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The role of self-care on compassion satisfaction, burnout and secondary trauma among child welfare workers

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ABSTRACT

Child welfare workers are routinely exposed to multiple traumatic events when working with children and families, and are at an increased risk of experiencing burnout and secondary trauma. Self-care is often recommended as a restorative or protective activity against the negative effects of working with traumatized individuals, although few studies have examined the benefit of self-care empirically. Trauma-informed self-care (TISC) includes being aware of one's own emotional experience in response to exposure to traumatized clients and planning/engaging in positive coping strategies, such as seeking supervision, attending trainings on secondary trauma, working within a team, balancing caseloads, and work–life balance. Compared with generic personal care activities, TISC is likely to be especially relevant for child welfare workers. This study examined the role of TISC on compassion satisfaction, burnout and secondary trauma which was assessed by administering surveys to a sample of 104 child welfare case managers and supervisors. Almost one third of the sample reported high levels of burnout (29.8%) and secondary trauma (28.8%), and low levels of compassion satisfaction (31.7%). Results suggested that workers who engaged in higher levels of TISC experienced higher levels of compassion satisfaction and lower levels of burnout, although there was no relationship with secondary trauma. Findings provide preliminary evidence that TISC may be a beneficial practice to reduce risk of burnout and preserve workers' positive experience of their job, however workers experiencing secondary trauma are likely to need additional specialized intervention to assist them with their recovery.

1. Introduction

Child welfare work is a demanding and challenging role for a variety of reasons, including the emotional nature of the work, the severity and complexity of cases, and the high levels of organizational demand and workload. High levels of burnout and secondary traumatic stress can contribute to staff turnover (Boyas & Wind, 2010; Cahalane & Sites, 2008; Drake & Yadama, 1996; Mor Barak, Nissly, & Levin, 2001; Strolin-Goltzman, 2010; Zlotnik et al., 2005), as well as have deleterious consequences for the individual child welfare worker (CWW) and the children and families under their care. However, some workers experience pleasure from helping others known as compassion satisfaction (Figley, 1995a), and higher levels of compassion satisfaction may be protective against burnout and secondary trauma (Conrad & Kellar-Guenther, 2006). While there may be several factors that are protective or buffer against negative outcomes for the worker, self-care practices are often recommended (e.g., Child Welfare Committee National Child Traumatic Stress Network, 2008; Maslach, 2003; Newell & MacNeil, 2010) despite minimal empirical research. In particular, trauma-informed self-care strategies that incorporate an understanding of trauma and the effects of trauma on the worker and clients, may play a significant role in burnout, secondary trauma and compassion satisfaction, although research in this area is limited.

Burnout refers to a syndrome characterized by emotional exhaustion, depersonalization and reduced feelings of personal accomplishment that results as a consequence of chronic exposure or work with populations which are vulnerable and/or suffering (Freudenberger, 1974; Maslach & Jackson, 1981; Pines & Aronson, 1988). Burnout is common in a range of helping professions, including CWWs (Meyers & Cornille, 2002). As workers become depleted in their emotional resources, they can develop negative and cynical attitudes towards the people they are helping (Maslach & Jackson, 1981). Left unresolved, increased burnout has the potential to impact on the quality of care provided by workers (Maslach, 1982), including impairing worker decision making about child risk (McGee, 1989), reducing job satisfaction (Jayaratne, Chess, & Kunkel, 1986), and increasing staff absenteeism (Maslach & Jackson, 1981) and turnover (Cahalane & Sites, 2008; Drake & Yadama, 1996; Mor Barak et al., 2001; Strolin-Goltzman, 2010; Zlotnik et al., 2005).

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Secondary trauma, also referred to as compassion fatigue, has been recognized in helping professions such as CWWs, and describes the experience of psychological distress and posttraumatic stress symptoms resulting from helping clients who have been exposed to trauma (Figley, 1995a). Secondary trauma is sometimes referred to as vicarious trauma, and although these concepts are related, vicarious trauma is theoretically oriented and refers mostly to the cognitive changes resulting from cumulative exposure to trauma populations rather than the experience of trauma symptoms. Reactions often involve similar symptoms to posttraumatic stress disorder (including increased arousal or avoidance symptoms such as hypervigilance, hopelessness, avoidance, intrusive imagery of a client's trauma, sleep disturbance, exhaustion, guilt and fear). Research suggests that 34%–50% of CWWs experience high or very high levels of compassion fatigue (Bride, Jones, & Macmaster, 2007; Conrad & Kellar-Guenther, 2006; Meyers & Cornille, 2002) although the relationship between secondary trauma and turnover has not been well examined.

Although working in child welfare is often discussed in the context of negative wellbeing outcomes, it can be a rich and fulfilling career for many individuals. One of the areas often associated with positive emotional experiences in CWW is compassion satisfaction. Compassion satisfaction refers to a positive benefit that one receives from direct interaction with individuals who are suffering or traumatized (Figley, 1995a, 1995b; Stamm, 2002). This can include feelings of pleasure as a result of being able to help others as part of their work, and CWWs often report a strong belief in the significance and value of their role (Meyers & Cornille, 2002). Higher levels of compassion satisfaction are associated with reduced risk of compassion fatigue (vicarious trauma) and burnout in CWWs (Conrad & Kellar-Guenther, 2006; Van Hook & Rothenberg, 2009), and thus is considered to be protective for staff.

Burnout and secondary trauma are significant problems within child welfare organizations given the potential impact on staff turnover. Staff turnover in child welfare organizations varies between studies, but is generally high with reported rates ranging between 14 and 60% annually (Drake & Yadama, 1996; Fulcher & Smith, 2010; Smith, 2005). The impact of staff turnover can be immense for the organization, remaining staff and the clients. Consequences can include increased workload burden on remaining staff (exacerbating the potential for burnout), increased financial burdens on organizations, and decreased availability and quality of services provided to children and their families (Graef & Hill, 2000). Turnover of staff can cause considerable disruption for children, and increased number of case mangers have been associated with lower chance of permanency for children in child welfare services (Flower, McDonald, & Sumski, 2005). Understanding and addressing the factors impacting on staff turnover, including burnout and secondary trauma, are clearly important for all stakeholders to consider.

There are a number of personal and organizational factors that have been found to be associated with increased levels of burnout and secondary trauma in welfare workers more generally, with relevant personal factors including younger age (Augsberger, Schudrich, McGowan, & Auerbach, 2012; Boyas et al., 2012, 2012; Hamama, 2012; Lizano & Mor Barak, 2012; Mor Barak, Levin, Nissly, & Lane, 2006; Sprang, Craig, & Clark, 2011; Vredenburgh, Carlozzi, & Stein, 1999), fewer years of professional experience (Hamama, 2012; Pearlman & Mac Ian, 1995; Sprang, Clark, & Whitt-Woosley, 2007) and personal history of trauma (Bride et al., 2007; Jenkins & Baird, 2002; Nelson-Gardell & Harris, 2003; Pearlman & Mac Ian, 1995). There are mixed findings on the effect of gender, with studies tending to find higher rates of compassion fatigue and burnout in female workers (Baum, Rahav, & Sharon, 2014; Sprang et al., 2007; Van Hook & Rothenberg, 2009), while others have failed to find a gender effect on symptomatology (e.g., Connally, 2012), or have found higher rates in male workers (Sprang et al., 2011; Vredenburgh et al., 1999). A number of workplace factors associated with burnout and secondary trauma have also been identified, including salary (Font, 2012; Jayaratne & Chess, 1984), workload/caseload demands (Bride et al., 2007; Jayaratne & Chess, 1984), and workplace and supervisory support (Bakker, Demerouti, & Euwema, 2005; Bride et al., 2007; Kickul & Posig, 2001).

Despite widespread assumptions and recommendations that encourage workers to engage in self-care practices to buffer against the negative effects of working with traumatized individuals (e.g., Maslach, 2003; Newell & MacNeil, 2010), there has been surprisingly little evaluation of the relationship between self-care and worker wellbeing. One study found that specific self-care practices have been associated with lower levels of burnout (socializing with family) and compassion fatigue (having a hobby, reading for pleasure and taking pleasure trips or vacations) in residential treatment facility childcare workers (Eastwood & Ecklund, 2008). Killian (2008) did not find any relationship between specific self-care practices and compassion satisfaction, compassion fatigue or burnout in therapists working with children who had been sexually abused, although did find a relationship between increased social support, decreased work hours and increased locus of control on levels of compassion satisfaction. Similarly, Bober and Regehr (2006) failed to find any protective effects of self-care against secondary stress in therapists. Conversely, another study did find that increased self-care practices were associated with lower levels of burnout and compassion fatigue, and higher levels of compassion satisfaction in hospice workers (Alkema, Linton, & Davies, 2008), although this has not been examined in CWWs. Clearly, research examining the role of self-care practices in relation to burnout, secondary trauma and compassion satisfaction in CWWs is limited and warranted.

The term self-care encompasses a range of activities that an individual may engage in with the purpose of managing their physical and emotional health (Lee & Miller, 2013), however trauma-informed self-care (TISC) practices may be especially relevant for CWWs. Trauma-informed care refers to the evidence-based practices for trauma, including understanding and recognizing the effect that trauma exposure has on children and families, as well as workers, and adequate knowledge and skill in responding to the effects of trauma exposure (Child Welfare Committee National Child Traumatic Stress Network, 2008). The National Child Traumatic Stress Network is one of many organizations that promote the value of self-care practices in CWWs. For example the Child Welfare Trauma Training Toolkit (Child Welfare Committee National Child Traumatic Stress Network, 2008) provides guidelines on managing personal and professional stress as one of the essential factors to working within a trauma-informed care framework. These guidelines highlight the importance of workers being aware of their emotional experience and planning positive coping strategies to prevent the risk of secondary trauma. Specialized trauma training has been associated with greater levels of compassion satisfaction and lower levels of compassion fatigue in mental health workers, and shows trends towards lower levels of burnout (Sprang et al., 2007), although this relationship has not been replicated in CWWs specifically and the relationship between TISC, burnout, secondary trauma and compassion satisfaction has not been tested empirically in child welfare workers.

The purpose of this study is to explore the role of TISC in predicting compassion satisfaction, burnout and compassion fatigue among child welfare workers. Holding constant gender, age, and years of experience (given their previous associations with outcome), it was hypothesized that 1) there would be a positive association between TISC and compassion satisfaction; 2) there would be a negative association between TISC and burnout and 3) between TISC and compassion fatigue.

2. Method

2.1. Participants

Child welfare case managers and supervisors were recruited from a large private child welfare organization in South Florida during three separate organizational trainings. Any case manager or supervisor

working for the organization was eligible to participate, although participants were excluded if they had not yet completed their orientation training. Of the 120 case managers and 19 supervisors that attended the training, a total of 108 (78%) consented to participate. Two case managers started the survey, but did not complete it. A further two workers who were identified as transgender were excluded from the final analyses given the potential limitations of anonymity when reporting the effects of gender, as well as the limited statistical power to adequately explore gender as related to outcome variables with such a low frequency in this group. This is a limitation and future studies would benefit from increasing the representation of transgender workers to better understand their experience of child welfare work. Thus, the final sample consisted of 104 workers (85 case managers and 19 supervisors). Demographic information for the final sample is summarized in Table 1.

2.2. Procedure

This study was approved by the University Institutional Review Board. Participants were recruited during three separate trainings on domestic violence. During the first distribution of surveys, participants were asked to stay after the training and complete the surveys (11 of 55 declined to participate); whereas in the second two distribution of surveys, participants were allowed time during the training time to complete the survey (with 1 of 29 and 0 of 36 declining to participate, respectively). Participants were provided with a written consent to participate prior to completing the survey, although a signature was not required. To minimize undue influence and to protect anonymity in terms of who completed the survey and who did not, all participants were provided with a survey. Participants could check on the survey if they wanted their responses to be included or not. The survey took approximately 15 min to complete. Light refreshments were provided to all participants whether they completed the survey or not, and the first author administered the surveys.

Table 1
Demographic summary table.

	Total (N = 104)		Case managers (n = 85)		Supervisors (n = 19)	
	n	%	n	%	n	%
Female	86	82.7	67	78.8	19	100
Age						
20–24	13	12.5	13	15.3	0	0
25–29	39	37.5	36	42.4	3	15.8
30–34	17	16.3	12	14.1	5	26.3
35–39	16	15.4	13	15.3	3	15.8
40–44	5	4.8	3	3.5	2	10.5
45–49	4	3.8	1	1.2	3	15.8
50–54	3	2.9	3	3.5	0	0
55–59	4	3.8	3	3.5	1	5.3
60–64	1	1.0	0	0	1	5.3
65 and older	1	1.0	1	1.2	0	0
Unknown	1	1.0	0	0	1	5.3
Ethnicity						
Hispanic	21	20.2	18	21.2	3	15.8
Non-Hispanic	75	72.1	61	71.8	14	73.7
Unknown	8	7.7	6	7.1	2	10.5
Race						
Black/African American	36	34.6	33	38.8	3	15.8
White	58	55.8	44	51.8	14	73.7
Asian	1	1.0	0	0	1	5.3
American Indian	1	1.0	1	1.2	0	0
Bi-racial/mixed race	1	1.0	1	1.2	0	0
Haitian	1	1.0	1	1.2	0	0
Dominican	1	1.0	1	1.2	0	0
Hispanic	2	1.9	2	2.4	0	0
Unknown	3	2.9	2	2.4	1	5.3
Annual salary						
$25,001 to $30,000	14	13.5	14	16.5	0	0
$30,001 to $35,000	52	50.0	52	61.2	0	0
$35,001 to $40,000	17	16.3	16	18.8	1	5.3
$40,001 to $45,000	11	10.6	2	2.4	9	47.4
$45,001 to $50,000	5	4.8	0	0	5	26.3
More than $50,001	2	1.9	0	0	2	10.5
Unknown	3	2.9	1	1.2	2	10.5

2.3. Measures

2.3.1. Demographics

Information about the participant's gender, age, ethnicity, race, salary range, and educational level was collected and is summarized in Table 1.

2.3.2. Experience in child welfare

In the current study, experience in child welfare was measured by asking participants if they have been in child welfare for at least one year with a response format of yes or no.

2.3.3. Burnout, secondary traumatic stress and compassion satisfaction

The Professional Quality of Life Version 5 (ProQOL 5; Stamm, 2010) is a 30-item self-report measure used to measure burnout (10 items), compassion fatigue (10 items) and compassion satisfaction (10 items). Burnout is characterized by feelings of unhappiness and feeling overwhelmed. Compassion fatigue encompasses the negative feelings and fears associated with working with people who have experienced extreme stress or trauma, which includes elements of secondary traumatic stress. Compassion satisfaction consists of feelings of satisfaction from one's job and from helping others. Each subscale uses a five-point Likert scale ranging from *never* to *very often*. Scores for all subscales were converted to a t-score with scores below 43 indicating low levels, 43–56 indicating average levels, and scores above 57 indicating high levels of burnout, compassion fatigue and satisfaction (Stamm, 2010). This measure has demonstrated adequate reliability for the burnout, secondary trauma, and compassion satisfaction subscales (Cronbach's $\alpha = .75, .81$ and .88 respectively; Stamm, 2010). Internal consistency was adequate for each subscale in the current sample ($\alpha = .74, .91$ and .78 for the burnout, compassion satisfaction, and secondary traumatic stress subscales respectively).

2.3.4. Trauma-informed self-care (TISC)

We developed a 14-item TISC measure for child welfare workers using suggestions for trauma-informed self-care practices adapted directly from the practice recommendations in the Child Welfare Trauma Training Toolkit (Child Welfare Committee National Child Traumatic Stress Network, 2008). The listed self-care suggestions were originally developed from the literature and by an expert committee (Child Welfare Committee National Child Traumatic Stress Network, 2008, p. 34), and were adapted into specific "I" statements each with a 4-point response format ranging from 0 = *not at all* to 4 = *to a very great extent*. For example, the suggested practical assistance of "set realistic goals and expectations" in the toolkit (Child Welfare Committee National Child Traumatic Stress Network, 2008, p. 34) was changed to, "I set realistic goals and expectations." Worker endorsement of each item is summarized in Table 2. The items are categorized into three types of self-care strategies. Items 1 to 7 entailed recommended standard child welfare practices such as a team approach, regular supervision, peer support, safety training, balanced caseload, release time and safe work environment, and training on secondary trauma. Items 8 to 11 involved resources and supports for the worker in terms of continuing education, employee assistance programs, positive workplace culture, and utilization of therapy for unresolved personal trauma. Items 12 to 14 referred to specific personal self-care practices such as setting realistic goals and expectations, practicing self-management and developing a written work–life balance plan (Child Welfare Committee National Child Traumatic Stress

Table 2
Participants of trauma-informed self-care responses (N = 104).

	Not at all	Slight extent	Moderate extent	Great extent	Very great extent	
	%	%		%	%	M(SD)
1. I work with teams within the child welfare agency and within the provider community.	3.8	4.8	18.3	36.5	36.5	3.0 (1.1)
2. I request and expect regular supervision and supportive consultation.	1.0	3.8	17.3	39.4	38.5	3.1 (.89)
3. I utilize peer support.	0	2.9	21.2	35.6	40.4	3.1 (.85)
4. I attend regular safety training for child welfare workers.	3.8	7.7	20.2	34.6	33.7	2.9 (1.1)
5. I balance my caseloads so that I am not dealing only with traumatized children and their families.	34.6	15.4	24.0	19.2	6.8	1.5 (1.3)
6. I have sufficient release time and safe physical space for workers.	11.5	15.4	27.9	31.7	13.5	2.2 (1.2)
7. I attend trainings on secondary trauma.	21.2	20.2	33.7	16.4	8.7	1.7 (1.2)
8. I seek continuing education on the effects of trauma on child welfare professionals.	14.5	13.5	31.8	27.9	12.5	2.1 (1.2)
9. I utilize agency resources such as employee assistant programs for intermittent support if needed.	41.3	14.5	18.3	18.3	7.7	1.4 (1.4)
10. I cultivate a workplace culture that normalizes (and does not stigmatize) getting help for mental health professionals.	8.7	11.6	31.8	29.8	18.3	2.4 (1.2)
11. I would consider therapy for unresolved trauma that the child welfare work may be activating.	6.8	10.7	30.8	35.6	16.3	2.4 (1.1)
12. I set realistic goals and expectations for myself.	2.9	6.7	26.9	38.5	25.0	2.8 (1.0)
13. I practice stress management through meditation, prayer, conscious relaxation, deep breathing, and exercise.	12.5	10.6	25.0	30.8	21.2	2.4 (1.3)
14. I have a developed a written plan for myself that is focused on work–life balance.	41.3	10.6	20.3	16.3	11.5	1.5 (1.5)

Note. Items were adapted directly from the Child Welfare Trauma Training Toolkit (Child Welfare Committee National Child Traumatic Stress Network, 2008, p. 34).

Network, 2008). The structure and preliminary psychometric properties of this measure are examined in Section 3 Results.

2.4. Data analysis

Hierarchical multiple regression analyses were used to answer the three research questions. In hierarchical multiple regression analysis, independent variables are added to the regression model in a series of steps, or increments, as determined by the researchers. This statistical method allows researchers to explore the amount of variance explained at each step. Variance explained in each step is estimated using the R^2 change. Demographic variables (gender and age) were entered in the first step, professional characteristics (role and experience working in the child welfare system: greater or less than one year) in the second step, and TISC in the third step. Given the three analyses conducted, a Bonferroni adjustment was used to control the type I error rate, thus an alpha level of $p = .017$ was used for the three hierarchical regression equations. The authors calculated the required sample size for a small effect of .2, a power of .8, a type one error level of .017, and 5 predictors. Based on the power analysis, the authors determined that 88 cases were needed to achieve a power of .8.

While the majority of respondents answered each question, there was a small amount of missing data. Hertel (1976) recommends that any given variable should have no more than 15% missing data. Within the self-care variable, five (.34%) of 1466 data points were missing. About 4% of cases are missing between one to two values on this 14 item scale. Of 1037 data points on the compassion satisfaction scale, 3 (.29%) were missing data; four (4%) of cases are missing data on between one and three of 11 items. On the burnout scale, 2 data points (.19%) are missing data, with 2 cases (2%) missing one value on the 11 question scale. Of 1036 possible data points on the secondary trauma scale, 4 (.39%) are missing data, with four cases (4%) of missing data. The amount of missing data in the current study falls below Hertel's 15% suggestion.

Using Little's Missing Completely at Random (MCAR) Test, the researchers tentatively determined that the data were MCAR, $\chi^2 = 1216.17$, df = 1152, $p > .09$. Given the potential for this missing data to influence the results (Allison, 2002), to reduce the reliability of the composite scores (Enders, 2003) as well as to limit statistical power (Roth, Switzer, & Switzer, 1999) we used maximum likelihood estimation, including expectation maximization (EM; Peugh & Enders, 2004) to impute missing data. EM utilizes a two-step, iterative process based on maximum likelihood estimation to obtain missing values (see Ruud, 1999 for a full explanation of EM data replacement). EM provides accurate and efficient estimates for replacing missing data at the item level, including accurately reproducing internal consistency reliability estimates (Enders, 2003) and is appropriate when there are small amounts of data MCAR (Enders, 2010). Enders (2003) found that EM provides more accurate estimates compared to other methods of replacing missing data with as few as 100 cases and with as much as 15% missing data.

3. Results

3.1. Preliminary validation of the trauma-informed self-care measure

The four most commonly endorsed TISC practices were requesting and expecting regular supervision/supportive consultation, utilizing peer support, attending regular safety training for CWWs and working with a team within the child welfare agency and provider community (see Table 2). The four least commonly endorsed TISC practices were attending trainings on secondary trauma, balancing caseloads so that the worker is not only dealing with traumatized children and their families, utilizing agency resources (such as employee assistance programs) for support, and developing a written plan focused on work–life balance (see Table 2).

To provide some preliminary validation of this measure for use in further analyses we examined the factor structure and internal reliability of the scale. An exploratory factor analysis was conducted using principal axis factoring with direct oblimin rotations, requiring factors to have a minimum of four items loading higher than .4. The diagonal value in the anti-image correlation matrix for item 11 fell below .7 (.68), and the communality value for item 10 fell below the suggested value of .3 (.26), and, as such, these items were removed from the scale. Using the revised 12-item scale, the Kaiser–Meyer–Olkin Measure of Sampling Adequacy (KMO) for the TISC was acceptable (.81), and Bartlett's test of sphericity was significant ($\chi 2 = 419.01$, $p < .001$). Examination of the scree plot and eigenvalues suggested a three factor solution that explained 49.5% of the variance. Item loadings are summarized in Table 3.

In the original list of trauma-informed self-care strategies, items 1–7 consisted of standard organizational practices. For factor 2, the first 4-items were congruent with the organizational practice strategies (i.e., team approach, supervision and consultation, peer support and safety training) and thus, have been termed Organizational Practices. In the original list of strategies, items 8–11 were categorized as self-care resources and supports. For factor 1, only items 8 and 9 that

Table 3
Revised trauma-informed self-care measure item loadings.

Item	Factor 1	Factor 2	Factor 3
	Utilizing organizational resources and supports	Organizational practices	Personal self-care practices
1		.66	
2		.62	
3		.56	
4		.74	
5	.67		
6			.52
7	.80		
8	.54		
9	.72		
12			.51
13			.71
14			.53

Note. Item 10 (I cultivate a workplace culture that normalizes and does not stigmatize getting help for mental health professionals) and item 11 (I would consider therapy for unresolved trauma that the child welfare work may be activating) were removed.

involved self-care resources and support (i.e., continuing education, employee assistance program) were included in this factor, and 2 items from organizational practices (items 5 = release time and safe working environment and item 7 = training on secondary trauma) were also included. We have termed this factor, Utilizing Organizational Resources and Supports since it is a combination of organizational practices and resources and supports. In the original list of strategies, items 12–14 are categorized as specific personal self-care practices. For factor 3, items 12–14 all loaded together but an additional item (i.e., items 6 = balance caseload) from organizational practices was also included. While having a balanced caseload such that the worker does not have all traumatized children and their families is often an organizational decision, workers may be able to structure their caseloads and thus, this factor is labeled Personal Self-Care Practices.

Internal reliability was good for Utilizing Organizational Resources, Organizational Practices and Personal Self-Care subscales (Cronbach's $\alpha = .79, .75$ and .73 respectively), as well as the total score ($\alpha = .82$). Given the preliminary nature of the psychometric validation of this scale, the small sample size for scale development, and the inconsistency of item loadings compared to original categories, the total TISC score was used given that it encompasses a range of TISC practices and is likely to be more stable. The factor structure is promising and warrants replication before being used for individual analyses. The 12-item total score was used in subsequent analyses, although results were consistent when using the original 14-item scale.

4. Descriptive statistics

Differences on a range of demographic variables were examined. Firstly, differences between the case manager and supervisor groups on demographic and professional variables were assessed. There was a significant difference on gender ($\chi^2(1) = 4.87$, $p = .027$) with the supervisor group being all female. There was also a significant difference on age ($\chi^2(9) = 23.70$, $p = .005$) and salary ($\chi^2(5) = 82.59$, $p < .001$) with supervisors tending to be older and have a higher salary, but there was no difference in level of education (having a master's degree), ethnicity or race (p's > .05). Given these differences, role was controlled for analyses. Group comparisons using t-tests revealed that there were no significant differences on mean level of compassion satisfaction, burnout or secondary traumatic stress between case managers and supervisors. Of the 19 supervisors, 16 of them also carried a caseload providing direct care to children. The total sample (N = 104) was used in the hierarchical multiple regression analyses. Almost one third of workers reported high levels of burnout and secondary traumatic stress, and low levels of compassion satisfaction. Descriptive statistics for measures of burnout, compassion satisfaction and secondary trauma are provided in Table 4.

Table 4
Descriptive information for ProQoL subscales and trauma-informed self-care (N = 104).

	Range	M	SD	% in 'high' range
Burnout	26.20–75.64	50.12	10.06	29.8
Secondary traumatic stress	30.20–80.92	50.06	10.06	28.8
Compassion satisfaction[a]	30.21–71.00	49.90	9.98	31.7[a]

[a] Percent in 'low' range.

Women reported significantly higher levels of compassion satisfaction than men, $t(102) = -2.11$, $p = .038$, although there was no significant difference in their levels of burnout or secondary trauma. Older age was associated with lower levels of burnout ($r = -.24$, $p = .014$) and secondary trauma ($r = -.24$, $p = .016$) but not compassion satisfaction ($r = .18$, $p = .072$). In terms of professional experience, eighty workers (75.9%) had been in child welfare for at least one year. Those who had been working in child welfare for more than one year reported significantly higher levels of burnout compared with those who had been in child welfare for less than one year, $t(103) = -2.32$, $p = .023$, and lower levels of compassion satisfaction ($t(103) = 2.39$, $p = .019$), although there were no significant differences in their level of secondary traumatic stress. To account for these differences, age, gender and professional experience were entered into the regression.

All workers had a bachelor's degree and 19 (18.3%) had a master's degree. There was no significant difference on mean compassion satisfaction, burnout, secondary traumatic stress and TISC between those who had a master's degree and those who did not.

4.1. Role of trauma-informed self-care on compassion satisfaction, burnout and secondary trauma

Pearson correlations were used to assess the bivariate relationships between the TISC subscales and total score with outcome variables. The TISC total score was associated with higher levels of compassion satisfaction ($r = .35$, $p < .001$), and lower levels of burnout ($r = -.42$, $p < .001$), and secondary trauma ($r = -.30$, $p = .002$). There was evidence of a relationship between the three outcome measures. Increased compassion satisfaction was associated with lower levels of burnout ($r = -.60$, $p < .001$) and secondary trauma ($r = -.26$, $p = .007$), and there was a strong relationship between burnout and secondary trauma ($r = .73$, $p < .001$).

Hierarchical multivariate regression was used to answer each of the three research questions, entering demographic predictors (age and gender) on the first step, professional variables (role and experience)

Table 5
Hierarchical multiple regression analysis predicting compassion satisfaction, burnout, and secondary trauma from gender, age, years of experience, and self-care.

Predictor	Compassion satisfaction		Burnout		Secondary trauma	
	ΔR^2	β	ΔR^2	β	ΔR^2	β
Step 1	.068		.053		.057	
Age		.22		−.27**		−.25
Gender		4.19		.01		.09
Step 2	.089**		.078*		.014	
Professional experience (±1 year)		−.28**		.27**		.11
Role		−.01		−.06		.01
Step 3	.088**		.065**		.013	
Self-care		.30**		−.26**		−.12
Total R^2	.245		.197		.085	

* $p < .017$.
** $p < .01$.

on step 2, and TISC practices on step 3. Results are summarized in Table 5.

The first analysis explored the extent to which TISC explained variance in compassion satisfaction. The first step did not explain a significant amount of variance in compassion satisfaction ($F(2, 101) = 3.62$, $p = .03$). The second step, which included role and years of working in the child welfare field, did explain a significant amount of variance, $F(1,101) = 4.53$, $p = .002$. Being in child welfare for a year or longer ($\beta = -.30$, $t = -3.12$, $p = .002$) and gender ($\beta = .24$, $t = 2.52$, $p = .013$) were significant predictors of compassion satisfaction and explained 8.9% of the variance. The third step, which included TISC, added an additional 8.8% of variance in compassion satisfaction, $F(5,101) = 6.24$, $p < .001$. Greater scores on TISC were associated with increases in compassion satisfaction ($\beta = .30$, $t = 3.34$, $p = .001$). Professional experience remained a significant predictor of compassion satisfaction on the final step ($\beta = -.28$, $t = -3.01$, $p = .003$).

Next, we explored the impact of TISC on burnout. The first step did not explain a significant amount of variance in burnout scores ($F(2,101) = 2.78$, $p = .066$). The second step was significant ($F(4,101) = 3.66$, $p = .008$) and explained a significant additional 7.8% of the variance in burnout, with age and professional experience being significant predictors ($\beta = -.25$, $p = .012$ and $\beta = .29$, $p = .004$ respectively). The third step was a significant predictor of burnout, $F(5, 96) = 4.70$, $p = .001$. Trauma-informed self-care was inversely related to burnout, with greater TISC scores being associated with reductions in burnout scores, $\beta = -.26$, $t = -2.80$, $p = .006$. Experience and age were also significant predictors in this final model, with greater than one year of experience being associated with increased levels of burnout ($\beta = .27$, $t = 2.82$, $p = .006$) and younger age ($\beta = -.27$, $t = -2.83$, $p = .006$).

The final analysis explored the impact of TISC on secondary traumatic stress. None of the steps was associated with significant changes in secondary traumatic stress scores. Thus, TISC was not associated with secondary trauma stress.

5. Discussion

Child welfare workers are at risk of negative emotional outcomes, including burnout and secondary trauma. These symptoms can have detrimental outcomes for the individual worker, the organizations they work for, along with the children and families they work with, making it important to understand the factors that may be protective against these outcomes. Trauma-informed care is optimal for providers working with children exposed to trauma, and includes suggestions about ways to manage the effect of exposure to client's trauma experiences on workers. This study examined the role of TISC on compassion satisfaction, burnout and secondary trauma among CWWs.

Age, gender and professional experience have previously been associated with levels of burnout and secondary trauma. There were higher levels of burnout in those with more than one year of CWW experience, contrary to previous studies that have found lower levels of burnout and secondary trauma in those with more experience (e.g., Hamama, 2012; Pearlman & Mac Ian, 1995; Sprang et al., 2007). It is possible that the duration of employment shows a U or J-shaped relationship with burnout, with those in the first year of their career experiencing less burnout, with higher rates observed in early to mid-stage careers as the chronicity of workload and exposure increases. Lower rates of burnout and secondary trauma may then be observed in the later stages of CWW careers either as an artifact of burned out or traumatized staff leaving the profession, or as a result of workers developing increased coping strategies and resilience over time.

Lower levels of compassion satisfaction were found in those with more than one year of experience, and although these results do not suggest causality, this result may suggest that low compassion satisfaction is a risk factor for the development of burnout, as workers decline in their sense of reward from CWW over longer periods of employment. Alternatively, this decline in compassion satisfaction may be a consequence of increasing levels of burnout in more experienced workers reducing their experience of reward from their work. CWWs are often highly engaged and dedicated to the families with which they work. It is a limitation of this study that data on professional experience was collected only in reference to whether workers had more than one year experience. Future studies would benefit from collecting continuous data on professional experience to allow more detailed understanding of the nature of this relationship. It is this high level of involvement, compassion and empathy that often drives workers to pursue a career in child welfare, however these traits can leave them vulnerable to becoming over-involved or enmeshed in the problems of their clients and make it difficult for workers to set professional boundaries that may be protective for their own mental health. Indeed, lower levels of compassion satisfaction were associated with increased risk of burnout, highlighting the importance of compassion satisfaction in workers.

Greater levels of TISC were associated with higher levels of compassion satisfaction and lower levels of burnout (but not secondary trauma). It appears that TISC may be an important protective factor to consider among CWWs. While self-care is often recommended and promoted as a preventative measure or cure for burnout (e.g., Maslach, 2003; Newell & MacNeil, 2010), there has been surprisingly little research examining this. In particular, self-care can refer to a range of activities that may or may not be relevant to alleviating distress from professional roles. Trauma-informed self-care refers to a specific type of practice that is relevant to dealing with traumatized populations, such as seeking supervision, working within teams, attending trauma-specific training, and balancing caseloads so that the worker is not only dealing with traumatized children, but also assessing a range of personal stress-reducing strategies, such as practicing stress management techniques, developing a plan for work–life balance and seeking therapy for personal issues triggered by their work. Addressing the type of self-care needs that are likely to be most relevant to workers dealing with traumatized populations, such as CWWs, appears to be protective for the development of burnout, as well as for increasing levels of compassion satisfaction.

Contrary to predictions, TISC was not related to secondary stress. It is likely that burnout and secondary trauma may lie on a continuum, with unresolved high levels of burnout increasing the risk of developing vicarious trauma. Findings may suggest a threshold issue, whereby TISC may alleviate symptoms of burnout, while symptoms of secondary trauma are more severe and pervasive, and may require more intensive treatment interventions to assist with recovery. In fact, recently, repeated or extreme exposure to traumatic details while in the helping role has been included as one type of exposure that may lead to posttraumatic stress disorder (American Psychiatric Association, 2013). It may be that workers experiencing secondary trauma may need interventions for posttraumatic stress and are beyond any ameliorating effect of TISC practices alone. It is also possible that certain types of TISC practices may be more salient than others in decreasing secondary trauma. For example, maybe practices that were endorsed the least in this sample such as trainings on secondary trauma, balancing caseloads with traumatized and non-traumatized children and families, utilizing agency resources (such as employee assistance programs) for support, and developing a written plan focused on work–life balance would have contributed more to decreasing secondary stress than some of the other practices used more frequently.

There are several limitations of this study. First, the measure of TISC used in this study, while based on recommendations from an expert group, was unvalidated. Self-care as a construct has not been adequately examined in the literature, and measures are limited, with those studies that have examined it using a variety of definitions and checklists of behaviors. In particular, research on the construct of trauma-informed care remains in its infancy, and to our knowledge there is no trauma-specific measure of professional self-care. This measure demonstrated

good internal reliability in the current study and has promising utility for use in child welfare organizations, along with other professionals working with those exposed to trauma. However, the psychometric properties of this measure warrant further examination. The wording of some items may include non-essential elements, and may warrant clarification in future versions. For example, in the item "I have developed a written plan for myself that is focused on work–life balance" it is likely that it is the *execution* of a plan for work–life balance that is more relevant for coping outcomes, rather than the *writing down* of the plan. Some further clarification of item wording may be beneficial in future studies utilizing this measure. The early stages of psychometric validation of the TISC measure is a limitation of the current study; although it provides the foundation for future studies on the validation of TISC. Secondly, the cross-sectional nature of the study does not allow for causal inferences and prospective assessment of burnout, compassion satisfaction and secondary trauma, along with TISC practices over time would elucidate important relationships. Finally, given that the sample was recruited from one region, the generalizability of the findings is limited.

There is preliminary evidence that TISC may be a beneficial practice for CWWs to reduce risk of burnout, however workers experiencing secondary trauma are likely to need additional specialist intervention to assist them with their recovery. Additionally, it appears that TISC may play a role in either enhancing or preserving worker levels of compassion satisfaction, which may have positive effects on worker retention and engagement. This study contributes to the paucity of research examining the role of self-care on worker wellbeing, and extends this work by examining a set of practices likely to be most relevant for CWWs exposed to traumatized populations. These findings have implications for organizational policies as well as recommendations for workers, including improving the provision and practice of trainings on secondary trauma, balancing caseloads, developing written plans for work–life balance, and utilizing organizational resources (including employee assistance programs) when needed.

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