Vicarious/Secondary Trauma (VT). A frequently used instrument for measuring VT, burnout, and compassion satisfaction is also discussed. The second section reviews the research relating supervision to CPS worker satisfaction. The third deals with coping strategies available to the CPS worker. The fourth section examines research findings concerning organizational and environmental factors with respect to CPS job satisfaction. The main findings as they relate to the purpose of this study are summarized in the last section of this literature review.

Review and Critique of Literature

Compassion Fatigue: Vicarious/Secondary Trauma and Burnout

Professionals who are exposed to graphic descriptions of violent events, the realities of people's cruelty to one another and traumatic event reenactments may develop psychological distress as a natural consequence of their work. These are typical scenarios of everyday child protective services work (Sprang, Craig, & Clark, 2011).

Child welfare workers are assigned a critical role to protect children. However, little focus has been placed on helping them cope with stress and secondary trauma that can occur

when they experience traumatic situations described by their clients (Fisher-Hertz & DiMarzo, 2002). The general signs and symptoms of vicarious traumatization are "decreased sense of energy; no time for one's self; increased disconnections from loved ones; social withdrawal; increased sensitivity to violence, threat, or fear-or the opposite, decreased sensitivity, cynicism, generalized despair and hopelessness."

Tyler (2012) summarized research identifying the psychological symptoms of compassion fatigue associated with working with clients who are experiencing trauma. A review of the literature on the brain and neuropsychological processes that accompany trauma indicated that physiological changes also be manifested. According to Tyler (2012), psychological and physiological changes can be transferred from the traumatized clients to individuals working with the traumatized person. In an organization characterized by insufficient support and high caseloads, research identified negative physiological changes among caseworkers that led to flawed decision-making.

Secondary Traumatic Stress can impact a caseworker's critical thinking skills. Child welfare workers with higher levels of traumatic stress symptoms were less likely to identify risk factors in cases (Anderson, 2000). The symptoms of avoidance, reactivity, and diminished critical thinking skills were common; therefore, child welfare workers were less likely to effectively intervene for their clients (ACS-NYU Children's Trauma Institute, 2011).

Vicarious/Secondary Trauma is operationalized through such manifestations (symptoms) as: having difficulty talking about feelings; free floating anger and/or irritation; startle effect/being jumpy; over-eating or under-eating; difficulty falling asleep and/or staying asleep; losing sleep over clients; worry that the worker is not doing enough for their clients; dreams about their

clients/their clients' trauma experiences; diminished joy toward things they once enjoyed; feeling trapped by their work; diminished feelings of satisfaction and personal accomplishment; intrusive thoughts of clients with especially severe trauma; feelings of hopelessness associated with their work/clients; and, blame shifting.

Jankoski (2010) conducted a study grounded in the constructive self-development theory, which is a developmental and interpersonal theory with a trauma focus. The theory attempts to explain the impact of trauma on an individual's psychological development, identity, and adaptation. In a qualitative, multi-case study of child welfare, the researcher found that VT was the main cause of changes among child welfare workers. Related to VT is compassion fatigue, which refers to the decline of an individual's ability to feel compassion for others (DePanfilis, 2006).

"Burnout" is another term commonly heard in the field of child welfare. Maslach (1993) characterized burnout as a "syndrome of emotional exhaustion, depersonalization and reduced personal accomplishment that can occur among individuals who conduct people work of some kind." Burnout, unlike VT, has been conceptualized as a *process* rather than a *condition or state*. Organizational, personal and individual characteristics are contributors to the process of burnout.

Measuring Compassion Satisfaction, Burnout, and VT/Compassion Fatigue: The Professional Quality of Life Instrument

The Professional Quality of Life Survey (ProQOL) is "the most commonly used measure of the negative and positive affects of helping others who experience suffering and trauma" (ProQOL, 2012). In use since 1995, it has three subscales: compassion satisfaction, burnout, and

compassion fatigue (VT) and has developed a large database from which it has derived population means and standard deviations for each of the three subscales.

The first element of the ProQOL is Compassion Satisfaction, as illustrated in **Error! Reference source not found.**. Compassion Satisfaction is comprised of questions about the work environment, client environment, and personal environment. The ProQOL questions are constructed to feed into indices (see discussion, above) – specifically Compassion Satisfaction, Burnout, and VT/Secondary Trauma. (See Figure 2 Professional Quality of Life and Compassion.)

Figure 1 Professional Quality of Life Measure

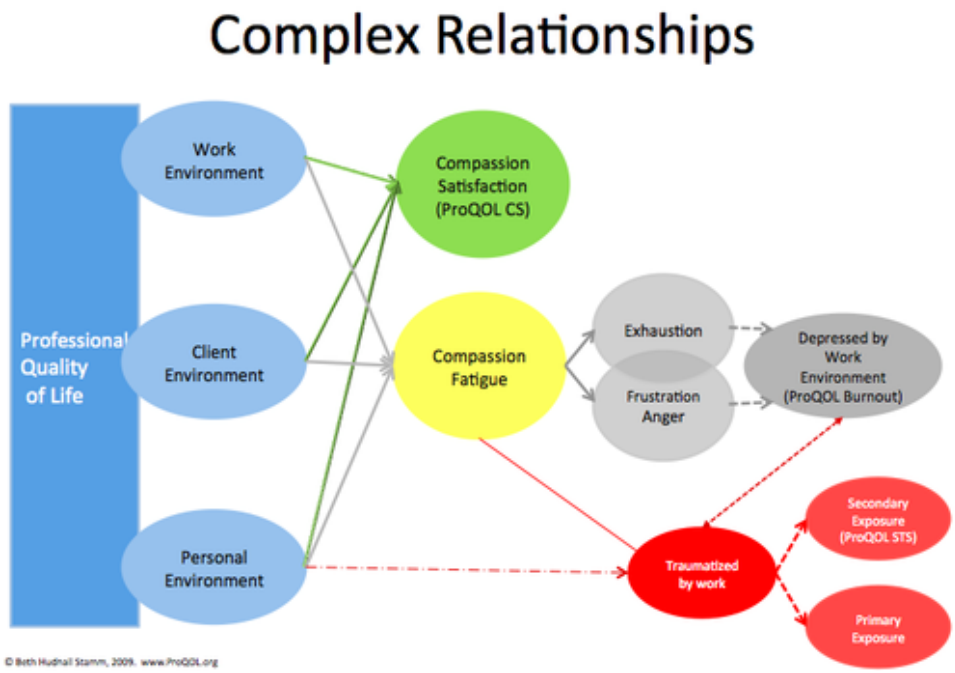
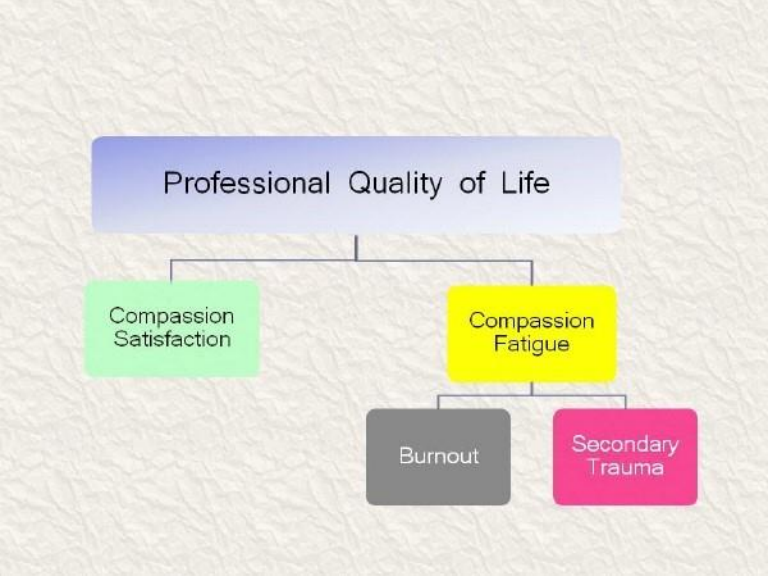


Image Source: www.ProQOL.org

The ProQOL survey is considered valid and reliable due to its acceptance in the field, its testing by many professionals and researchers in the helping professions, and triangulation with other data collections methods. It is especially valuable as a referent tool because the ProQOL includes population means and standard deviations for each of the three indices. ProQOL has been used in studies of child welfare workers. For example, a study in Central Florida measured levels of compassion satisfaction, burnout, and compassion fatigue/VT among child welfare staff members utilizing the ProQOL survey. The study found that compassion satisfaction was positively associated with lower levels of burnout and fatigue.

Figure 2 Professional Quality of Life and Compassion



Levels of burnout were similar to other helping professions, but were higher for younger workers and both burnout and VT and for direct line staff and supervisors working in the most vulnerable and troubled situations. The respondents collectively indicated the need for realistic caseloads and administrative support (Van Hook & Rothenberg, 2009).

In another study utilizing the ProQOL instrument, Conrad and Kellar-Guenther (2006) asked 363 Colorado child welfare workers who participated in a secondary trauma training seminar focused on compassion fatigue, burnout and compassion satisfaction. Their study also tested the interaction of these three variables. The results of the study demonstrated that approximately 50 percent of the sample suffered from "high" or "very high" levels of compassion fatigue (VT). The risk of burnout was considerably lower. At the same time, more than 70 percent of the sample expressed a "high" or "good" potential for compassion satisfaction. The results of this study revealed that compassion satisfaction may have helped alleviate the effects of burnout.

Organizational and Environmental Factors

Similar to the burnout research, early research on VT had identified both personal and organizational factors. In a comprehensive review of related literature, Dombo and Gray (2013) emphasized stresses specifically associated with working with victims of VT, suggesting that a change in organizational culture, workload, group support, supervision, self-care, education, and work environment would help prevent VT in staff. Significantly, the researchers concluded that the source of stress was not solely from responding to people in pain and crisis, but was associated with the characteristics of the organization.

At the organizational level, Killian (2008) showed that excessive caseloads or work responsibilities may heighten stress, leading to difficulties with concentration, memory problems, or the inability to act compassionately towards clients. Furthermore, child welfare workers are better equipped to assist others when they have input in decision-making, and are

able to anticipate and control how many hours they must work each day, and have a sense of clearly defined professional boundaries and limits.

Effective Supervision

According to the literature, the prevention and management of VT should be a shared initiative among the CPS workers, their supervisors, and administrators. Social support, especially the support of colleagues and supervisors, was identified as the coping strategy which offers the strongest prevention strategy of burnout in child welfare workers (Parry, 1989).

Clinical practice that supports reflective supervision can help workers to process their clients' trauma and prevent a traumatized professional system. These psycho-social connections between child welfare workers and the type of work that is expected of them make it especially difficult to be effective in assisting children and their families. There are preventative measures, however, that organizations can put into place to support the work environment in helping to prevent and manage VT for staff (Tyler, 2012).

A skilled supervisor should recognize these changes in their worker caused by vicarious trauma and burnout. The supervisor would then model an effective approach for the worker to use. The supervisor who wants the worker to find and use the strengths of the client must demonstrate this by jointly evaluating the worker's recent successes and building upon them (Cearley, 2004). The use of this parallel process is a type of modeling that repeats at all levels of the supervisor-worker-client relationship (Williams, 1997). One example of how this parallel process can be used is in supervisory consultations. The supervisor may observe the worker unconsciously present an emotional or behavioral reaction that they have observed in the client.

The parallel process is an unconscious replication in the supervisory session of therapeutic difficulties which a supervisee has with a client. This supervisor models the behavior which is then taken into the interaction with the client (Williams, 1997).

Cearley (2004) identified several factors that influenced the empowerment of child welfare workers. Working with a sample of 85 child welfare workers, she compared relationships among workers' perceptions of supervisors' assistive behaviors, workers' perceptions of agency support, and workers' perception of their own empowerment. The study further investigated the associations between length of employment and type of educational degree and worker empowerment. The results of this research indicated that workers perceived their supervisors' assistive behaviors as the only factor that influenced their empowerment.

Abassary and Goodrich (2014) explored the impact of clinical supervision on the reduction of stress for professional counselors working with clients who experienced crisis on a routine basis. The relationship between the therapeutic relationship, posttraumatic growth, and VT were outlined to demonstrate the necessity of meaningful, crisis-based supervision. The authors recommended the incorporation of existing supervisory models while emphasizing the significance of empathy in the counselor-supervisory relationship.

Blackman and Schmidt (2013) studied child protection social workers, supervisors, and managers in the North Region of the Ministry of Children and Family Development in British Columbia in order to gain a better understanding of how this agency prepares social workers to assume supervisory responsibilities. The researchers found that training and professional development, mentoring, and acting leadership opportunities were the most important elements in developing supervision and leadership skills.

Finally, Kadushin and Harkness (2002) suggest there are several important support functions in supervision, including sustaining worker morale, helping with job-related discouragements, and giving supervisees a sense of worth as professionals, a sense of belonging in the agency and a sense of security in their performance.

Coping Strategies

Dombo and Gray (2013) focused on spirituality as aid in the reduction of VT, finding that VT resulted in great personal and professional costs for those people working in a human services profession. Human services workers were particularly vulnerable to burnout in spiritual dimensions, as evidenced by loss of purpose, hopelessness, internalizing the suffering of their clients' trauma and questioning the meaning of their work. Spiritual practices have often been engaged to lessen the effect of trauma and facilitate personal and professional growth. Dumbo and Gray (2013) also emphasize the ways in which human services workers can support themselves and their work through spiritual self-care and in the process better improve client outcomes through sustained connection. Spiritually-based practices were explored as a means of reconnecting with the meaning of the work and with the satisfaction that compassion can bring. A self-care model was presented to help individual workers address the impact of the work, and to help organizations address the environmental and cultural contributors to VT. This model integrates spiritual practice and present-specific spiritual self-care meditation practices.

Tyler (2012) identified additional strategies that stressed the importance of workers having time to reflect on their own thoughts and feelings in relationship to their clients. Agency staff involved in painful and stressful work should be given space to think about anxieties stirred

up as a result of their work, and the effects that such anxieties have on them. This strategy helps individual workers to ameliorate the effects that emotional exhaustion by allowing them to vent their own emotional responses to their work. This process can be facilitated by allowing workers to take "thinking time" with another professional who is trained in using reflective practice, whether therapeutically or as a component of the supervisory process. Workers can process the trauma that their clients' project onto them, thereby empowering workers to maintain balanced, objective views of their cases. In addition, being able to process the projected trauma of their clients enables workers to prevent their neurobiological system from mirroring that of their clients, and helping to avoid possible trauma stress response in the worker. Significantly, these thinking spaces were often viewed as time-consuming and low on the list of priorities in child welfare organizations.

Summary

The literature suggests that there is a basis to understand child welfare caseworkers in terms of the variables identified in this review of the literature. The main factors that seem to be associated with job satisfaction are:

- compassion fatigue (which consists of two components – VT and burnout),
- organizational and environmental factors
- supervisory style and training, and
- coping strategies

This literature also found that the ProQOL is considered a reliable self-administered measure of compassion satisfaction and compassion fatigue.

Hypotheses

The first set of factors – compassion satisfaction and the two concepts related to compassion fatigue –VT and burnout, can be measured utilizing the ProQOL. The ProQOL survey consists of 30 questions which are used into three "screening" categories:

Compassion Satisfaction Scale (Questions 3, 6, 12, 16, 18, 20, 22, 24, 27, and 30);

Burnout Scale (Questions 1, 4, 8, 10, 15, 17, 19, 21, 26, 29 – with 1, 4, 15, 17, & 29 requiring reverse scoring).

Secondary Traumatic Stress Scale (Questions 2, 5, 7, 9, 11, 13, 14, 23, 25, 28).[5]

This study proposes directional (one-tailed) hypotheses—specifically, due to the problems that the Erie County CPS Division has experienced over the past few years due to the 2011-2014 crises, the number of newly hired caseworkers will be manifested in low compassion satisfaction, high burnout scores, and high VT scores.

Hypothesis 1_A: Erie County Child Protective caseworkers will have lower compassion satisfaction scores as compared to the population mean on the ProQOL.

Hypothesis 1_0: Erie County Child Protective caseworkers will have equal or higher compassion satisfaction as compared to the population mean on the ProQOL.

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[5] The ProQOL is available at http://www.proqol.org/uploads/ProQOL_5_English.pdf.

Hypothesis 2_A: Erie County Child Protective caseworkers will have higher or equal burnout scores as compared to the population mean on the ProQOL.

Hypothesis 2_0: Erie County Child Protective caseworkers have lower burnout scores as compared to the population mean on the ProQOL.

Hypothesis 3_A: Erie County Child Protective caseworkers will have higher or equal secondary trauma scores as compared to the population mean on the ProQOL.

Hypothesis 3_0: Erie County Child Protective caseworkers will have lower secondary trauma scores as compared to the population mean on the ProQOL.

Chapter III: Methodology

Design of Study

This is an agency-based project with Erie County Department of Social Services Child Protective Services Unit. The study was designed to occur directly at the agency to ensure a convenient location for the participants.

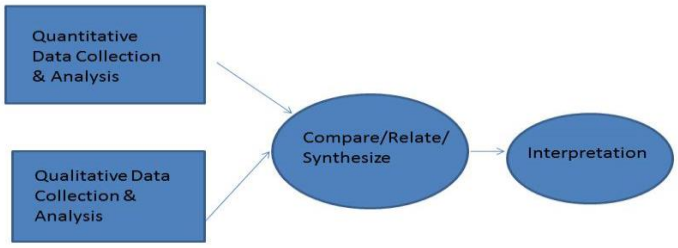
The research design is a ***convergent parallel mixed methods*** study which included a web-administered survey (quantitative data) and focus groups utilizing reflective open-ended question design (qualitative data). The convergent parallel mixed methods design, depicted in Figure 3 Convergent Parallel Mixed Method Design was selected to facilitate the collection of two different types of information about the CPS caseworkers who participated in this study. The goal was to analyze the two sets of data separately and then to compare, relate them to the general knowledge about CPS job and compassion satisfaction from the general literature, and synthesize the findings. At the final stage (Chapter 4 Discussion), the findings will be interpreted in tandem in order to provide a fuller, richer understanding of Erie County CPS caseworker job and compassion satisfaction.

Quantitative Phase - ProQOL

ProQOL provides scores and enables us to make numerical comparisons to the population of the ProQOL database. ProQOL cannot, however, explain all of the reasons for the scores. In other words, ProQOL is an "early warning system" that should be used as the basis for further investigation. Thus, the IRB application included a focus group component with questions

designed to "dig" deeper into the CPS caseworkers' attitudes with respect to organizational and safety, attitudes about supervision, and coping strategies.

Figure 3 Convergent Parallel Mixed Method Design



Qualitative Phase

No systematic study has been conducted of Erie County CPS caseworkers in the past, and our knowledge of their feelings, attitudes, and working conditions is gleaned from informal meetings, evaluations, etc. Therefore, ten focus groups were convened in which 5-7 CPS workers discussed the ten questions listed in Table 1 Focus Group Questions. Table 1 also matches the questions with the factors identified in Chapter 2's review of the literature as important in impacting child welfare workers (effective supervision, coping strategies, and organizational and environmental factors).[6] These focus group questions were derived from a similar study conducted in 2013 by Berscheit (2003).

[6] Each focus group was comprised of different participants.

Table 1 Focus Group Questions

FOCUS GROUP QUESTIONS	ASSOCIATED FACTOR[7]
1. Does the organization make staff self-care part of the mission understanding that it affects client care?	Coping
2. Are staff encouraged to participate in social change activities, outreach and influencing policy which can create a sense of hope, empowerment and be energizing?	Organizational/Environmental
3. Is the work environment safe, comfortable, and private for the caseworker to work?	Organizational/Environmental
4. Does the agency have safety protocol for protection of the staff, is there a security system or security guards?	Organizational/Environmental
5. Is there a break room where staff can address self-care needs, soft music, and comfortable furniture?	Coping
6. Is there opportunity and encouragement for staff to informally debrief with peers or formal debriefing opportunities at the agency?	Coping
7. Are there peer support groups such as consultation, case conferences, and clinical seminars to provide help prevent vicarious trauma.	Coping
8. Does the agency provide and encourage supervision?	Supervisory
9. Does the administration require the supervisor is trained in supervision of trauma counselor?	Supervisory
10. Does the agency provide to the CPS caseworker with resources for personal therapy, structured stress management or structure physical activities such as walking, meditation, or yoga groups?	Coping

Sample Selection and Description of Participants

The sample selection for this research consisted of Erie County New York Child Protective caseworkers. The caseworkers are primarily female (80%). The participants range in age from 21 to 60 years old. The participants' experience in the Child Protective Services field ranges

[7] See Chapter 3 for a review of the literature with respect to these three factors.

from 1 month to 30 years. The study used a convenience sample of the available CPS caseworkers (n=70) employed by Erie County during the period of this research (June-September 2015).

Data collection and instrumentation

The quantitative phase utilized the Professional Quality of Life Measure (ProQOL) survey[8], which was administered via *Qualtrics*[9] an online survey and software insight platform. A link to the survey was emailed to each CPS caseworker.

The qualitative data collection consisted of focus-group discussions with Erie County Child Protective caseworkers. Ten focus groups were conducted consisting of only CPS caseworkers. A social work intern facilitated the focus group, while a clerk employed in the Human Resources Division of Erie County Department of Social Services took notes. The researcher trained the intern and the scribe. However, the researcher did not attend the focus groups to assure that all of the focus participates could openly and freely express their opinions without fear of reprisal or retaliation.

Data analysis

The Questionnaire

The survey was opened on the Qualtrics platform in July 2015 and closed in September 2015.[10] (See Appendix I for the survey instrument, which includes a statement on informed consent and

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[8] The survey is downloadable and available free of charge from http://www.proqol.org/.

[9] See http://www.qualtrics.com/.

other research procedures as required by SUNY Buffalo State's Institutional Review Board.) An email was sent to 70 CPS workers inviting them to fill out this survey: 68 took the survey, which is a response rate of 97.1%. This is a very high response rate, where standards range from a minimum of 40 percent to 70 percent considered very high.[11] Standard demographic data of the respondents are listed in Table 2 Demographics of Survey Respondents.

Table 2 Demographics of Survey Respondents

	Responses	%*	Total %
Gender			
Male	13	20	
Female	51	80	100
Age			
18-35	36	57	
36 and up	27	43	100
Race/Ethnicity			
White	49	77	
African American	9	14	
Latino/Hispanic	5	8	
East Asian	1	2	100

*May not equal 100% due to rounding.

Table 3 Years at Erie County contains data on years of employment with Erie County. As suggested in Chapters 1 and 2 of this study as to the "longevity" of CPS caseworkers, a majority (61%) of Erie County CPS caseworkers have been with Erie County for less than five years and of these, 50% have been in the child welfare field less than five years (see *Table 4 Years in the Child Welfare Field*).

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[10] The researcher found no evidence that any of these days was "out of the ordinary."
[11] See, for example, standards required by *American Journal of Pharmaceutical Education* at http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2384218/.

Table 3 Years at Erie County

#	Answer		Response	%
1	< 5		39	61%
2	5 - 15		17	27%
3	15 >		8	13%
	Total		64	100%

Table 4 Years in the Child Welfare Field

#	Answer		Response	%
1	< 5		32	50%
2	5 - 15		24	38%
3	15 >		8	13%
	Total		64	100%

Table 5 Compassion and Compassion Fatigue contains percentages for each of the Likert (interval) responses for ProQOL instrument. Looking at the responses, there do not seem to be any significant problems. However, the ProQOL is designed as a weighted self-score test where questions need to be considered and scored on three scales: compassion satisfaction, burnout, and secondary trauma stress. It is misleading to try to draw conclusions from responses to individual questions.

Table 5 Compassion and Compassion Fatigue

Q #	ProQOL Q #	% responses	Never	Rarely	Some-times	Often	Very Often
7	1	I am happy	0	5	28	49	18
8	2	I am preoccupied with more than one person I help	0	13	37	35	15
9	3	Satisfaction helping people	0	2	16	51	31
10	4	Feel connected to others	0	2	33	51	15
11	5	Jump or am startled by unexpected sounds	7	39	46	7	2
12	6	I feel invigorated after working with those I help	0	3	41	48	8
13	7	I find it difficult to separate my personal life from my life as a caseworker	13	46	30	8	3
14	8	I am not as productive at work because I am losing sleep over traumatic experiences of a person I help	25	49	23	3	0
15	9	I think I may have been affected by the traumatic stress of those I help	15	48	29	8	0
16	10	I feel trapped by my job as a caseworker	20	21	46	10	3
17	11	Because of my helping, I have felt on edge about various things	13	43	30	10	3
18	11	I like my work as a caseworker	0	3	25	49	23
19	13	I feel depressed because of the traumatic experiences about the people I help	29	51	20	0	0
20	14	I feel as though I am experiencing the trauma of someone I have helped	42	47	10	2	0
21	15	I have beliefs that sustain me	0	8	23	43	25
22	16	I am pleased with how I am able to keep up with caseworker techniques and protocols	2	10	38	41	10
23	17	I am the person I always wanted to be	0	70	36	48	10
24	18	My work makes me feel satisfied	2	5	48	39	7
25	19	I feel worn out because of my work as a caseworker.	2	7	56	20	16

Q #	ProQOL Q #	% responses	Never	Rarely	Some-times	Often	Very Often
26	20	I have happy thoughts and feelings about those I help, and how I could help them	0	5	43	44	8
27	21	I feel overwhelmed because my caseload seems endless	3	8	39	26	23
28	22	I believe I can make a difference through my work	0	3	38	44	15
29	23	I avoid certain activities or situations because they remind me of frightening experiences of the people I help	50	45	2	2	2
30	24	I am proud of what I can do to help	0	2	23	54	21
31	25	As a result of my casework, I have intrusive, frightening thoughts	35	45	17	3	0
32	26	I feel "bogged down" by the system	7	23	30	21	20
33	27	I have thoughts that I am a success as a caseworker	0	10	48	31	11
34	28	I can't recall important parts of my work with trauma victims	25	58	17	0	0
35	29	I am a very caring person	0	0	7	54	39
36	30	I am happy that I chose to do this work	0	5	38	37	20

Scoring the PROQOL

The ProQOL is an index-based measure of the quality of life for professionals in helping fields. There are three indices: Compassion Satisfaction, Burnout, and Secondary Trauma Stress – with the latter two being expressions of "Compassion Fatigue." (See Chapter 2's discussion.) The data file contained the raw data from the questionnaire responses. In order to draw inferences

from the ProQOL it was necessary to compute new variables for compassion satisfaction, burnout, and trauma.[12]

Compassion Satisfaction

According to the ProQOL Instructions[13]:

> Compassion satisfaction is about the pleasure you derive from being able to do your work well. For example, you may feel like it is a pleasure to help others through your work. You may feel positively about your colleagues or your ability to contribute to the work setting or even the greater good of society. Higher scores on this scale represent a greater satisfaction related to your ability to be an effective caregiver in your job. The average score is 50 (SD 10; alpha scale reliability .88). About 25% of people score higher than 57 and about 25% of people score below 43. If you are in the higher range, you probably derive a good deal of professional satisfaction from your position. If your scores are below 40, you may either find problems with your job, or there may be some other reason—for example, you might derive your satisfaction from activities other than your job.

Compassion Satisfaction Scale

The questions are added together, as follows, to compute the Compassion Satisfaction Score (see **Error! Reference source not found.** for the ProQOL questions associated with each number):
3. ____
6. ____
12. ____
16. ____
18. ____
20. ____
22. ____
24. ____
27. ____

---

[12] SPPS - Step 1: I computed a new variable by summing the variables in this index. (Transform<Compute Variable).
Step 2: The next step was to determine the appropriate statistical test in order to draw inferences from the data.
[13] http://www.proqol.org/ProQol_Test.html

30. ____

The sum of my Compassion Satisfaction questions is	**So My Score Equals**	**And my Compassion Satisfaction level is**
22 or less	43 or less	Low
Between 23 and 41	Around 50	Average
42 or more	57 or more	High

The appropriate test is the Single-Sample t-test. The single sample t-test compares the mean of a single sample to a known population mean. It is useful for determining if the current data (CPS worker scores) is different from the long-term value calculated on a large datasets (in this case, the average score of 50 on the Compassion Satisfaction Scale – SD 10; alpha reliability .75).[14]

Single Sample t-test

Table 6 t-test results - Compassion Satisfaction

One-Sample Statistics

	N	Mean	Std. Deviation	Std. Error Mean
CPSAT	60	36.9667	5.31058	.68559

[14] See Professional Quality of Life Scale for population means and standard deviation, etc.

One-Sample Test

	Test Value = 50					
					95% Confidence Interval of the Difference	
	t	df	Sig. (2-tailed)	Mean Difference	Lower	Upper
CPSAT	-19.010	59	.000	-13.03333	-14.4052	-11.6615

Conclusion:

Statistical Significance

A single sample t-test that compared the mean score of the sample (Erie County CPS caseworkers) to a population mean score of 50 was conducted. A significant difference was found ($t(59) = -19.010$, $p < 001$.) The sample mean of 36.9667 (sd=5.31058) was significantly less than the population mean.

Interpretation

Scores below 40 indicate that CPS caseworkers may either find problems with their jobs, or there may be some other reason—for example, they might derive satisfaction from activities other than their jobs.[15] The frequencies tables, below, indicate that all measures of central tendency – mean, mode, and median – fall below 40. The maximum score was 49 and the minimum was 27. Finally, the sample standard deviation was lower than that of the population standard deviation. In terms of the referent population, 25% scored higher than 57 and about 25% of people scored below 43. The CPS workers exhibit very different percentages as follows: no respondent scored

[15] This indicates the need to analyze another set of data using the convergent parallel methodology, which will be explained when we undertake the data analysis of the focus group responses.

at 57, with the highest score being 49, and 75% of the respondents scored at or below 40. (See quartiles, below.)

Table 7 Compassion Satisfaction - Frequencies

Statistics

CPSAT

N	Valid	60
	Missing	8
Mean		36.9667
Median		37.0000
Mode		33.00[a]
Std. Deviation		5.31058
Range		22.00
Minimum		27.00
Maximum		49.00
Percentiles	25	33.0000
	50	37.0000
	75	40.0000
	100	49.0000

a. Multiple modes exist. The smallest value is shown

CPSAT

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	27.00	2	2.9	3.3	3.3
	28.00	2	2.9	3.3	6.7
	29.00	1	1.5	1.7	8.3
	30.00	3	4.4	5.0	13.3
	32.00	3	4.4	5.0	18.3

	33.00	6	8.8	10.0	28.3
	34.00	4	5.9	6.7	35.0
	35.00	2	2.9	3.3	38.3
	36.00	6	8.8	10.0	48.3
	37.00	5	7.4	8.3	56.7
	38.00	4	5.9	6.7	63.3
	39.00	3	4.4	5.0	68.3
	40.00	5	7.4	8.3	76.7
	41.00	2	2.9	3.3	80.0
	42.00	2	2.9	3.3	83.3
	43.00	2	2.9	3.3	86.7
	44.00	3	4.4	5.0	91.7
	46.00	3	4.4	5.0	96.7
	48.00	1	1.5	1.7	98.3
	49.00	1	1.5	1.7	100.0
	Total	60	88.2	100.0	
Missing	System	8	11.8		
Total		68	100.0		

Given that "Compassion Satisfaction" is about the pleasure one derives from being able to do one's work well, higher scores on this scale represent a greater satisfaction related to one's ability to be an effective caregiver in one's job. These low scores for Erie County CPS caseworkers indicate some concern and merit further investigation into the causes of this dissatisfaction. This is an important illustration of the need to follow up quantitative data collection with qualitative research. (See focus group results, below.)

For Compassion Satisfaction, we accept Hypothesis 1_A – Erie County CPS caseworkers have lower compassion satisfaction than the general population human service workers and this difference is statistically significant.

Burnout

According to the ProQOL:

> Most people have an intuitive idea of what burnout is. From the research perspective, burnout is one of the elements of Compassion Fatigue (CF). It is associated with feelings of hopelessness and difficulties in dealing with work or in doing your job effectively. These negative feelings usually have a gradual onset. They can reflect the feeling that your efforts make no difference, or they can be associated with a very high workload or a non-supportive work environment. Higher scores on this scale mean that you are at higher risk for burnout. The average score on the burnout scale is 50 (SD 10; alpha scale reliability .75). About 25% of people score above 57 and about 25% of people score below 43. If your score is below 43, this probably reflects positive feelings about your ability to be effective in your work. If you score above 57 you may wish to think about what at work makes you feel like you are not effective in your position. Your score may reflect your mood; perhaps you were having a "bad day" or are in need of some time off. If the high score persists or if it is reflective of other worries, it may be a cause for concern.

Burnout Scale

On the burnout scale, starred items are "reverse scored." If the respondent scored the item 1, it becomes a 5. Reverse scoring is used because scientifically the measure works better when these questions are asked in a positive way though they can tell us more about their negative form. For example, question 1. "I am happy" tells us more about the effects of helping when you are *not* happy so you reverse the score.[16]

*1. ____ = ____
*4. ____ = ____
8. ____

---

[16] I recoded (as below) in SPSS (Transform<Recode Into Different Variables). After I recoded the variables, I added the variables and created a new variable (BURN).

10. ____
*15. ____ = ____
*17. ____ = ____
19. ____
21. ____
26. ____
*29. ____ = ____
Total : _____

Interpretation

The sum of my Compassion Satisfaction questions is	**So My Score Equals**	**And my Compassion Satisfaction level is**
22 or less	43 or less	Low
Between 23 and 41	Around 50	Average
42 or more	57 or more	High

The appropriate test is the Single-Sample t-test. The single sample t-test compares the mean of a single sample to a known population mean. It is useful for determining if the current set of data has changed from a long-term value (in this case, the average score of 50 on the Burnout Scale – SD 10; alpha reliability .75).

Single Sample t-test

Table 8 t-test results - Burnout

One-Sample Statistics

	N	Mean	Std. Deviation	Std. Error Mean
BURN	60	25.3500	5.73666	.74060

One-Sample Test

	Test Value = 50					
					95% Confidence Interval of the Difference	
	t	df	Sig. (2-tailed)	Mean Difference	Lower	Upper
BURN	-33.284	59	.000	-24.65000	-26.1319	-23.1681

Conclusion:

Statistical Significance

A single sample t-test that compared the mean score of the sample (Erie County CPS caseworkers) to a population score of 50 was conducted. A significant difference was found ($t(59) = -32.284$, $p < .001$.) The sample mean of 25.3500 (sd=5.73666) was significantly less than the population mean.

Interpretation

Scores above 57 indicate that CPS caseworkers may either find problems with their jobs, or there may be some other reason—for example, they might derive satisfaction from activities other than their jobs. The frequencies tables, below, indicate that all measures of central tendency – mean, mode, and median – all fall well below 57. The maximum score was 39 and the minimum was 14. The standard deviation was below that of the population.

We can conclude that Erie County CPS workers are **not** exhibiting signs of burnout. In fact, CPS workers are experiencing burnout at a much lower rate than that of the population of ProQOL test-takers, where 25% score below 43, as compared to 21 for CPS; and 25% fall above 57 (no CPS workers score above 39. (See quartiles, below.)

Therefore, we fail to reject Hypothesis 2_0. We conclude that Erie County Child Protective caseworkers do not exhibit the symptoms of burnout.

Table 9 Burnout – Frequencies

Statistics

BURN

N	Valid	60
	Missing	8
Mean		25.3500
Median		25.5000
Mode		25.00
Std. Deviation		5.73666
Range		25.00
Minimum		14.00
Maximum		39.00
Percentiles	25	21.2500
	50	25.5000
	75	29.0000
	100	39.0000

BURNOUT

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	14.00	3	4.4	5.0	5.0
	15.00	1	1.5	1.7	6.7
	17.00	2	2.9	3.3	10.0
	19.00	4	5.9	6.7	16.7
	20.00	1	1.5	1.7	18.3
	21.00	4	5.9	6.7	25.0
	22.00	4	5.9	6.7	31.7
	23.00	3	4.4	5.0	36.7
	24.00	2	2.9	3.3	40.0
	25.00	6	8.8	10.0	50.0
	26.00	4	5.9	6.7	56.7
	27.00	5	7.4	8.3	65.0

	28.00	5	7.4	8.3	73.3
	29.00	5	7.4	8.3	81.7
	30.00	3	4.4	5.0	86.7
	33.00	2	2.9	3.3	90.0
	34.00	2	2.9	3.3	93.3
	35.00	1	1.5	1.7	95.0
	36.00	1	1.5	1.7	96.7
	37.00	1	1.5	1.7	98.3
	39.00	1	1.5	1.7	100.0
	Total	60	88.2	100.0	
Missing	System	8	11.8		
Total		68	100.0		

Secondary Traumatic Stress

The second component of Compassion Fatigue (CF) is secondary traumatic stress (STS). (See Figure 2 Professional Quality of Life and Compassion.) According to the ProQOL:

> It is about work related, secondary exposure to extremely or traumatically stressful events. Developing problems due to exposure to other's trauma is somewhat rare but does happen to many people who care for those who have experienced extremely or traumatically stressful events. For example, you may repeatedly hear stories about the traumatic things that happen to other people, commonly called Vicarious Traumatization. If your work puts you directly in the path of danger, for example, field work in a war or area of civil violence, this is not secondary exposure; your exposure is primary. However, if you are exposed to others' traumatic events as a result of your work, for example, as a therapist or an emergency worker, this is secondary exposure. The symptoms of STS are usually rapid in onset and associated with a particular event. They may include being afraid, having difficulty sleeping, having images of the upsetting event pop into your mind, or avoiding things that remind you of the event. The average score on this scale is 50 (SD 10; alpha scale reliability .81). About 25% of people score below 43 and about 25% of people score above 57. If your score is above 57, you may want to take some time to think about what at work may be frightening to you or if there is some other reason for the elevated score. While higher scores do not mean that you do have a problem, they are an indication that you may want to examine how you feel about your work and your work environment. You may wish to discuss this with your supervisor, a colleague, or a health care professional.

The appropriate test is the Single-Sample t-test. The single sample t-test compares the mean of a single sample to a known population mean. It is useful for determining if the current set of data has changed from a long-term value (in this case, the average score of 50 on the Secondary Traumatic Stress scale – SD 10; alpha reliability .81). See Professional Quality of Life Scale at http://www.ProQOL.org/ProQOL_Test.html.

Table 10 t-test - Secondary Traumatic Stress

One-Sample Statistics

	N	Mean	Std. Deviation	Std. Error Mean
TRAUMA	58	22.2414	4.46943	.58686

One-Sample Test

	Test Value = 50					
					95% Confidence Interval of the Difference	
	t	df	Sig. (2-tailed)	Mean Difference	Lower	Upper
TRAUMA	-47.300	57	.000	-27.75862	-28.9338	-26.5834

Conclusion:

Single Sample t-test

A single sample t-test that compared the mean score of the sample (Erie County CPS caseworkers) to a population score of 50 was conducted. A significant difference was found ($t(57) = -47.300$, $p < .001$.) The sample mean of 22.2414 (sd=4.46943) was significantly lower than the population mean.

Interpretation

Scores above 57 indicate that CPS caseworkers may be experiencing STS/VT – work related secondary exposure to extremely or traumatically stressful events. The frequencies tables, below, indicate that all measures of central tendency – mean, mode, and median – all fall well below 57. The maximum score was 39 and the minimum was 14. The sample standard deviation was below that of the population's. Furthermore, this difference was statistically significant (see t-test analysis).

We can conclude that Erie County CPS workers are **not** exhibiting signs of STS. In fact, CPS workers are experiencing STS at a much lower rate than exhibited by the referent population, where 25% score below 43, as compared to 19 for CPS; and 25% fall above 57 (no CPS workers score above 33. (See quartiles, below.)

Therefore, we fail to reject Hypothesis 3_0. We conclude that Erie County Child Protective caseworkers do not exhibit the symptoms of VT/STS.

Table 11 Secondary Traumatic Stress - Frequencies

Statistics

TRAUMA

N	Valid	58
	Missing	10
Mean		22.2414
Median		23.0000
Mode		25.00
Std. Deviation		4.46943
Range		20.00
Minimum		13.00
Maximum		33.00
Percentiles	25	19.0000
	50	23.0000

	75	25.0000
	100	33.0000

TRAUMA

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	13.00	1	1.5	1.7	1.7
	15.00	2	2.9	3.4	5.2
	16.00	5	7.4	8.6	13.8
	17.00	3	4.4	5.2	19.0
	18.00	1	1.5	1.7	20.7
	19.00	6	8.8	10.3	31.0
	20.00	3	4.4	5.2	36.2
	21.00	4	5.9	6.9	43.1
	22.00	3	4.4	5.2	48.3
	23.00	6	8.8	10.3	58.6
	24.00	4	5.9	6.9	65.5
	25.00	9	13.2	15.5	81.0
	27.00	4	5.9	6.9	87.9
	28.00	2	2.9	3.4	91.4
	29.00	2	2.9	3.4	94.8
	30.00	2	2.9	3.4	98.3
	33.00	1	1.5	1.7	100.0
	Total	58	85.3	100.0	
Missing	System	10	14.7		
Total		68	100.0		

Demographics and Experience and ProQOL Scales

The questionnaire also asked standard demographic and job-related information. Therefore, it was possible to explore whether age of the caseworker, length of years of County service, years as a child welfare worker, gender, and ethnicity might differ in terms of ProQOL scores. Therefore, I ran several independent t-tests for each of these factors.

Age of CPS Caseworker

Compassion Satisfaction

An independent-samples t test was calculated comparing the mean age of CPS caseworkers (grouped as 18-35, 36 and up) with the ProQOL Compassion Satisfaction score. No significant difference was found ($t(57) = .563$, $p > .05$). The mean of the CPS caseworkers aged 18-35 (m= 36.6, sd = 5.73) was not statistically different from the mean of CPS caseworkers aged 36 and up (m=37.4, sd=4.81). [17]

Trauma

An independent-samples t test was calculated comparing the mean age of CPS caseworkers (grouped as 18-35, 36 and up) with the ProQOL Trauma score. No significant difference was found ($t(55) = 1.809$, $p > .05$). The mean of the CPS caseworkers aged 18-35 (m= 23.2, sd = 4.6) was not statistically different from them mean of CPS caseworkers aged 36 and up (m=21.0, sd=4.2).[18]

[17] See Appendix E, Table 13 t-Test, Age and Compassion Satisfaction

[18] See Table 14 t-test Age and Trauma.

Burnout

An independent-samples t test was calculated comparing the mean age of CPS caseworkers (grouped as 18-35, 36 and up) with the ProQOL Burnout score. No significant difference was found ($t(57) = 1.129$, $p > .05$). The mean of the CPS caseworkers aged 18-35 ($m= 26.2$, $sd = 6.7$) was not statistically different from the mean of CPS caseworkers aged 36 and up ($m=24.5$, $sd=3.8$).[19]

Years of County Service

I also asked respondents to select one of three responses designating years of service at Erie County: <5 years, 5-15 years, and >15 years. The appropriate statistical test is the One-Way Anova.[20]

Compassion Satisfaction

"Years of Erie County Service" was compared on Compassion Satisfaction using a one-way ANOVA. No significant difference was found ($F(2, 57) =.254$, $p > .05$). CPS caseworkers do not differ in their compassion satisfaction based on years of service in the County. Caseworkers employed for less than five years with the County had a mean score of 37.3 (sd=5.6). Caseworkers employed from 5-15 years with the County had a mean score of 36.1 (sd=5.1). Caseworkers employed for more than 15 years with the County had a mean score of 37.1 (sd = 4.4).

Trauma

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[19] See Table 15 t-test Age and Burnout.

[20] The One-Way ANOVA compares the means of two or more groups of participants on a single independent variable. Using multiple t-tests would inflate the Type I error rate and, thereby, increase the possibility of drawing an inappropriate conclusion (Cronk, 2012, p. 69).

The means for Years of Erie County Service was compared on Trauma using a one-way ANOVA. No significant difference was found (F (2,55) = 1.041, p > .05). CPS caseworkers do not differ in their trauma score based on years of service in the County. Caseworkers employed for less than five years with the County had a mean score of 22.4 (sd=4.8). Caseworkers employed from 5-15 years with the County had a mean score of 22.8 (sd=3.3). Caseworkers employed for more than 15 years with the County had a mean score of 20 (sd=4.2).[21]

Burnout

The Years of Erie County service was compared on Burnout using a one-way ANOVA. No significant difference was found (F (2,57) = .071, p > .05). CPS caseworkers do not differ in their trauma score based on years of service in the County. Caseworkers employed for less than five years with the County had a mean score of 25.5 (sd=6.7). Caseworkers employed from 5-15 years with the County had a mean score of 25.4 (sd=3.7). Caseworkers employed for more than 15 years with the County had a mean score of 24.6 (sd=3.5).[22]

Years as Child Welfare Worker

The questionnaire asked respondents how many years they had been in the child welfare field, selecting from <5 years, 5-15 years, and > 15 years.

[21] See Table 17 One-Way ANOVA-Years of Service and Trauma.

[22] See Table 18 One-way ANOVA -Years of Service and Burnout.

Compassion Satisfaction

Years in the child welfare field was compared on Compassion Satisfaction using a one-way ANOVA. No significant difference was found ($F(2, 57) = .837$, $p > .05$). CPS caseworkers do not differ in their compassion satisfaction based on years in the child welfare field. Caseworkers with less than five years in the child welfare field had a mean score of 37.1 (sd=5.5). Caseworkers with 5-15 years in the child welfare field had a mean score of 36.2 (sd=5.1). Caseworkers employed for more than 15 years in the child welfare field had a mean score of 39.3 (sd=5.3).[23]

Trauma

Years in the child welfare field was compared on Trauma using a one-way ANOVA. No significant difference was found ($F(2,55) = 1.037$, $p > .05$). CPS caseworkers do not differ in their trauma score based on years in the child welfare field. Caseworkers with less than five years in the child welfare field had a mean score of 23.0 (sd=5.0). Caseworkers with 5-15 years in the child welfare field had a mean score of 21.6 (sd=3.5). Caseworkers employed for more than 15 years in the child welfare field had a mean score of 20.4 (sd=4.8).[24]

Burnout

Years in the child welfare field was compared on Burnout using a one-way ANOVA. No significant difference was found ($F(2, 55) = .931$, $p > .05$). CPS caseworkers do not differ in their burnout score based on years in the child welfare field. Caseworkers with less than five

[23] See Table 19 One-Way ANOVA Years as Child Welfare Worker and Compassion Satisfaction

[24] See Table 20 One-Way ANOVA - Years as Child Welfare Worker and Trauma,

years in the child welfare field had a mean score of 25.8 (sd = 6.9). Caseworkers with 5-15 years in the child welfare field had a mean score of 25.5 (sd=3.9). Caseworkers employed for more than 15 years in the child welfare field had a mean score of 22.3(sd=4.5).[25]

Gender

Eleven males and 49 females participated in the questionnaire. There was no significant difference in their scores on compassion satisfaction, trauma, or burnout.[26]

Ethnicity

The respondents' self-reported ethnicity can be found in Table 12 Ethnicity of Respondents. One-way ANOVAs were run for ethnicity and compassion satisfaction, trauma, and burnout. None of these statistical tests were statistically significant.[27]

Table 12 Ethnicity of Respondents

Race

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	White	49	72.1	76.6	76.6
	Black, Afro-Caribbean, or African American	9	13.2	14.1	90.6
	Latino or Hispanic American	5	7.4	7.8	98.4
	East Asian or Asian American	1	1.5	1.6	100.0
	Total	64	94.1	100.0	

[25] See Table 21 One-Way ANOVA - Years as Child Welfare Worker and Burnout.

[26] See Table 22 t-Test Gender and Compassion Satisfaction; Table 23 t-test Gender and Trauma; and, Table 24 t-test Gender and Burnout.

[27] Table 25 One-Way ANOVA, Ethnicity and Compassion Satisfaction; Table 26 One-way ANOVA: Ethnicity and Trauma; and, Table 27 One-Way ANOVA: Ethnicity and Burnout.

Missing	System	4	5.9		
Total		68	100.0		

Focus Groups

The parallel qualitative analysis was designed to understand the extent to which effective supervision, coping strategies, and organizational/environmental factors were affecting CPS job satisfaction. (See Appendix for a complete report of the focus group data.)

FOCUS GROUP QUESTIONS	**Summary of Findings**
1. Does the organization make staff self-care part of the mission understanding that it affects client care? (Coping)	Overall Conclusions: The Focus Group participants responded that the organization does not make self-care a part of the mission. Caseworkers noted that informal peer support was used as a method of coping.
2. Are staff encouraged to participate in social change activities, outreach and influencing policy which can create a sense of hope, empowerment and be energizing? (Organizational/Environmental)	Overall Conclusions: The Focus Group participants responded that they are seldom asked for their opinions. The organization does not encourage them to speak out regarding policies. Some participants believe that they have no voice and fear retribution if they speak out.
3. Is the work environment safe, comfortable, and private for the caseworker to work? (Organizational/Environmental)	Overall Conclusions: The Focus Group participants responded that the organization did not provide a safe and comfortable workspace. The work areas were cited as cramped and there is no privacy. The furniture is old and often broken. The building is old. Elevators and toilets often malfunction.
4. Does the agency have safety protocol for protection of the staff, is there a security system or security guards? (Organizational/Environmental)	Overall Conclusions: The Focus Group participants responded that no in-house security existed. The Sheriff's Department can be called in a crisis within the building. Workers sometimes conduct their field work in pairs. More often they conduct their field work on their own.
5. Is there a break room where staff can address self-care needs, soft music, and	Overall Conclusions: The Focus Group participants agreed that no

comfortable furniture? (Coping)	breakrooms exist. The respondents stated that they often eat lunch at their desk. There are no areas that provide a relaxing atmosphere.
6. Is there opportunity and encouragement for staff to informally debrief with peers or formal debriefing opportunities at the agency? (Coping)	Overall Conclusions: The Focus Group participants cited that there are little to no opportunities for the staff to debrief. It was noted that the supervisors are extremely busy and have not been trained in Trauma-Informed Care.
7. Are there peer support groups such as consultation, case conferences, and clinical seminars to provide help prevent vicarious trauma. (Coping)	Overall Conclusions: Participants responded that case conferences occur but are only case specific. Training is provided but not specifically dealing with the prevention of vicarious trauma.
8. Does the agency provide and encourage supervision? (Supervisory)	Overall Conclusions: The Focus Group participants believe that case conferences and support vary among each unit. Supervisors' conference on an ad hoc basis. The respondents stated that building a rapport with their supervisor is difficult, as they often change teams.
9. Does the administration require the supervisor is trained in supervision of trauma informed care? (Supervisory)	Overall Conclusions: The Focus Group participants responded that there was no formal training for Trauma-Informed Care for the supervisors. The supervisors would only possess knowledge based on their personal experience.
10. Does the agency provide to the CPS caseworker with resources for personal therapy, structured stress management or structure physical activities such as walking, meditation, or yoga groups? (Coping)	Overall Conclusions: The organization once offered massages as part of their insurance coverage. This benefit was taken away. Zumba classes have been offered during lunch hours. Peer support was the primary response as a coping strategy.

Chapter IV. Discussion of Results

The focus group phase of this study revealed the negative bureaucratic culture that exists in Erie County's Department of Social Services. I hypothesized that the Erie County Child Protective caseworkers were experiencing Vicarious/Secondary trauma rooted in client interaction. This study found that Child Protective caseworkers were distressed, but the root cause was not from their interaction with clients.

In the ProQOL data analysis section of this study, I found that Erie County CPS caseworkers are not experiencing burnout or STS. I did find, however, that the respondents are reporting lower scores on compassion satisfaction than that of the referent population, and this difference is statistically significant. However, the scores do not reveal why caseworkers are reporting low compassion satisfaction. This is why I selected a methodology that would allow me to compare and relate my quantitative and qualitative data collection to each other. This section of my projects provides an in-depth discussion of the **meaning** of my findings.

The results of the focus groups identified several major areas of concern for the emotional and mental well-being of the caseworkers. Question 1 asked if the organization makes self-care a part of the mission, with the understanding of how it affects the client. The responses were consistent across all the focus groups stating that it is their belief that the self-care is not recognized as part of the agency mission. No self-care strategies are embedded within the organization and the caseworkers are left with an individual responsibility to meet their own self-care needs.

The caseworkers were asked about their ability to have a voice within the agency. Some of the caseworkers stated they have attempted to voice their concerns in the past, but felt that their doing so was not recognized as a good thing. Others stated that speaking up is frowned upon by the supervisors and there is an unspoken fear of retaliation if they voice their opinions.

Environmental factors such as safety and privacy were also discussed. The caseworkers stated that their fieldwork environment is not safe. The caseworkers are not permitted to carry any type of weapon and often make home visits alone. The CPS caseworker conducts home visits in the most crime laden areas in the City of Buffalo and also to the most rural areas of Erie County. If they are threatened or if the police need to be called, it can take up to thirty-five minutes or more for the police to respond.

The CPS caseworkers' offices are located at 478 Main Street in the City of Buffalo. This building was once the Hens and Kelly's department store. The building's heating and cooling system is not equipped for the array of small offices that exist to house the many CPS Units. The elevators in the building often malfunction and workers have been trapped in the elevator for hours. The work spaces are cramped with anywhere from 8-10 people in one room. The noise factor and inability to concentrate were cited as ongoing issues. There is no breakroom for the caseworkers and they often eat their lunch at their desk. The only time that they can get away from the work is when they leave the building. The lavatories cannot handle the number of staff located in the building. Toilets do not function appropriately and the bathrooms are closed for several days due to necessary repairs.

Turning to the supervision dimension, it was found that the supervisors have not received training in trauma-informed practice. Most participants felt that there was no genuine concern

throughout the agency for their well-being as workers (several reiterated, "It's all about the numbers, that's all they care about…closing cases.") The caseworkers discussed the practice of "bouncing" caseworkers to different teams. They stated that this is very stressful and disruptive to work flow for three reasons: logistics, work relationships, and the caseworker-supervisory relationships. In terms of logistics, the focus group participants reported that it is disruptive to have to switch office work space, have their phone number changed over, and having to repeatedly take calls from the person who last had that extension. With respect to team relationships, caseworkers reported that it requires establishing new work relationships and trying to gel with new teammates, both of which take time. The practice of "bouncing" hinders support-seeking among peers and caseworkers felt the need to seek out former teammates (and feel guilty about taking up their time, in doing so). Finally, caseworkers also have to take time to readjust to a new supervisor who may have expectations that are not consistent with previous supervisor.

Chapter V: Recommendations, Conclusions, and Future Research

Recommendations

The findings of this study support several recommendations that can be implemented immediately or in the near future that should improve the ability of Erie County CPS caseworkers to provide more effective child welfare protection to the citizens of Erie County. These are as follows:

- EFFECTIVE SUPERVISION
    - Supervisors and front line staff should receive training in Trauma Informed Care practices. These practices need to be interwoven through the entire agency, supported and sustained by the agency administration.
- COPING
    - Discussions must be held with those people entering the child welfare workforce concerning the impact that their work will have on them and on the families they will serve. These conversations must emphasize strategies for self-care. In addition, workloads must be continually assessed to ensure that they remain manageable.
- ORGANIZATIONAL STRUCTURE
    - The Child Protective System is more than forty years old. Little has been done during that period to update policies and procedures to ensure that the system remains relevant to the type of work that is required today.
        - A Statewide Workgroup comprised of frontline workers, supervisors, administrators, community leaders, and other relevant stakeholders should be established in the spirit of deliberative democracy suggested by the New Public Service paradigm. This workgroup would be charged with correcting the inadequacies in the current system and bringing it into the 21st century.
        - An Advisory Group of frontline CPS caseworkers and their immediate supervisors should be a part of each and every county child welfare agency. These advisory groups would allow the caseworkers to have a

say in the day-to-day operations. This structure would empower the caseworkers and provide them with some control over the procedures that they are expected to perform.

- SAFETY AND OTHER ENVIRONMENTAL FACTORS

    - Many CPS workers have felt unsafe in the field. The County needs to work with its CPS caseworkers to mutually arrive at strategies that will help them feel safer. Erie County needs assistance in this area.
    - The Hens and Kelly building is not suitable in its current state for CPS workers.
    - Erie County Administration is in the process of searching for a new work space for all child welfare staff. The lease at 478 Main Street expires in March of 2017. The caseworkers have provided the Erie County Administration with a list of their requests for what they would like to have in a new building. One of the high priorities is free parking. CPS workers should continue to be consulted as to their workspace needs, perhaps with townhall style meetings where everyone has the opportunity to listen and provide input.

Implications

Child welfare caseworkers are front-line bureaucrats responsible for implementing state law regarding child welfare each and every day. The public administration of the early 20th century – where civil servants were seen as "cogs in the wheel" of scientific management practices designed to govern by routinized SOPs developed by "omniscient" supervisors and managers – is no longer feasible for administering programs and laws in the complex societies public servants inhabit in the twenty-first century. Caseworkers – as with all educated professionals serving the public – are both citizens and public servants, and rightly seek a voice within their agency and desire to be included in the policy-making process.

It should be recognized that each county and state child welfare organization has a responsibility to care for its staff, whose knowledge, public spirited service, and compassion for the citizens they serve are the county's most valuable resource. These individuals serve an invaluable function, as they accept the challenge to insure the safety and well-being of children.

The quantitative phase of this study found that the respondents were below the norm for compassion satisfaction. There was little indication of Burnout and Secondary/VT, however, as compared to the norms for human service workers. However, the qualitative focus group phase of the study indicated that the CPS caseworkers were dissatisfied with continued high caseloads, bureaucratic and punitive agency practices, lack of work-life balance, lack of organizational support and lack of perceived organizational fairness in both procedures and outcomes. Specifically, the caseworkers reported having little say in decision-making, expressed concern for their safety and well-being (which they believed supervisors did not take seriously), and disliked the shuffling of work teams (especially as these changes did not have an accompanying rationale).

It can be argued that the focus groups revealed a classic public administration dilemma in Erie County's Department of Social Services – one that exists in many public bureaucracies. Bureaucracy characteristics include a hierarchical structure, task division, and formal rules and regulations. Furthermore, there is little communication between line workers and supervisors in this top-down management style. The decision-making is repetitive and centralized and there is a reluctance to consider and initiate innovations. The Department of Social Services is characterized by separation between management (management confidential) and policy control (politicians). In this culture of conformity, there is little autonomy and flexibility in decision-

making, which can impede the ability of the organization to make necessary changes to improve both service and efficiency.

There are larger issues that this study cannot specifically address, but must be considered as we continuously seek to improve our system of child protection in Erie County. Responsibility for the care and protection of maltreated children must be shared by parents (who abuse children and conceal abuse), neighbors who fail to report, and other professionals who see the results of abuse and fail to recognize and report it. There is a misperception that Child Protective Services has absolute power in making the determination that children remain in a home or are removed and placed with a relative or in a foster home. This is a misnomer that is widely accepted by the community. The child protective caseworker may find it necessary to remove a child from the home, but it is the family court judge who must uphold this decision. All levels of government must be cognizant of budget cuts that negatively affect children's services and to be aware of the media reports which target child protective services and fail to show the contribution of all participants in the tragic outcome.

Future Research

A salary survey was beyond the scope of this study. In terms of future research, a study by the administration of the Erie County Department of Social Services is now underway which will compare salaries of Erie County CPS caseworkers with those salaries of CPS caseworkers in neighboring counties. The results of this salary survey will fill in the missing pieces to the puzzle of the factors influencing turnover of CPS caseworkers in Erie County.

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APPENDIX A Survey Administered via Qualtrics

Q1 INFORMED CONSENT: PARTICIPATION IN RESEARCH BUFFALO STATE COLLEGE

Purpose for the Research This is a quantitative study of currently employed Erie County Child Protective caseworkers to assess and intercept VT. The goal is to identify the current practices, needs, and recommendations of caseworkers to protect themselves from the impact of working with traumatized clients. There are several reasons for this research: a) to determine if the current precautionary efforts of the agency to deflect the impact of secondary trauma stress and VT match the level of warnings and advice found in the vast amount of literature, b) to improve casework practice, and c) articulate the needs of the caseworker to improve supervision, training, organization and professional support. The aim of this research project is to learn factors to preserve the health of the most important tool in the protection of children; the Child Protective caseworker. This study is being conducted in partial fulfillment of the Masters in Public Administration at SUNY Buffalo State.

Confidentiality You were selected as a possible participant because you are a trained Child Protective caseworker that has worked with trauma. Participation in this study is voluntary and confidential. All identifying information of the participant and their place of employment will be kept confidential. The surveys associated with this study will be destroyed after completion and presentation of this research project. Please read this form and ask any questions you may have

before agreeing to be in the study. This study is being conducted by: Sharon L. Rochelle, a graduate student in the Masters of Public Administration at Buffalo State College with instructional assistance from Dr. Laurie Buonanno.

Risks There is minimal risk to participating in this research. During the survey, participants will be encouraged to explore the impact of VT and their responses to VT. The potential minimal risk in this study is that the participant may recall or begin to recognize symptoms of secondary trauma stress or VT and this may be disturbing. The participant has permission to pass on a question or terminate the survey at any time if feeling uncomfortable. There are no repercussions for withdrawing from this study. Should the participant feel any disturbance during or after this interview the participant is encouraged to see the support of a supervisor or consult with a clinical colleague, access their Employee Assistance Program (EAP). I agree to participate in this study:

- ❍ Yes (1)
- ❍ No (2)

Q2 Please let us know a little bit about yourself:

- ❍ Male (1)
- ❍ Female (2)
- ❍ Transgender (3)
- ❍ Androgynous (4)
- ❍ Intersex (5)
- ❍ Transsexual (6)
- ❍ FTM (female-to-male) (7)
- ❍ MTF (male-to-female) (8)
- ❍ Other (9)

Q3 What is your age?

- ❍ 18 - 35 (1)
- ❍ 36 and up (2)

Q4 Race

- ❍ White (1)
- ❍ Non-Hispanic White or Euro-American (2)
- ❍ Black, Afro-Caribbean, or African American (3)
- ❍ Latino or Hispanic American (4)
- ❍ East Asian or Asian American (5)
- ❍ South Asian or Indian American (6)
- ❍ Middle Eastern or Arab American (7)
- ❍ Native American or Alaskan Native (8)
- ❍ Other (9)

Q5 Years at current place of employment:

- ❍ < 5 (1)
- ❍ 5 - 15 (2)
- ❍ 15 > (3)

Q6 Years in the Child Welfare field:

- ❍ < 5 (1)
- ❍ 5 - 15 (2)
- ❍ 15 > (3)

Q7 I am happy.

- ❍ Never (1)
- ❍ Rarely (2)
- ❍ Sometimes (3)
- ❍ Often (4)
- ❍ Very Often (5)

Q8 I am preoccupied with more than one person I help.

- ❍ Never (1)
- ❍ Rarely (2)
- ❍ Sometimes (3)
- ❍ Often (4)
- ❍ Very Often (5)

Q9 I get satisfaction from being able to help people.

- ❍ Never (1)
- ❍ Rarely (2)
- ❍ Sometimes (3)
- ❍ Often (4)
- ❍ Very Often (5)

Q10 I feel connected to others.

- ❍ Never (1)
- ❍ Rarely (2)
- ❍ Sometimes (3)
- ❍ Often (4)
- ❍ Very Often (5)

Q11 I jump or am startled by unexpected sounds.

- ❍ Never (1)
- ❍ Rarely (2)
- ❍ Sometimes (3)
- ❍ Often (4)
- ❍ Very Often (5)

Q12 I feel invigorated after working with those I help.

- ❍ Never (1)
- ❍ Rarely (2)
- ❍ Sometimes (3)
- ❍ Often (4)
- ❍ Very Often (5)

Q13 I find it difficult to separate my personal life from my life as a caseworker.

- ❍ Never (1)
- ❍ Rarely (2)
- ❍ Sometimes (3)
- ❍ Often (4)
- ❍ Very Often (5)

Q14 I am not as productive at work because I am losing sleep over traumatic experiences of a person I help.

- ❍ Never (1)
- ❍ Rarely (2)
- ❍ Sometimes (3)
- ❍ Often (4)
- ❍ Very Often (5)

Q15 I think I may have been affected by the traumatic stress of those I help.

- ❍ Never (1)
- ❍ Rarely (2)
- ❍ Sometimes (3)
- ❍ Often (4)
- ❍ Very Often (5)

Q16 I feel trapped by my job as a caseworker.

- ❍ Never (1)
- ❍ Rarely (2)
- ❍ Sometimes (3)
- ❍ Often (4)
- ❍ Very Often (5)

Q17 Because of my helping, I have felt on edge about various things.

- ❍ Never (1)
- ❍ Rarely (2)
- ❍ Sometimes (3)
- ❍ Often (4)
- ❍ Very Often (5)

Q18 I like my work as a caseworker.

- ❍ Never (1)
- ❍ Rarely (2)
- ❍ Sometimes (3)
- ❍ Often (4)
- ❍ Very Often (5)

Q19 I feel depressed because of the traumatic experiences about the people I help.

- ❍ Never (1)
- ❍ Rarely (2)
- ❍ Sometimes (3)
- ❍ Often (4)
- ❍ Very Often (5)

Q20 I feel as though I am experiencing the trauma of someone I have helped.

- ❍ Never (1)
- ❍ Rarely (2)
- ❍ Sometimes (3)
- ❍ Often (4)
- ❍ Very Often (5)

Q21 I have beliefs that sustain me.

- ❍ Never (1)
- ❍ Rarely (2)
- ❍ Sometimes (3)
- ❍ Often (4)
- ❍ Very Often (5)

Q22 I am pleased with how I am able to keep up with caseworker techniques and protocols.

- ❍ Never (1)
- ❍ Rarely (2)
- ❍ Sometimes (3)
- ❍ Often (4)
- ❍ Very Often (5)

Q23 I am the person I always wanted to be.

- ❍ Never (1)
- ❍ Rarely (2)
- ❍ Sometimes (3)
- ❍ Often (4)
- ❍ Very Often (5)

Q24 My work makes me feel satisfied.

- ❍ Never (1)
- ❍ Rarely (2)
- ❍ Sometimes (3)
- ❍ Often (4)
- ❍ Very Often (5)

Q25 I feel worn out because of my work as a caseworker.

- ❍ Never (1)
- ❍ Rarely (2)
- ❍ Sometimes (3)
- ❍ Often (4)
- ❍ Very Often (5)

Q26 I have happy thoughts and feelings about those I help, and how I could help them.

- ❍ Never (1)
- ❍ Rarely (2)
- ❍ Sometimes (3)
- ❍ Often (4)
- ❍ Very Often (5)

Q27 I feel overwhelmed because my caseload seems endless.

- ❍ Never (1)
- ❍ Rarely (2)
- ❍ Sometimes (3)
- ❍ Often (4)
- ❍ Very Often (5)

Q28 I believe I can make a difference through my work.

- ❍ Never (1)
- ❍ Rarely (2)
- ❍ Sometimes (3)
- ❍ Often (4)
- ❍ Very Often (5)

Q29 I avoid certain activities or situations because they remind me of frightening experiences of the people I [help].

- ❍ Never (1)
- ❍ Rarely (2)
- ❍ Sometimes (3)
- ❍ Often (4)
- ❍ Very Often (5)

Q30 I am proud of what I can do to help.

- ❍ Never (1)
- ❍ Rarely (2)
- ❍ Sometimes (3)
- ❍ Often (4)
- ❍ Very Often (5)

Q31 As a result of my casework, I have intrusive frightening thoughts.

- ❍ Never (1)
- ❍ Rarely (2)
- ❍ Sometimes (3)
- ❍ Often (4)
- ❍ Very Often (5)

Q32 I feel "bogged down" by the system.

- ❍ Never (1)
- ❍ Rarely (2)
- ❍ Sometimes (3)
- ❍ Often (4)
- ❍ Very Often (5)

Q33 I have thoughts that I am a success as a caseworker.

- ❍ Never (1)
- ❍ Rarely (2)
- ❍ Sometimes (3)
- ❍ Often (4)
- ❍ Very Often (5)

Q34 I can't recall important parts of my work with trauma victims.

- ❍ Never (1)
- ❍ Rarely (2)
- ❍ Sometimes (3)
- ❍ Often (4)
- ❍ Very Often (5)

Q35 I am a very caring person.

- ❍ Never (1)
- ❍ Rarely (2)
- ❍ Sometimes (3)
- ❍ Often (4)
- ❍ Very Often (5)

Q36 I am happy that I chose to do this work.

- ❍ Never (1)
- ❍ Rarely (2)
- ❍ Sometimes (3)
- ❍ Often (4)
- ❍ Very Often (5)

APPENDIX B Reflective Questions about Agency Culture Regarding Vicarious Trauma (Focus Group Questions)

1. Does the organization make staff self-care part of the mission understanding that it affects client care?

2. Are staff encouraged to participate in social change activities, outreach and influencing policy which can create a sense of hope, empowerment and be energizing?

3. Is the work environment safe, comfortable, and private for the caseworker to work?

4. Does the agency have safety protocol for protection of the staff, is there a security system or security guards?

5. Is there a break room where staff can address self-care needs, soft music, and comfortable furniture?

6. Is there opportunity and encouragement for staff to informally debrief with peers or formal debriefing opportunities at the agency?

7. Are there peer support groups such as consultation, case conferences, and clinical seminars to provide help prevent vicarious trauma.

8. Does the agency provide and encourage supervision?

9. Does the administration require the supervisor is trained in supervision of trauma counselor?

10. Does the agency provide to the CPS caseworker with resources for personal therapy, structured stress management or structure physical activities such as walking, meditation, or yoga groups?

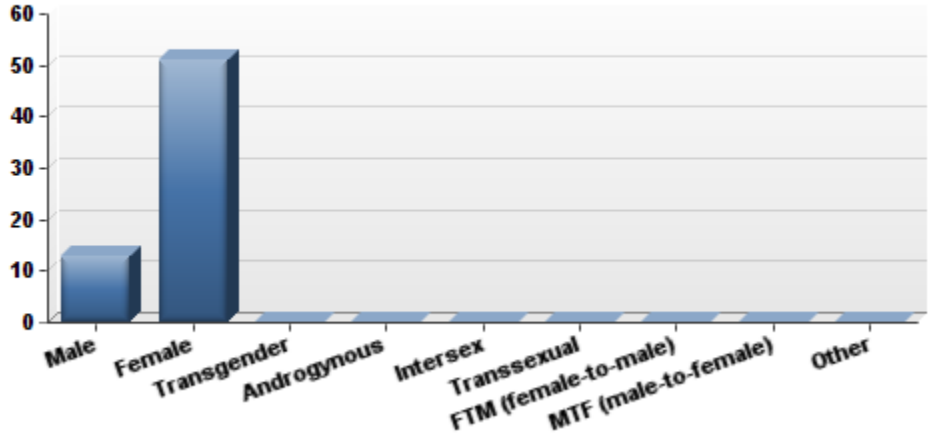
Appendix C Results of the ProQOL Survey

#	Answer		Response	%
1	Yes		68	100%
2	No		0	0%
	Total		68	100%

Statistic	Value
Min Value	1
Max Value	1
Mean	1.00
Variance	0.00
Standard Deviation	0.00
Total Responses	68

2. What is your gender identity?

#	Answer		Response	%
1	Male		13	20%
2	Female		51	80%
3	Transgender		0	0%
4	Androgynous		0	0%
5	Intersex		0	0%
6	Transsexual		0	0%
7	FTM (female-to-male)		0	0%
8	MTF (male-to-female)		0	0%
9	Other		0	0%
	Total		64	100%



#	Answer		Response	%
1	Male		13	20%
2	Female		51	80%
3	Transgender		0	0%
4	Androgynous		0	0%
5	Intersex		0	0%
6	Transsexual		0	0%
7	FTM (female-to-male)		0	0%
8	MTF (male-to-female)		0	0%
9	Other		0	0%
	Total		64	100%

Statistic	Value
Min Value	1
Max Value	2
Mean	1.80
Variance	0.16
Standard Deviation	0.41
Total Responses	64

3. What is your age?

#	Answer		Response	%
1	18 - 35		36	57%
2	36 and up		27	43%
	Total		63	100%

Statistic	Value
Min Value	1
Max Value	2
Mean	1.43
Variance	0.25
Standard Deviation	0.50
Total Responses	63

4. Race

#	Answer		Response	%
1	White		49	77%
3	Non-Hispanic White or Euro-American		0	0%
4	Black, Afro-Caribbean, or African American		9	14%
5	Latino or Hispanic American		5	8%
6	East Asian or Asian American		1	2%
7	South Asian or Indian American		0	0%
8	Middle Easter or Arab American		0	0%
9	Native American or Alaskan Native		0	0%
10	Other		0	0%
	Total		64	100%

Other

Statistic	Value
Min Value	1
Max Value	6
Mean	1.81
Variance	2.28
Standard Deviation	1.51
Total Responses	64

5. Years at current place of employment:

#	Answer		Response	%
1	< 5		39	61%
2	5 - 15		17	27%
3	15 >		8	13%
	Total		64	100%

Years

Statistic	Value
Min Value	1
Max Value	3
Mean	1.52
Variance	0.51
Standard Deviation	0.71
Total Responses	64

6. Years in the Child Welfare field:

#	Answer		Response	%
1	< 5		32	50%
2	5 - 15		24	38%
3	15 >		8	13%
	Total		64	100%

Statistic	Value
Min Value	1
Max Value	3
Mean	1.63
Variance	0.49
Standard Deviation	0.70
Total Responses	64

7. I am happy.

#	Answer		Response	%
1	Never		0	0%
2	Rarely		3	5%
3	Sometimes		17	28%
4	Often		30	49%
5	Very Often		11	18%
	Total		61	100%

#	Answer		Response	%
1	Never		0	0%
2	Rarely		3	5%
3	Sometimes		17	28%
4	Often		30	49%
5	Very Often		11	18%
	Total		61	100%

Statistic	Value
Min Value	2
Max Value	5
Mean	3.80
Variance	0.63
Standard Deviation	0.79
Total Responses	61

8. I am preoccupied with more than one person I help.

#	Answer		Response	%
1	Never		0	0%
2	Rarely		8	13%
3	Sometimes		22	37%
4	Often		21	35%
5	Very Often		9	15%
	Total		60	100%

Statistic	Value
Min Value	2
Max Value	5
Mean	3.52
Variance	0.83
Standard Deviation	0.91
Total Responses	60

9. I get satisfaction from being able to help people.

#	Answer		Response	%
1	Never		0	0%
2	Rarely		1	2%
3	Sometimes		10	16%
4	Often		31	51%
5	Very Often		19	31%
	Total		61	100%

Statistic	Value
Min Value	2
Max Value	5
Mean	4.11
Variance	0.54
Standard Deviation	0.73
Total Responses	61

10. I feel connected to others.

#	Answer		Response	%
1	Never		0	0%
2	Rarely		1	2%
3	Sometimes		20	33%
4	Often		31	51%
5	Very Often		9	15%
	Total		61	100%

Statistic	Value
Min Value	2
Max Value	5
Mean	3.79
Variance	0.50
Standard Deviation	0.71
Total Responses	61

11. I jump or am startled by unexpected sounds.

#	Answer		Response	%
1	Never		4	7%
2	Rarely		24	39%
3	Sometimes		28	46%
4	Often		4	7%
5	Very Often		1	2%
	Total		61	100%

Statistic	Value
Min Value	1
Max Value	5
Mean	2.57
Variance	0.62
Standard Deviation	0.78
Total Responses	61

12. I feel invigorated after working with those I help.

#	Answer		Response	%
1	Never		0	0%
2	Rarely		2	3%
3	Sometimes		25	41%
4	Often		29	48%
5	Very Often		5	8%
	Total		61	100%

Statistic	Value
Min Value	2
Max Value	5
Mean	3.61
Variance	0.48
Standard Deviation	0.69
Total Responses	61

13. I find it difficult to separate my personal life from my life as a caseworker.

#	Answer		Response	%
1	Never		8	13%
2	Rarely		28	46%
3	Sometimes		18	30%
4	Often		5	8%
5	Very Often		2	3%
	Total		61	100%

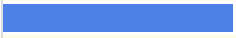
Statistic	Value
Min Value	1
Max Value	5
Mean	2.43
Variance	0.88
Standard Deviation	0.94
Total Responses	61

14. I am not as productive at work because I am losing sleep over traumatic experiences of a person I help.

#	Answer		Response	%
1	Never		15	25%
2	Rarely		30	49%
3	Sometimes		14	23%
4	Often		2	3%
5	Very Often		0	0%
	Total		61	100%

Statistic	Value
Min Value	1
Max Value	4
Mean	2.05
Variance	0.61
Standard Deviation	0.78
Total Responses	61

15. I think I may have been affected by the traumatic stress of those I help.

#	Answer		Response	%
1	Never		9	15%
2	Rarely		29	48%
3	Sometimes		17	28%
4	Often		5	8%
5	Very Often		0	0%
	Total		60	100%

Statistic	Value
Min Value	1
Max Value	4
Mean	2.30
Variance	0.69
Standard Deviation	0.83
Total Responses	60

16. I feel trapped by my job as a caseworker.

#	Answer		Response	%
1	Never		12	20%
2	Rarely		13	21%
3	Sometimes		28	46%
4	Often		6	10%
5	Very Often		2	3%
	Total		61	100%

Statistic	Value
Min Value	1
Max Value	5
Mean	2.56
Variance	1.05
Standard Deviation	1.03
Total Responses	61

17. Because of my helping, I have felt on edge about various things.

#	Answer		Response	%
1	Never		8	13%
2	Rarely		26	43%
3	Sometimes		18	30%
4	Often		6	10%
5	Very Often		2	3%
	Total		60	100%

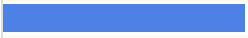
Statistic	Value
Min Value	1
Max Value	5
Mean	2.47
Variance	0.93
Standard Deviation	0.96
Total Responses	60

18. I like my work as a caseworker.

#	Answer		Response	%
1	Never		0	0%
2	Rarely		2	3%
3	Sometimes		15	25%
4	Often		30	49%
5	Very Often		14	23%
	Total		61	100%

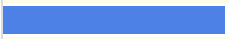
Statistic	Value
Min Value	2
Max Value	5
Mean	3.92
Variance	0.61
Standard Deviation	0.78
Total Responses	61

19. I feel depressed because of the traumatic experiences about the people I help.

#	Answer		Response	%
1	Never		17	29%
2	Rarely		30	51%
3	Sometimes		12	20%
4	Often		0	0%
5	Very Often		0	0%
	Total		59	100%

Statistic	Value
Min Value	1
Max Value	3
Mean	1.92
Variance	0.49
Standard Deviation	0.70
Total Responses	59

20. I feel as though I am experiencing the trauma of someone I have helped.

#	Answer		Response	%
1	Never		25	42%
2	Rarely		28	47%
3	Sometimes		6	10%
4	Often		1	2%
5	Very Often		0	0%
	Total		60	100%

Statistic	Value
Min Value	1
Max Value	4
Mean	1.72
Variance	0.51
Standard Deviation	0.72
Total Responses	60

21. I have beliefs that sustain me.

#	Answer		Response	%
1	Never		0	0%
2	Rarely		5	8%
3	Sometimes		14	23%
4	Often		26	43%
5	Very Often		15	25%
	Total		60	100%

Statistic	Value
Min Value	2
Max Value	5
Mean	3.85
Variance	0.81
Standard Deviation	0.90
Total Responses	60

22. I am pleased with how I am able to keep up with caseworker techniques and protocols.

#	Answer		Response	%
1	Never		1	2%
2	Rarely		6	10%
3	Sometimes		23	38%
4	Often		25	41%
5	Very Often		6	10%
	Total		61	100%

Statistic	Value
Min Value	1
Max Value	5
Mean	3.48
Variance	0.75
Standard Deviation	0.87
Total Responses	61

23. I am the person I always wanted to be.

#	Answer		Response	%
1	Never		0	0%
2	Rarely		4	7%
3	Sometimes		22	36%
4	Often		29	48%
5	Very Often		6	10%
	Total		61	100%

Statistic	Value
Min Value	2
Max Value	5
Mean	3.61
Variance	0.58
Standard Deviation	0.76
Total Responses	61

24. My work makes me feel satisfied.

#	Answer		Response	%
1	Never		1	2%
2	Rarely		3	5%
3	Sometimes		29	48%
4	Often		24	39%
5	Very Often		4	7%
	Total		61	100%

Statistic	Value
Min Value	1
Max Value	5
Mean	3.44
Variance	0.58
Standard Deviation	0.76
Total Responses	61

25. I feel worn out because of my work as a caseworker.

#	Answer		Response	%
1	Never		1	2%
2	Rarely		4	7%
3	Sometimes		34	56%
4	Often		12	20%
5	Very Often		10	16%
	Total		61	100%

Statistic	Value
Min Value	1
Max Value	5
Mean	3.43
Variance	0.82
Standard Deviation	0.90
Total Responses	61

26. I have happy thoughts and feelings about those I help, and how I could help them.

#	Answer		Response	%
1	Never		0	0%
2	Rarely		3	5%
3	Sometimes		26	43%
4	Often		27	44%
5	Very Often		5	8%
	Total		61	100%

Statistic	Value
Min Value	2
Max Value	5
Mean	3.56
Variance	0.52
Standard Deviation	0.72
Total Responses	61

27. I feel overwhelmed because my caseload seems endless.

#	Answer		Response	%
1	Never		2	3%
2	Rarely		5	8%
3	Sometimes		24	39%
4	Often		16	26%
5	Very Often		14	23%
	Total		61	100%

Statistic	Value
Min Value	1
Max Value	5
Mean	3.57
Variance	1.08
Standard Deviation	1.04
Total Responses	61

28. I believe I can make a difference through my work.

#	Answer		Response	%
1	Never		0	0%
2	Rarely		2	3%
3	Sometimes		23	38%
4	Often		27	44%
5	Very Often		9	15%
	Total		61	100%

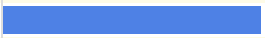
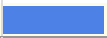
Statistic	Value
Min Value	2
Max Value	5
Mean	3.70
Variance	0.58
Standard Deviation	0.76
Total Responses	61

29. I avoid certain activities or situations because they remind me of frightening experiences of the people I help.

#	Answer		Response	%
1	Never		30	50%
2	Rarely		27	45%
3	Sometimes		1	2%
4	Often		1	2%
5	Very Often		1	2%
	Total		60	100%

Statistic	Value
Min Value	1
Max Value	5
Mean	1.60
Variance	0.58
Standard Deviation	0.76
Total Responses	60

30. I am proud of what I can do to help.

#	Answer		Response	%
1	Never		0	0%
2	Rarely		1	2%
3	Sometimes		14	23%
4	Often		33	54%
5	Very Often		13	21%
	Total		61	100%

Statistic	Value
Min Value	2
Max Value	5
Mean	3.95
Variance	0.51
Standard Deviation	0.72
Total Responses	61

31. As a result of my casework, I have intrusive, frightening thoughts.

#	Answer		Response	%
1	Never		21	35%
2	Rarely		27	45%
3	Sometimes		10	17%
4	Often		2	3%
5	Very Often		0	0%
	Total		60	100%

Statistic	Value
Min Value	1
Max Value	4
Mean	1.88
Variance	0.65
Standard Deviation	0.80
Total Responses	60

32. I feel "bogged down" by the system.

#	Answer		Response	%
1	Never		4	7%
2	Rarely		14	23%
3	Sometimes		18	30%
4	Often		13	21%
5	Very Often		12	20%
	Total		61	100%

Statistic	Value
Min Value	1
Max Value	5
Mean	3.25
Variance	1.46
Standard Deviation	1.21
Total Responses	61

33. I have thoughts that I am a “success” as a caseworker.

#	Answer		Response	%
1	Never		0	0%
2	Rarely		6	10%
3	Sometimes		29	48%
4	Often		19	31%
5	Very Often		7	11%
	Total		61	100%

Statistic	Value
Min Value	2
Max Value	5
Mean	3.44
Variance	0.68
Standard Deviation	0.83
Total Responses	61

34. I can't recall important parts of my work with trauma victims.

#	Answer		Response	%
1	Never		15	25%
2	Rarely		35	58%
3	Sometimes		10	17%
4	Often		0	0%
5	Very Often		0	0%
	Total		60	100%

Statistic	Value
Min Value	1
Max Value	3
Mean	1.92
Variance	0.42
Standard Deviation	0.65
Total Responses	60

35. I am a very caring person.

#	Answer		Response	%
1	Never		0	0%
2	Rarely		0	0%
3	Sometimes		4	7%
4	Often		33	54%
5	Very Often		24	39%
	Total		61	100%

Statistic	Value
Min Value	3
Max Value	5
Mean	4.33
Variance	0.36
Standard Deviation	0.60
Total Responses	61

36. I am happy that I chose to do this work.

#	Answer		Response	%
1	Never		0	0%
2	Rarely		3	5%
3	Sometimes		23	38%
4	Often		22	37%
5	Very Often		12	20%
	Total		60	100%

Statistic	Value
Min Value	2
Max Value	5
Mean	3.72
Variance	0.71
Standard Deviation	0.85
Total Responses	60

Appendix D Focus Group Results

Q1: In what ways does the organization make staff self-care part of the mission with the understanding that it affects client care?

Group 1	Group 2	Group 3	Group 4	Group 5	Group 6	Group 7	Group 8	Group 9	Group 10
No self-care.	Unknown	EAP Contact (not utilized)	None.	Individual responsibility of the CW.	Nothing.	It doesn't.	They don't.	Group Laughter--"No" (collective)	Laughter. No.
Do not believe self-care is recognized within the agency.	Employee Assistance Program (EAP)	Informal peer support, used whenever time allows, and often on the fly.	EAP, which is not utilized.	Nothing structurally embedded within the organization.	Some teams have celebrations.	Some TLs do this (team-building), depending on their individual personalities.	We have counseling covered in our health insurance, but we don't have time to use it.	We're denied vacations	It should be, but it's not.
Believe self-care is overlooked individually and systemically.		Participants feel they need to be cautious for fear that they	No team-building.	Depends on the team culture/ dynamics as well as the TL.	One team has monthly luncheons (TL initiates).	One person stated that workers have time off, sick time, personal	We neglect ourselves. When asked, respondents	We have an informal support system within.	You can turn to TLs when you're overwhelmed.

Too many barriers to structural support.	Most not aware	will be perceived as socializing, rather than engaging in emotional self-care.		We rely on each other (peers) for support.	Participants state they either miss lunch, eat at desk or eat while driving to/from home visits in community. Only one participant states she makes sure she eats lunch daily.	comp and health insurance through BC for MH counseling & medications for $15 copay. This also includes chiropractic care, massages, etc. 2 of the 11 participants stated they take advantage of these services. One of those 2 participants emphasized that utilizing these	clarified: "Our health, our personal lives.	There is EAP, but there's no time to utilize it. Only one participant knew of one instance in which EAP was used, over the course of many years. All participants stated EAP is difficult to access, many didn't know how to access, requires those trying to access it to "jump through hoops," and is very "complicated."	Happy Hour every 2-3 months (peer led).
Participants believe that the responsibility for maintaining good self-care is placed	Nothing	Participants have the perception that "venting" frustrations or emotions		It's very informal.			Some of us take a lunch.	No confidentiality.	We had small caseloads by week 2. Some of new CWs were given mentoring/advice here and there on maintaining

solely on the individual and is not viewed as the responsibility of the agency.		tied to the work will invite accusations of being "negative."				services was a matter of personal choice, and that if a worker can't keep up with the demands of the job, they should find another job.			self care and avoiding burnout. This varies from TL to TL.
	No longer have insurance coverage for massages	Go drinking together at the bar.		Some TLs have an open-door policy for CWs to seek support.	Meet teammates outside of work for lunch (on occasion).			There now seem to be a couple of individuals who are part of the new administration who we can probably go to, who appear to care.	Some participants stated they started going out to do home visits in 2 weeks, and all participants stated they did not feel that this was adequate preparation.
	It's the caseworkers' individual responsibility	Utilize former team members when able. Participants also		We're always in "crisis mode." Self care is the last thing on our minds.	Happy Hour at bar.	The rest of the members of the group disagreed with this last		There's a lot of negative gossip.	

	Would like a counselor	expressed feeling guilty about burdening their peers, once having moved to a different team.				statement, stating that the job comes first and that it was very difficult to balance family and personal needs (including medical) with the demands of the job.		One TL stated s/he liked to have group discussions (with her/his team) whenever someone experienced a traumatic event: asked them how they were feeling, and process.	
	Informal peer support							There's a lack of sensitivity.	
	Some feel they can go to their TLs (depends on the TL)					Some trainings offered, but It just gets too crazy to take days off.			
						They bounce team members around once they develop a			

good vibe.

Q2: Are staff encouraged to participate in social change activities, outreach and influencing policy which can create a sense of hope, empowerment and be energizing?

Group 1	Group 2	Group 3	Group 4	Group 5	Group 6	Group 7	Group 8	Group 9	Group 10
Not at all.	Some participants feel it's encouraged	NO!	Not at all.	Some state they are asked for their opinions.	No.	No knowledge.	No.	As TLs, we are encouraged to share our input with coordinators.	Nervous laughter.
Participants feel discouraged from reaching out or speaking up on anything political or of "rocking the boat."	Some participants feel discouraged	Participants feel their suggestions are not taken seriously.	Some stated they have attempted to voice their concerns in the past, but felt that their doing so was not recognized as a good thing.	Others state they fear repercussions for providing any kind of suggestions, input, etc.	Participants stated that they didn't believe that any of their input went very far up the chain of command.	One participant gave an example of taking part in Kinship focus groups (they believe this may have been state initiated	We have no voice.	Ideas are usually heard, but there is rarely any follow-up.	No encouragement to speak out about policies (probation makes this difficult).

						w/ state trainer (re-writing policy in Erie County?) .			
Participants state they barely have opportunities for personal lunches, much less involving themselves in social change activities.	Most expressed a fear to share due to job insecurity .	Feeling they have "no voice."	Speaking up will get you punished.	Nothing comes of what we say / of us providing our opinions and feedback.	No consistency in terms of adhering to policies and procedures . Many not sure of policies and state that they seem to change often.	They listen to us, but hands are tied all the way up the chain (of command).	We did have a couple of those "town meetings " at the library.	We want feedback.	Speaking up is "frowned upon."
		Inhibited due to fear of job loss.	Viewed as "insubordination."	There is no consistency in responses.	Would like to see policies & procedures made easily accessible, such as on		Policies change very often. We receive email notices,	During "Town Hall meeting, a TL made a suggestion & the coordinators shot it down.	
		Believe that their TLs/supervisors and		Several stated their belief that TL's					

		even the Director have a limited voice, if any at all.		don't have much say, either.	Sharepoint.		but it's very difficult to keep up with all of them. We'd have to save all of those emails and sort through them to find policy information. There isn't easy access, like on Sharepoint.		
				One person stated that some coordinators have the power to make things happen. One or two other participants agreed with that statement.	There seems to be a lot of procedural ambiguity, depending on who the TL/Supervisor or Coordinator happens to be (which changes often, due to "bouncing.")			There is a lot of entrenched thinking.	
								There are always repercussions for speaking out.	
							We are part of a union, but we never see our union	There's a lack of trust do to a lack of confidentiality in	

							rep. The only time they get involved is when there's disciplinary action.	supervisions.	
					Participants state there are unspoken repercussions for voicing any concerns or engaging in any social/political activities, or making complaints or suggestions.				

3. Is the work environment safe, comfortable, and private for the caseworker to work?

Group 1	Group 2	Group 3	Group 4	Group 5	Group 6	Group 7	Group 8	Group 9	Group 10
It depends on the team.	Not enough security	No Privacy	Not safe.	We have to make personal calls in the hallways.	The workrooms are cramped: usually 8 people per room.	"None of the above."	It's not (any of those things).	No!!!	It feels like a call-center; no privacy.
Some feel there is too hostile a work environment.	Need physical safety	Not always safe (i.e., neighborhoods, while in field).	Probation workers have (Kevlar) vests.			In the field, we get threatened, it's dangerous, there are guns, it takes up to 35 minutes or more for police response.	Privacy is scarce.	Technically, there are rooms (for privacy) on floors 2 & 6, but no one uses them.	One participant stated that she prefers the smaller rooms because it feels like there is more privacy in them, even though they are smaller.
Some feel they are supported, socially but not in the physical environment.	Feel desensitized to on-the-job threats to safety	Working alone not safe (in field)	Limited info is provided when traumatic incidents do occur (in field and at office), leaving the workers feeling as though their safety may be compromised.	Safety depends on where you go.	There are a lot of distractions while working, (due to noise factor, etc.)		Furniture and technology is outdated and unprofessional.	Thin walls; the walls have ears; no boundaries	
The dated furniture and office layout is	Safety when entering/exiting the building is	The responsibility is on the individual		It takes a while for police to arrive if we	Participants report paranoia on many	One participant reported to a	I feel safe for the most part.	We wash our dishes in the	Regarding the lack of privacy, on participant

uncomfortable for some.	questionable	CW to request assistance.	They are also not able to process trauma when one of their peers are assaulted, and are forced to seek information through the agency grapevine (which may not be reliable).	need an escort, while on a site visit.	teams, from constant supervision.	supervisor a dangerous incident that happened to them in the field, and no CI report was filed.		bathroom sink.	stated that it's good to have others around when you're just learning and training (can ask questions).
Participants feel that their support is not consistent across the board, and that much is based on hierarchical rank of worker and/or seniority.	Would like more tech security, such as metal detectors	One participant stated she sometimes makes use of community liaisons for assistance in field (i.e., local police).		There is a double bind in calling the police to escort in dangerous community environments, as we are also trying to maintain/build our relationships in the communities and not all families will open up in the presence of police, at their homes.	Participants report that it is not safe to work alone in the field. Would prefer to work with a partner, to have their back & another set of eyes, in the event they need a witness. They feel that the job is far more dangerous now than it		Access to building is very easy (stated in a negative way, in terms of worker safety).	Safety in the Field' training should be CPS-oriented (currently is not) and should start in core.	
Toxic individuals on some teams ruin it for everyone.	More Sheriff presence needed	Bathrooms in the building don't always work.	No forewarning of gang activity in the vicinity, when going into the field. This is information that the CW has to obtain through their			No in-house security or Sheriff on patrol on the premises. One participant states they feel	All you have to do is "press the green button" on the 6th floor to gain access. (laughter).	We wish we had a better relationship with police, and not have to wait well over an hour	If you feel uncomfortable about a home visit, you can request a police report--which can take up to a few hours

			own self-initiated research of the neighborhoods and through community contacts, if they have had a chance to establish any.		was in years past, and that this is partly due to the increased stigma (brought on by the media), for CPS workers.	less safe in the building.		(which is common) for them to show up.	to obtain.
There is too much fear of losing their jobs to complain.	Up to the individual CW to investigate neighborhood, when in field.	Hazardous wiring, faulty elevators, no swiping to enter doors, like at the Rath Bldg.		We text each other, to let each other know if we feel there may be danger (in the field). We use our own phones because our work (cell) phones are not user friendly, especially in an emergency.		Out of control clients on 6th floor. No support in some cases--any clients can come up and, on the 6th floor, demand to see us and get to employees.		Police need better mandated reporters and mental health training. They don't prioritize our calls.	One participant reports going out (to home visits) without any information (blind).
There is a sense of job task uncertainty as well as employment insecurity	Building issues: Bathroom out of order, temperature extremes, bad lighting,	Cramped rooms, thin walls (can overhear others)			Participants report that In office, it is safe.	No security checkpoints, no motion sensor. Anyone		Our Erie Co. Sheriff has jurisdiction, so why	We see the stress of seasoned peers, and how overwhelmed they are.

among the workers, which leads to speculation and gossip, which increases their stress levels.	mold					can enter building and demand to see them.		don't they assist us (in the field) instead (rather than local police).	
	Concern over high rates of cancer among long-time staff.	Probation officers protected by guns, Kevlar vests, radios, etc.	CWs state they only meet clients on the 3rd floor of H&K, but that they don't have in-house security, available. They verbalize need for greater Sheriff presence, in-house.	We let our teammates know what Zip code we plan to be in, in the field.	The temperature in the office building is inconsistent.	Once, Buffalo police took 5 hrs. to respond to a call to address a volatile client, after 5 PM. It is difficult to get in touch with anyone to request emergency		The courts frequently are missing warrants during removals, yet TLs can find them.	Two participants report feeling no fear of danger in the field.
	Privacy is "OK"	Poor communication while out on field visits. Often feel that there is no rationale for requesting assistance.		There is ongoing stress of the unknown--ongoing anxiety of what may happen in the field. Hypervigilan	Bathrooms do not work.			Numerous building problems: structural, the air system, water leaking, no	When asked how peers and TLs would respond if something were to happen while on a home visit,

		This varies based on peers & the team.		ce.		assistance in the field, at that hour.		natural light.	and whether or not peers/TLs would know their whereabouts, all stated, "they have the zip codes of where we're going."
			Clients have access during visitations.	Fear of running into clients out in public.	People get stuck in the elevator (one participant reports this happened to her).	Entry doors trigger to "green" when you leave to use the bathroom. That's when anyone can walk in.		The security system is flawed.	
			Building issues, such as bathrooms not working, noise issues when talking to clients on the phone, no cubicles, no code or swipe available for access to stairwells.	Security to building (work) questionable. We believe we need more Sheriff presence.	Ceiling leaks (ruined a laptop).	We only recently received cell phones from the county.		No safety in the field: had to wait 3 hours for Buffalo Police to show up to assist a worker in an emergent situation in the field.	Participants stated they feel safe in the building.
					Personal conflicts due to shared workspace & limited,	We leave our zip codes with others we share a room			

					antiquated technology (disputes over office lighting, etc.).	with.			
						Case size prohibits using buddy system in field.			
						We're very desensitized to the fear.			
						The county should offer self-defense classes--this participant stated they took			

						one on their own.			
						Several participants were concerned that if self-defense training isn't offered by the county, and the workers had to obtaining this type of training on their own, would the county back workers who end up using it?			
						SKIP			

						method			
						Safety in the Field training is not designed to meet the specific needs of CPS workforce .			
						One of the stairwells doesn't go to street level, which would be a a problem, in the state of an emergenc y.			

4. Does the agency have safety protocol for protection of the staff, is there a security system or security guards?

Group 1	Group 2	Group 3	Group 4	Group 5	Group 6	Group 7	Group 8	Group 9	Group 10
It depends on the team.	Not enough security	No Privacy	Not safe.	We have to make personal calls in the hallways.	The workrooms are cramped: usually 8 people per room.	"None of the above."	It's not (any of those things).	No!!!	It feels like a call-center; no privacy.
Some feel there is too hostile a work environment.	Need physical safety	Not always safe (i.e., neighborhoods, while in field).	Probation workers have (Kevlar) vests.			In the field, we get threatened, it's dangerous, there are guns, it takes up to 35 minutes or more for police response.	Privacy is scarce.	Technically, there are rooms (for privacy) on floors 2 & 6, but no one uses them.	One participant stated that she prefers the smaller rooms because it feels like there is more privacy in them, even though they are smaller.
Some feel they are supported, socially but not in the physical environment.	Feel desensitized to on-the-job threats to safety	Working alone not safe (in field)	Limited info is provided when traumatic incidents do occur (in field and at office), leaving the workers feeling as though their safety may be compromised.	Safety depends on where you go.	There are a lot of distractions while working, (due to noise factor, etc.)		Furniture and technology is outdated and unprofessional.	Thin walls; the walls have ears; no boundaries	
The dated furniture and office layout is	Safety when entering/exiting the building is	The responsibility is on the individual		It takes a while for police to arrive if we	Participants report paranoia on many	One participant reported to a	I feel safe for the most part.	We wash our dishes in the	Regarding the lack of privacy, on participant

uncomfortable for some.	questionable	CW to request assistance.	They are also not able to process trauma when one of their peers are assaulted, and are forced to seek information through the agency grapevine (which may not be reliable).	need an escort, while on a site visit.	teams, from constant supervision.	supervisor a dangerous incident that happened to them in the field, and no CI report was filed.		bathroom sink.	stated that it's good to have others around when you're just learning and training (can ask questions).
Participants feel that their support is not consistent across the board, and that much is based on hierarchical rank of worker and/or seniority.	Would like more tech security, such as metal detectors	One participant stated she sometimes makes use of community liaisons for assistance in field (i.e., local police).		There is a double bind in calling the police to escort in dangerous community environments, as we are also trying to maintain/build our relationships in the communities and not all families will open up in the presence of police, at their homes.	Participants report that it is not safe to work alone in the field. Would prefer to work with a partner, to have their back & another set of eyes, in the event they need a witness. They feel that the job is far more dangerous now than it		Access to building is very easy (stated in a negative way, in terms of worker safety).	Safety in the Field' training should be CPS-oriented (currently is not) and should start in core.	
Toxic individuals on some teams ruin it for everyone.	More Sheriff presence needed	Bathrooms in the building don't always work.	No forewarning of gang activity in the vicinity, when going into the field. This is information that the CW has to obtain through their			No in-house security or Sheriff on patrol on the premises. One participant states they feel	All you have to do is "press the green button" on the 6th floor to gain access. (laughter).	We wish we had a better relationship with police, and not have to wait well over an hour	If you feel uncomfortable about a home visit, you can request a police report--which can take up to a few hours

			own self-initiated research of the neighborhoods and through community contacts, if they have had a chance to establish any.		was in years past, and that this is partly due to the increased stigma (brought on by the media), for CPS workers.	less safe in the building.		(which is common) for them to show up.	to obtain.
There is too much fear of losing their jobs to complain.	Up to the individual CW to investigate neighborhood, when in field.	Hazardous wiring, faulty elevators, no swiping to enter doors, like at the Rath Bldg.		We text each other, to let each other know if we feel there may be danger (in the field). We use our own phones because our work (cell) phones are not user friendly, especially in an emergency.		Out of control clients on 6th floor. No support in some cases--any clients can come up and, on the 6th floor, demand to see us and get to employees.		Police need better mandated reporters and mental health training. They don't prioritize our calls.	One participant reports going out (to home visits) without any information (blind).
There is a sense of job task uncertainty as well as employment insecurity	Building issues: Bathroom out of order, temperature extremes, bad lighting,	Cramped rooms, thin walls (can overhear others)			Participants report that In office, it is safe.	No security checkpoints, no motion sensor. Anyone		Our Erie Co. Sheriff has jurisdiction, so why	We see the stress of seasoned peers, and how overwhelmed they are.

among the workers, which leads to speculation and gossip, which increases their stress levels.	mold					can enter building and demand to see them.		don't they assist us (in the field) instead (rather than local police).	
	Concern over high rates of cancer among long-time staff.	Probation officers protected by guns, Kevlar vests, radios, etc.	CWs state they only meet clients on the 3rd floor of H&K, but that they don't have in-house security, available. They verbalize need for greater Sheriff presence, in-house.	We let our teammates know what Zip code we plan to be in, in the field.	The temperature in the office building is inconsistent.	Once, Buffalo police took 5 hrs. to respond to a call to address a volatile client, after 5 PM. It is difficult to get in touch with anyone to request emergency		The courts frequently are missing warrants during removals, yet TLs can find them.	Two participants report feeling no fear of danger in the field.
	Privacy is "OK"	Poor communication while out on field visits. Often feel that there is no rationale for requesting assistance.		There is ongoing stress of the unknown--ongoing anxiety of what may happen in the field. Hypervigilan	Bathrooms do not work.			Numerous building problems: structural, the air system, water leaking, no	When asked how peers and TLs would respond if something were to happen while on a home visit,

		This varies based on peers & the team.		ce.		assistance in the field, at that hour.		natural light.	and whether or not peers/TLs would know their whereabouts, all stated, "they have the zip codes of where we're going."
			Clients have access during visitations.	Fear of running into clients out in public.	People get stuck in the elevator (one participant reports this happened to her).	Entry doors trigger to "green" when you leave to use the bathroom. That's when anyone can walk in.		The security system is flawed.	
			Building issues, such as bathrooms not working, noise issues when talking to clients on the phone, no cubicles, no code or swipe available for access to stairwells.	Security to building (work) questionable. We believe we need more Sheriff presence.	Ceiling leaks (ruined a laptop).	We only recently received cell phones from the county.		No safety in the field: had to wait 3 hours for Buffalo Police to show up to assist a worker in an emergent situation in the field.	Participants stated they feel safe in the building.
					Personal conflicts due to shared workspace & limited,	We leave our zip codes with others we share a room			

					antiquated technology (disputes over office lighting, etc.).	with.			
						Case size prohibits using buddy system in field.			
						We're very desensitized to the fear.			
						The county should offer self-defense classes--this participant stated they took			

						one on their own.			
						Several participants were concerned that if self-defense training isn't offered by the county, and the workers had to obtaining this type of training on their own, would the county back workers who end up using it?			
						SKIP			

						method			
						Safety in the Field training is not designed to meet the specific needs of CPS workforce .			
						One of the stairwells doesn't go to street level, which would be a a problem, in the state of an emergenc y.			

5. Is there a break room where staff can address self-care needs, soft music, and comfortable furniture?

Group 1	Group 2	Group 3	Group 4	Group 5	Group 6	Group 7	Group 8	Group 9	Group 10
No.	No	NO!	No!	There is a very small room on 2nd floor.	2nd Floor (no one uses).	Breastfeeding room. One participant stated, "Even that is a crappy, dirty-ass room." Another asked, "But, where will the men go?"	There's an empty room on the 7th floor, where a worker likes to go to de-stress. Worker states it's quiet, and s/he likes to lay down on the floor and close eyes for a few minutes. States this is only accessible by stairs.	Group laughter.	Laughter.
No Time.	Yes for adoptive services, but not for CPS.	Only possibility would be lactation room (which we are not allowed to use for other purposes and would be off limits to male staff).	There is a 2nd floor break room which is never used. This room is too small and not relaxing.	The 4th floor had a break room with couches, but that was turned into a training room.	We have to bring in our own personal appliances to put in our workspaces, so that we can eat while we work (otherwise, we would not get lunches).			No. There's a lactation room.	The small break room is "terrible" (on the 6th floor). It's been used as a meeting room.
Toilets out of order.	We sit at our desks.	No time to use if we had one,	Most eat lunch at desk and	We have no time. We work	Was one: on 4th floor w/ couches &	Most stated they were not aware	2nd floor (they don't use	We'd like a little	One states s/he takes all his/her

		anyway.	occasionally leave the building.	through lunch.	chairs.	of any.	it).	place on the rooftop to go for sanctuary (like a garden).	breaks. One sometimes uses 15min break.
Communicate with some co-workers, but this is social and not location-specific.	We take no lunch break.	There is a "break" room on the 2nd floor with a few hard chairs. The space is not inviting & we don't use it.		We need a gym--with a punching bag--and a treadmill.	No time.	There used to be a breakroom, but they took that away.	5th floor lactation room (not accessible to males, and it's very small).		A couple respondents state they don't take their 15min breaks, but state that their TLs do encourage them to take breaks.
Building issues (temperature regulation).	We have to leave the building.	Workspace is not conducive to relaxation.	Must make personal calls (re: children, MD appts., etc.) from desk for peers to overhear, or use the stairwell for	We eat at our desk (while working). Otherwise, we have to leave the building.	Too busy to take breaks or a lunch.	"We don't have time to destress."	We rest in our cars, while were traveling to/from home visits, in the field.	No time in the day. Not able to make breaks a part of daily habit.	They'd like a room with a window. It's also too cold in the break room.

			privacy.						
Cramped work areas & overcrowding.	Social interaction among peers not place-specific.	We take our lunches while working or while we're driving back and forth to visits.	"Make-shift" workspaces.	Almost never take 15-min breaks.	Participants state that TLs take their lunches.	"We need a paid listener."	We don't take breaks.		They state they need new phones in the office (preferably with caller ID), and better cell phones (they're too difficult to text; especially in an emergency).
Noise issues.	Feel guilty to take a break.	We don't take our 15 minute breaks.	No storage. Files all over the place. "Organized chaos."	A lot depends on the team (how cohesive they are). This determines how well we are able to share the load, which determines whether or not we get to take breaks, how stressed out we get, how hungry	Most participants stated that they wait until they are feeling symptoms/signs of burnout or are stressed out before they a break.	We have no privacy--7 desks and a secretary. There's a lot of background noise. We can bring in our own headphones, but we're not allowed to use our personal cell phones.	Sometimes, we do unit lunches, which is great for morale. We haven't done it as much lately.		
Have to leave building, such as walk to the mall.	No encouragement by supervisors to take breaks.	We hesitate to take sick days because we fall behind in our work. We end up regretting	Phone system is outdated. Don't have caller ID, can't do work while on				Happy Hour.		

		doing so.	hold, as there is no speaker phone or headset. Speaker phone would be difficult to hear, due to the noise level in the shared workspace .	(food) we get while we're working (can become very irritable), whether or not we can take days off (for appointments, etc.).					
Feel discouraged from taking personal time, during the day for stress release.	Rarely take the additional two 15 minute breaks because we will fall too far behind in our work.	Administration denies time off if behind in work, which leads to call-offs (when they stated they needed a MH day the most).			Morale is low.	One respondent stated, "Pandora saves my sanity," while others in the group stated, "we're locked out of that website."	We're too stressed out to laugh (lose sense of humor).		
Self-care is inconsistent.	Workload prohibits the use of a designated break room, even if we did have the space.	Often neglect medical appts due to work load and overtime hours.	Cramped work area: "we're all on top of each other." This is not as much of a problem when teams are cohesive and get along with	The TL sets the tone for each group (related to the above answer).	The job has become very "cut-throat" (compared to what it was a few years back).				
		Participants acknowledged feeling emotional strain, stress		We don't feel like we are able to help each other out.	Participants report feelings of paranoia about their				

		and trauma related to their work; some stated they often take it out on their partners/put strain on their personal relationships. Others stated they shut down after work and don't talk about their work or feelings with family/friends. Those who stated they shut down also stated that they continued to carry the emotional load.	one another.	We heard one co-worker needed help. Some of us wanted to help, but when we do, we are made to feel as though we are not working, or that we don't have enough to do. Then, we get more work piled on us (and don't have time for breaks).	jobs & about who they talk to. "Trust no one." Most of the above-mentioned sentiments and perceptions are team-specific. A couple of the participants stated that they either currently had a very good team (one participant stated s/he loved coming to work every day), or have had good teams with high morale, good cohesive teamwork and trust in				

					the past.				
		All participants stated that self-care of CWs was a matter of individual incentive, personal motivation and responsibility (did not feel it was supported or have mechanisms embedded within the structure of the agency).		It seems they're always breaking teams up that work well together (gel). (This comment was meant to piggyback off the previous comment, r/t sharing workload, efficiency and having the time to take breaks,					

				when needed).					
				Workload is too high (for breaks).					

6. Is there opportunity and encouragement for staff to informally debrief with peers or formal debriefing opportunities at the agency?

Group 1	Group 2	Group 3	Group 4	Group 5	Group 6	Group 7	Group 8	Group 9	Group 10
Responsibility on the individual CW, not the agency.	No.	No.	Conducted individually, between CWs & TLs.	Time is a big factor.	No (group laughter).	No.	EAP.	One participant recalled attending 'Vicarious Trauma' training at Catholic Charities, WIC.	Case conferences are with supervisors only, as groups would take forever.
Massage & other therapies should be covered by insurance.	Only conferences, which are case-specific.	Case conferences are 1:1 (CW & TL), not held with peers.	TL's should make CWs aware of these.	Some participants stated that they share case-specific info among team	No time.	Pick a couple of buddies to chat. You have to do this on your own.	Confidentiality is "null and void."	Case conferences are case-specific.	Group counseling/conferencing would be nice
Minimal coverage for psychother	Done on an individual basis, not	Case conferences are case-specifics only,	No time for case conferences.		Participants report feeling	"If your team hasn't been	There is a lot of gossip and inappropria	Very limited access to 'clinicals'--	Some TLs check in with the worker and ask how they're doing.

apy w/ high copay.	groups.	not focused on content processing or the well-being of the workers.		members, but (as stated in previous question), it depends on the culture of each individual team, how cohesive they are.	"too numb" or "too shut-down" to participate in these types of events, if they were available.	moved or broken up, you can expect changes."	te sharing of information "at all levels."	no longer promotional.	Some don't.
Some unsure of what's really covered.	When we are triggered, we put it out of our minds and try to forget about things.	Pre-placement conferences include the TL & Coordinators.	We should have a checklist for closing cases, based on type (DV, Ed Neglect).	One participant stated, "You're (we're) on your own." Several other participants agreed with this statement.		Not only are we bounced often to other teams, we're assigned to other caseload jurisdictions.		Not trauma focused.	Sometimes case conferences are about the worker.
Inappropriate humor are often a release valve.	Peer support-seeking depends on the case, the	The responsibility for obtaining peer support is on the individual CW,	Consultations not focused on CW strengths, expectatio					Community resources have been taken away	

	TL and/or supervisor.	not mechanisms embedded within the agency.	ns or goals for doing their job.					(have to figure out/make linkages for ourselves). We need to restore our clinical consults.	
Focus of case conferences is on the case, not on CW trauma or self-care.	When asked, no one in this group knew the definition of vicarious trauma, or secondary stress trauma. They were able to define burnout.	TLs are extremely busy and not trauma trained/informed.	Trainees train trainees (so no one has this kind of knowledge or experience).			Team cohesiveness is key.		Clinical consults don't currently have CPS history or experience (this position is no longer promotional). A lot of the TLs would be qualified for that position.	
Most feel unappreciated, thus have no		Participants verbalized the perception that their TLs	There is a lack of respect by coordinato			It's like a "revolving door"; we can't train		We need to build up the clinical office from	

loyalty to job.		are not well-supported, either.	rs: CWs get yelled at in front of peers; TLs get yelled at. Neither TLs nor coordinators feel that anyone has their back.			new hires fast enough--they need at least 2 years to be trained properly to take on caseloads.		within: we all have our own unique expertise at the case level.	
No sense of belonging.		It reflects poorly on you if you admit to difficulties by seeking formal support.						Opportunities for promotions are being cut off from long-term employees. Having more open-competitive positions has created a big morale issue.	
Jaded senior workers.									
"Cover your ass" is implicit to the mission statement.		We feel like we're expected to function like robots without feelings.	There is a pervasive fear of getting fired: supervisors are overheard talking about who they like and don't like; there is a lot of undermining; scapegoati			"They're giving senior titles after only 1-2 years. This is scary."			
Always trying to catch-up, and sacrificing in some area to get						No A.M. reports or team huddles. No one even says "hello" in			

the job done.			ng of front-line staff;			the morning. Most of us are too busy trying to catch up on our case notes or are already in territory.			
Trying to keep head above water.			There are no performance evaluations of our supervisors.						
Low incentive leads to low retention.						It's hard for everyone to be in office at once.			
			We feel very disillusioned about our work.						
			We can get very irritable, have high anxiety and other (somatic) symptoms						

			that are never addressed (goes with the job).						

8. Does the agency provide and encourage supervision?

Group 1	Group 2	Group 3	Group 4	Group 5	Group 6	Group 7	Group 8	Group 9	Group 10
On Demand	All but one participant stated "never."	As needed.	No time.	Not as it is supposed to.	Erratic/inconsistant.	No!	No (it doesn't).	Some provide daily supervision, others provide weekly at a set time. Some keep logs.	There's a benchmark supervision 1 month in (to being hired), and not since for another 5 months. But, each benchmark is at a different time per TL.
	One person stated she received regular supervison that was mostly case-specific.	Based on experience level of individual CWs and their teams.	No benchmarks.	This varies from team to team.	Only when there is an issue.	There's no feedback.	We're supposed to (have supervsion).		
Depends on the supervisor/ team.	Most stated they received bi-monthly case	Supervisor- & Coordinator-specific.	It depends on the TL and their training.	Based on individual need.	Not collaborative between CW and Supervisor.	Several participants stated they have to break chain of command	We don't know how we're doing. We only	We do crisis intervention: personal or case-related.	We review notes, receive hands-on training and receive

	review meeting that focused on the case details, not their own goals, strengths and challenges as workers.					because there is no trust, they don't feel comfortable discussing things with their direct supervisor. There is no confidentiality: TLs/Supervisors talk behind workers' backs. Medical/Mental Health info is not kept confidential. Everyone knows everyone else's business.	know when we're written up. And, even then, it's not always clear why (we're being written up).		training for interviewing skills at the very beginning of training.
Too much supervision.	All participants stated there were no set standards for evaluating their performances in supervision, when asked.	Depends on size of caseloads.			Not consistent.	Trainees are supposed to be supervised approximately 1x/month to get feedback (but doesn't always happen that way).	Workload prohibits regular 1:1 supervisions.	Very seldomly rewarded for good work.	Our coordinators expect weekly supervisions. We're supposed to complete 4 forms on each supervisee, 2x/month. This is new. Staff have to initial one	We don't know how we're doing. We feel adrift and don't always know what we're doing. Some of us have no supervisions, and don't know if we're doing good/bad.

								of those forms.	
No structured supervision.	All agreed that they wished TLs had more structured guidelines for evaluation.	The practice of "bouncing" CWs around to different teams is very stressful and disruptive to work flow. This is logistically disruptive (have to switch office work space, have phone number changed over, have to repeatedly take calls from the person who last had that	Based on personality, not on quality of work.	We're supposed to be provided supervision every 6 months, when we're no longer trainees.	Supervisions are case-specific; not focused on the well-being of the worker (or strengths, challenges and professional goals).		No time to care.	There's not enough time to meet all of these requirements.	We're supposed to have it 2x/wk, but we have informal discussions daily.
As needed.	Most stated they thought they were supposed to meet meet monthly for supervision, within the first year.		TLs not properly trained.	It depends on the TL.		We would like to be able to give our supervisors performance evaluations.		There's a quality review on one case sample per month. Quality Assurance: 1. We have to call clients to ensure that the worker has	TL styles determine the quality and frequency of supervision.

No sense of well-being from supervision.	All agreed they do not have strength-based supervisions to discuss what they are doing amd and where they need to improve. They all agreed that this is greatly needed, and felt that given the high CW turnover, this would eliminate some of	extension). This also requires establishing new work relationships and trying to gel with new teammates, which takes time. This hinders support-seeking among peers & CWs feel the need to seek out former teammates (and feel guilty about taking up their time, in doing so). They also have to take time to readjust to a new TL who may have	Some are compassionate.	It's more informal than that--every day, our TLs' eyes are on our work (focus is on the work itself, and not the worker or the worker's well-being).	Most participants felt that there was no genuine concern throughout the agency for their well-being as workers (several reiterated, "It's all about the numbers, that's all they care about…closing cases.")	It depends on the team and length of time you've been here. Usually only for probation (1st year).		showed & has done what s/he has documented having done. 2. There is no confidentiality and a lot of fear of getting "in trouble." 3. This leads to feelings of "doom." 4. They don't trust us. 5. This requires completing random 2 forms/wk. 6. This is all corrective action	There should be a standardized method of all TLs for supervision and case reviews, since there is so much movement between teams. This would also be useful when TLs / supervisors are out, and another has to cover. Supervision should be structured, and should not be style-based.

	their stress burden of wondering if they too were at risk of termination.	expectations that are not consistent with previous supervisor.						from the state. 7. We'd like more input into the design of these forms. 8. There's no open dialogue. 9. New workers are suffering burnout and are overly stressed.	Each review on the team is different. There's no consistency, or concrete guidelines. This is frustrating and confusing for the workers.
		Participants attribute team re-configurations to terminations and new hires. It is disconcerting to them that many of the current		Private (1:1) supervisions that happen between those times are usually because something is wrong. Then, we (workers) meet with TL with TL's					

		supervisors, TLs and senior staff have limited experience (not many "old-timers" left in the field).		office door closed. When that happens, everyone else knows something is wrong (due to not having regularly scheduled supervisions).					
		Participants also attribute "bouncing" to personality conflicts w/ TLs. Others verbalize fear of letting on that they enjoy working with their teammates. They feel that their comradery is looked down upon as		Supervisions are not strengths-based.					
				The walls are very thin (everyone can hear).					
				Some TL's are too micromanagi ng.					
				There's a culture of paranoia-- everyone is afraid of losing their job.					

		socializing over productivity. They believe that teams that gel have higher productivity because there is more work- & information-sharing and better support. They also expressed belief that if they appear to be doing something right, they may be sent to other teams that are falling behind as a band-aid remedy (and subsequently lose out on		There is no performance evaluation that we can give to our supervisors/TLs (they state they would like to be able to provide them).					

		good supervision w/ their TL).							

9. Does the administration require the supervisor is trained in supervision of trauma counselor?

Group 1	Group 2	Group 3	Group 4	Group 5	Group 6	Group 7	Group 8	Group 9	Group 10
No.	No one knows.	No.	No.	No.	No.	No.	No.	No. Not before Al.	No idea.
Depends on the supervisor.	New hires frequently receive more training than their TLs; especially when they receive State training; which they believe their TLs have not had.		We've even requested to have cases transferred due to triggers. We were told "no." This is frowned upon.	Some have more experience than others.	Participants stated that their TLs must have some experience with trauma, based on the fact that they were once CWs, themselves (but were not aware of any formal training in that area of expertise).	A bunch of supervisors went to Common Core training, but that was it. They took them all out at once.	The only training they have is their personal experience of having worked in the field.		There are no conversations re: exposure to trauma or how to manage. No discussions on coping skills. There's not time for that.

Based on the experience of the supervisor.	Participants state they are handed difficult cases at the start that they feel ill-prepared for.		Some TLs give no forethought as to how cases are assigned/handed to CWs.	It depends on the team.	Participants stated again that Administration is (or has been up until now) only concerned with "the numbers" and not their wellbeing.				
Supervisors often not well-trained in area of trauma.	When asked, participants stated they are not aware if there are any other trauma specialists in the agency.		We can be denied vacation days when we are falling behind in our notes.						
Some feel comfortable going to their own self-selected "go-to" "old-timer," but feel guilty	Participants stated they were aware of a clinical specialist whose job was to assist with cases only, not with CW well-being.		Some TLs assigned cases based on strict rotation. They frequently assign multiple difficult cases (to individual CWs) without considering the						

taking up their time.			(psychological or stress) impact this has on the worker.						
	Participants all state they fear disclosure regarding their own trauma, due to real/perceived threat of losing their jobs.								

10. Does the agency provide to the CPS caseworker with resources for personal therapy, structured stress management or structure physical activities such as walking, meditation, or yoga groups?

Group 1	Group 2	Group 3	Group 4	Group 5	Group 6	Group 7	Group 8	Group 9	Group 10
Have to take up lunch breaks for	There is Zumba during lunchtime,	Took away massages covered by insurance.	Only after work, if time.	They took our massages away. Now you have to	Most participants state "No."	That's our personal responsibility to do	Some of us utilize the massages	They took away our massages.	If it was offered, I would go.

walks.	but most don't attend because it is inconvenient, they would rather eat, don't have time to change clothes, etc.			have a higher insurance plan. Participants state they would like to have this made available again.		on our own time.	(through the higher tiered insurance).		
Miss stress relief for new cases.	Insurance no longer covers massage therapy, which many participants stated they would use and believe to be effective.	Insurance covers psychotherapy, but time prohibits making use of it.	Hard to schedule due to overtime hours (daily schedule is unpredictable & can't commit to any routine).	We are often too overwhelmed between family priorities and mental and physical exhaustion (from the job) to utilize these types of resources.	Some participants state "Yes."	They don't want you using personal time. We have to go through FMLA, if eligible.	We use headphones even though we're not allowed to use our phones at work (to play music--several stated that they had access to a music channel	Peer support & clinicals fell by the wayside. There was supposed to be an out of state trainer who never showed, and the initiative never materialized.	I walk (to my car).

Skipping vacations to keep up with caseload.	No longer able to enjoy summer hours, which they found helpful.	Not certain about a centralized trauma specialist within the agency. There is a clinical specialist for reviewing cases, but it is not clear if he is trauma-trained.	No time for lunch-time Zumba (by the time we change clothing, eat, it's not worth it).	Many of us have ulcers, sleep disturbance and are taking various medications, since starting this job (never had these symptoms before).	It's based on the individual incentive or motivation to engage in these activities outside of work, on their own time.	You get a "counseling memo," which is a warning for taking time off. One respondent stated that they received a counseling memo for taking medical time off for an injury sustained on the job.	on the Internet, but have since been blocked from using it.	Only if trauma counseling is mandated.	No info after orientation.
Days off cause additional stress because the workload they return to is overwhelming.	Too many hoops to jump through to obtain approval for over-time (OT). All agreed that there were often emergent situations that required OT, and because they are not	Participants would like to have a small room for a punching bag, treadmill on-site, as they have very little time to attend Zumba class. They are often too tired after work (especially when they work overtime) to	Coordinators deny vacations but take them (regardless of how far behind the work).	No crisis counselor on staff (One participant acknowledges see a private therapist because of stress on the job; states being an angry person because of job).	Participants state they barely have enough time or energy to devote to their families (some state their loved ones are being neglected) to engage in these activities.		Some respondents stated their teams celebrate birthdays.	There's a remand, and then new cases immediately follow. We need to increase the number of staff to maintain state mandates, but in order to	Some participants don't know what EAP is. Some utilize sick time.

	always able to plan ahead for obtaining OT approval due to time constraints, they do not receive reimbursement for that extra time they put in.	go to the gym. There are no gym membership discounts through the agency.						retain staff, we need to increase pay for workers.	
Limited coverage due to team-mates' vacations.	Participants don't have any formal opportunities for grievance until they've been in their position for one year (even though, they state, they pay union dues). They feel that this deprives them of any	There is low morale, as the participants feel "beat-down" in media and at work due to a "witch-hunt" environment. Apprehensive about asking for help.	Coordinators take full lunches (CWs often work through lunch or don't take a lunch).	On the 4th floor, there is Mid-Erie counseling, which provides mental health services for clients (assessments, drug-testing, etc.). Several participants stated that this might be something they'd	Some participants state they are too exhausted to do anything outside of work, but would consider using a "Wellness Center" if it were on site.	It's so hard to find time: we used to have Zumba on Tuesdays. When you do take the time for yourself, it makes you more productive.		Rather than spend on stress reduction programs, just stop special treatment of Specialty Teams. Also, Special Investigators get paid much more than	The participants final thoughts were to emphasize the need for consistency regarding "response"--coming out of response. Some people get no

	protection against being fired by a supervisor who may not like them (personality differences).			consider using, since it's on premises, but not part of the agency, itself (worried about losing their jobs).				workers and don't even do half of what we do. We could hire 2 Case Workers for every 1 Special Investigator.	cases, while others had cases dumped on them. They state that this is based on benchmarks that are not clearly defined. They state that for some new workers, there is no transition, and that they would like more farming out to different teams for
One CW floater for case assistance = > VERY POSITIVE & WANT MORE OF THIS.	Participants desire more support from upper administration.	Low incentive/rewards for completing cases in a timely manner, as they believe this gets more cases dumped on them from other workers who are struggling with their case loads.	Some TLs will help share the workload.	All participants report being unaware of a trauma counselor on staff.	Massages no longer available.			I would like to see our Admin. Director and coordinators walking around more; be more hands-on, accessible. Bob Dietz used to do rounds regularly.	

								One CW didn't meet the coordinator until 3 months after she was hired.	a broader range of good experiences and for more explanation for the "why."
Want more follow-up and feedback on their performance.	Fear of job loss is one of their biggest stressors; especially during probation.	Verbalize receiving no support when handed additional cases from slower workers--no assistance, no background info, etc. CWs are expected to go back and review historical documentation, which they have no time for, and have to contact	Feedback is needed.	Several participants stated that they frequently miss or don't schedule medical appts (self-neglect) due to the hassle of having to take time off (must take a full sick day for one appt.--due to receiving addtnl case assignments).	Would like someone safe to vent to, such as a "Crisis Counselor" available at the agency.				
Want tactical training for protection.	Believe there is a need for a vacation wheel.				Would like a suggestion box to be able to anonymously use (for fear of repercussions)			I feel hopeful.	

Gas/mileage deadlines cause additional stress.	Participants feel that their work life consumes them, and often neglect medical appointments. Those who don't have children don't believe they would be able to manage their private lives if they had children.	clients/families who may feel that they've been let down or abandoned by former CW who has not provided timely visits. Families often resent the change of worker and having to re-establish a whole new relationship (establishing trust is an issue). This further diminishes trust on the part of the CW for asking for emotional support when feeling overwhelmed.		Most participants in the group stated agreement with one participant's comment, "This job comes before our personal well-being and our families. At least that has been the attitude of the old Administration."					
	Participants feel that they should not receive any new cases when only working half days.								

	Those who manage high-risk cases state they are required to review every 7 days.	Heavy caseloads are prohibitive of good feedback, which they feel would be more conducive to their well-being than therapy. They do not feel that their strengths are recognized, and they fear discussing their challenges with supervisors for fears of reprisal. CWs feel like they are on their own, except for the support they give to one another, and are unlikely to							
	Participants feel apprehensive about taking mental health days due to their high case loads. 2 participants stated they will take a MH day following a child removal, but state they end up paying for this with the amount of work that								

	accumulates in their absence.	utilize any structured activities.							
	Others believe they should have more flexibility to work from home, especially if they were to take mental health days.								

APPENDIX E SPSS TABLES

Table 13 t-Test, Age and Compassion Satisfaction

Group Statistics

	What is your age?	N	Mean	Std. Deviation	Std. Error Mean
CPSAT	18 - 35	34	36.5588	5.72708	.98219
	36 and up	25	37.3600	4.81214	.96243

		t-test for Equality of Means						
		t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	95% Confidence Interval of the Difference	
							Lower	Upper
CPSAT	Equal variances assumed	-.567	57	.573	-.80118	1.41239	-3.62944	2.02709
	Equal variances not assumed	-.583	55.915	.562	-.80118	1.37512	-3.55597	1.95361

Table 14 t-test Age and Trauma

Group Statistics

	What is your age?	N	Mean	Std. Deviation	Std. Error Mean
TRAUMA	18 - 35	33	23.1818	4.56518	.79470
	36 and up	24	21.0417	4.18568	.85440

		t-test for Equality of Means						
							95% Confidence Interval of the Difference	
		t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	Lower	Upper
TRAUMA	Equal variances assumed	1.809	55	.076	2.14015	1.18320	-.23104	4.51134
	Equal variances not assumed	1.834	52.024	.072	2.14015	1.16685	-.20128	4.48158

Table 15 t-test Age and Burnout

Group Statistics

	What is your age?	N	Mean	Std. Deviation	Std. Error Mean

BURN	18 - 35	34	26.2059	6.68685	1.14678
	36 and up	25	24.5200	3.84187	.76837

		t-test for Equality of Means						
							95% Confidence Interval of the Difference	
		t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	Lower	Upper
BURN	Equal variances assumed	1.129	57	.263	1.68588	1.49273	-1.30325	4.67502
	Equal variances not assumed	1.221	54.247	.227	1.68588	1.38040	-1.08137	4.45314

Table 16 One-Way ANOVA-Years in Erie County and Compassion Satisfaction

Descriptives

CPSAT

	N	Mean	Std. Deviation	Std. Error	95% Confidence Interval for Mean		Minimum	Maximum
					Lower Bound	Upper Bound		
< 5	39	37.2564	5.62288	.90038	35.4337	39.0791	27.00	49.00
5 - 15	14	36.0714	5.06062	1.35251	33.1495	38.9933	28.00	46.00
15 >	7	37.1429	4.37526	1.65369	33.0964	41.1893	32.00	43.00
Total	60	36.9667	5.31058	.68559	35.5948	38.3385	27.00	49.00

ANOVA

CPSAT

	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	14.712	2	7.356	.254	.776
Within Groups	1649.222	57	28.934		
Total	1663.933	59			

Table 17 One-Way ANOVA-Years of Service and Trauma

Descriptives

TRAUMA

	N	Mean	Std. Deviation	Std. Error	95% Confidence Interval for Mean		Minimum	Maximum
					Lower Bound	Upper Bound		
< 5	38	22.4474	4.83063	.78363	20.8596	24.0352	13.00	33.00
5 - 15	13	22.8462	3.28751	.91179	20.8595	24.8328	16.00	27.00
15 >	7	20.0000	4.16333	1.57359	16.1496	23.8504	15.00	28.00
Total	58	22.2414	4.46943	.58686	21.0662	23.4166	13.00	33.00

ANOVA

TRAUMA

	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	41.534	2	20.767	1.041	.360
Within Groups	1097.087	55	19.947		

Total	1138.621	57			

Table 18 One-way ANOVA -Years of Service and Burnout

Descriptives

BURN

	N	Mean	Std. Deviation	Std. Error	95% Confidence Interval for Mean		Minimum	Maximum
					Lower Bound	Upper Bound		
< 5	39	25.4615	6.66035	1.06651	23.3025	27.6206	14.00	39.00
5 - 15	14	25.4286	3.69437	.98736	23.2955	27.5616	19.00	33.00
15 >	7	24.5714	3.50510	1.32480	21.3298	27.8131	19.00	29.00
Total	60	25.3500	5.73666	.74060	23.8681	26.8319	14.00	39.00

ANOVA

BURN

	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	4.815	2	2.407	.071	.932
Within Groups	1936.835	57	33.980		
Total	1941.650	59			

Table 19 One-Way ANOVA Years as Child Welfare Worker and Compassion Satisfaction

Descriptives

CPSAT

	N	Mean	Std. Deviation	Std. Error	95% Confidence Interval for Mean		Minimum	Maximum
					Lower Bound	Upper Bound		
< 5	32	37.0625	5.50623	.97337	35.0773	39.0477	27.00	49.00
5 - 15	22	36.1818	5.04868	1.07638	33.9434	38.4203	28.00	48.00
15 >	6	39.3333	5.31664	2.17051	33.7539	44.9128	33.00	46.00
Total	60	36.9667	5.31058	.68559	35.5948	38.3385	27.00	49.00

ANOVA

CPSAT

	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	47.452	2	23.726	.837	.438
Within Groups	1616.481	57	28.359		
Total	1663.933	59			

Table 20 One-Way ANOVA - Years as Child Welfare Worker and Trauma

Descriptives

TRAUMA

	N	Mean	Std. Deviation	Std. Error	95% Confidence Interval for Mean		Minimum	Maximum
					Lower Bound	Upper Bound		
< 5	31	22.9677	4.98988	.89621	21.1374	24.7980	13.00	33.00
5 - 15	22	21.6364	3.49892	.74597	20.0850	23.1877	15.00	27.00
15 >	5	20.4000	4.82701	2.15870	14.4065	26.3935	15.00	28.00
Total	58	22.2414	4.46943	.58686	21.0662	23.4166	13.00	33.00

ANOVA

TRAUMA

	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	41.362	2	20.681	1.037	.361
Within Groups	1097.259	55	19.950		
Total	1138.621	57			

Table 21 One-Way ANOVA - Years as Child Welfare Worker and Burnout

Descriptives

BURN

	N	Mean	Std. Deviation	Std. Error	95% Confidence Interval for Mean		Minimum	Maximum
					Lower Bound	Upper Bound		
< 5	32	25.7813	6.87086	1.21461	23.3040	28.2585	14.00	39.00
5 - 15	22	25.5455	3.88804	.82893	23.8216	27.2693	15.00	33.00
15 >	6	22.3333	4.45720	1.81965	17.6558	27.0109	17.00	29.00
Total	60	25.3500	5.73666	.74060	23.8681	26.8319	14.00	39.00

ANOVA

BURN

	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	61.393	2	30.697	.931	.400
Within Groups	1880.257	57	32.987		
Total	1941.650	59			

Table 22 t-Test Gender and Compassion Satisfaction

Group Statistics

	What is your gender identity?	N	Mean	Std. Deviation	Std. Error Mean
CPSAT	Male	11	36.9091	5.48552	1.65395
	Female	49	36.9796	5.32873	.76125

		t-test for Equality of Means						
		t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	95% Confidence Interval of the Difference	
							Lower	Upper
CPSAT	Equal variances assumed	-.039	58	.969	-.07050	1.78702	-3.64761	3.50661
	Equal variances not assumed	-.039	14.550	.970	-.07050	1.82072	-3.96177	3.82077

Table 23 t-test Gender and Trauma

Group Statistics

	What is your gender identity?	N	Mean	Std. Deviation	Std. Error Mean
TRAUMA	Male	11	22.3636	5.74931	1.73348
	Female	47	22.2128	4.19076	.61128

		t-test for Equality of Means						
		t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	95% Confidence Interval of the Difference	
							Lower	Upper
TRAUMA	Equal variances assumed	.100	56	.921	.15087	1.51017	-2.87436	3.17610
	Equal variances not assumed	.082	12.599	.936	.15087	1.83810	-3.83299	4.13473

Table 24 t-test Gender and Burnout

Group Statistics

	What is your gender identity?	N	Mean	Std. Deviation	Std. Error Mean
BURN	Male	11	26.9091	4.82607	1.45511
	Female	49	25.0000	5.90903	.84415

		t-test for Equality of Means						
		t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	95% Confidence Interval of the Difference	
							Lower	Upper
BURN	Equal variances assumed	.997	58	.323	1.90909	1.91408	-1.92235	5.74054
	Equal variances not assumed	1.135	17.452	.272	1.90909	1.68224	-1.63315	5.45133

Table 25 One-Way ANOVA, Ethnicity and Compassion Satisfaction

Descriptives

CPSAT

	N	Mean	Std. Deviation	Std. Error	95% Confidence Interval for Mean		Minimum	Maximum
					Lower Bound	Upper Bound		
White	46	37.0652	5.07456	.74820	35.5583	38.5722	27.00	49.00
Black, Afro-Caribbean, or African American	8	36.3750	5.47560	1.93592	31.7973	40.9527	28.00	44.00
Latino or Hispanic American	5	39.0000	6.55744	2.93258	30.8579	47.1421	32.00	48.00
East Asian or Asian American	1	27.0000	.	.	.	.	27.00	27.00
Total	60	36.9667	5.31058	.68559	35.5948	38.3385	27.00	49.00

ANOVA

CPSAT

	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	123.254	3	41.085	1.493	.226
Within Groups	1540.679	56	27.512		
Total	1663.933	59			

Table 26 One-way ANOVA: Ethnicity and Trauma

Descriptives

TRAUMA

	N	Mean	Std. Deviation	Std. Error	95% Confidence Interval for Mean		Minimum	Maximum
					Lower Bound	Upper Bound		
White	44	22.5682	4.50012	.67842	21.2000	23.9363	15.00	33.00
Black, Afro-Caribbean, or African American	8	19.5000	3.66450	1.29560	16.4364	22.5636	13.00	25.00
Latino or Hispanic American	5	22.8000	4.60435	2.05913	17.0829	28.5171	15.00	27.00
East Asian or Asian American	1	27.0000	.	.	.	.	27.00	27.00
Total	58	22.2414	4.46943	.58686	21.0662	23.4166	13.00	33.00

ANOVA

TRAUMA

	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	89.025	3	29.675	1.527	.218
Within Groups	1049.595	54	19.437		
Total	1138.621	57			

Table 27 One-Way ANOVA: Ethnicity and Burnout

Descriptives

BURN

	N	Mean	Std. Deviation	Std. Error	95% Confidence Interval for Mean		Minimum	Maximum
					Lower Bound	Upper Bound		
White	46	25.6739	5.24957	.77401	24.1150	27.2328	14.00	37.00
Black, Afro-Caribbean, or African American	8	22.2500	5.25765	1.85886	17.8545	26.6455	17.00	30.00
Latino or Hispanic American	5	25.2000	8.84308	3.95474	14.2199	36.1801	15.00	39.00
East Asian or Asian American	1	36.0000	.	.	.	.	36.00	36.00
Total	60	25.3500	5.73666	.74060	23.8681	26.8319	14.00	39.00

ANOVA

BURN

	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	195.241	3	65.080	2.087	.112
Within Groups	1746.409	56	31.186		
Total	1941.650	59			