

**Secondary Traumatic Stress in Rural Child Welfare Workers: A Push for Change**

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## SECONDARY TRAUMATIC STRESS IN RURAL CHILD WELFARE WORKERS

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### **Abstract**

This Capstone examines the pervasive issue of secondary traumatic stress (STS) among child welfare workers employed in rural settings in Canada, highlighting the unique challenges faced by this often overlooked workforce. Drawing on existing literature and integrating an individualized systems framework and trauma theory, the research emphasizes the critical need for systemic change to support workers who are routinely exposed to trauma through their roles. The research identifies key factors that contribute to the prevention of STS, including individual coping mechanisms, and organizational support, and also points on the unique impact of the rural setting on job performance and mental health. The findings suggest that effective interventions, both from a child welfare organizational lens, and also a counseling application lens, must encompass an individualized, holistic approach, integrating individual self-care practices, robust organizational support systems, and trauma-informed leadership strategies. This Capstone aims to not only illuminate the struggles faced by rural child welfare workers but also advocate for comprehensive policy and practice initiatives that mitigate STS, enhance job satisfaction, and ultimately improve outcomes for both workers and the families they serve. The implications of this study are significant for leaders in child welfare organizations and counseling practitioners, providing a foundation for future research and targeted interventions to mitigate STS and foster healthier workplace culture.

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## SECONDARY TRAUMATIC STRESS IN RURAL CHILD WELFARE WORKERS

### Chapter One: Introduction

#### Overview of the Topic

As a current employee of Children and Family Services of Alberta and someone who used to work on the front line of child protection for years, I have both experienced and witnessed secondary traumatic stress in my peers. All staff who work in such a traumatic environment, hearing the disturbing and detailed disclosures of children, family, and youth can be at risk for developing secondary traumatic stress (STS), however, not all staff are even aware of the impacts of the indirect exposure to trauma and traumatic material. This can impact practitioners, personally and professionally, in varying ways and is not discussed within the field to the depth it needs to be. The National Child Traumatic Stress Network (2016) notes that STS impacts individuals to different degrees, causing them to become overwhelmed, challenged, reactive, avoidant, and fully change their outlook, meaning they can become more pessimistic and can experience communication breakdown and lack of psychological safety. The guidelines, from an organizational and leadership lens, to support workers that experience such direct and indirect trauma are sparse, with Bride et al. (2024) noting only one set of guidelines found in the literature. While mental health professionals are primed and trained to support individuals dealing with trauma, child welfare organizations and leaders within the agencies are not as well equipped. While taking care of oneself is a topic of conversation in child welfare, intentional education, preventative practices and programs, and reflective practices are not put in place for workers and leadership to navigate the best interventions to ensure workers, who are routinely subjected to trauma either directly or indirectly, remain healthy, both physically and mentally.

Working in child welfare in rural settings, with populations of 10,000 or less, also adds a layer of complexity and stress to those employed. Rural child welfare workers are noted to have

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lower job satisfaction than other social workers in different fields in the same rural setting (Walters et al., 2019). Working in an area where resources are limited, dual relationships are inevitable, and child welfare workers may sometimes work in isolation, creating added pressures that city workers do not face to the same extent. Rural community members, including child welfare workers, have higher risk factors for suicidality due to isolation, fewer mental health supports, and less ability to access resources due to a lack of internet connection, available therapists, and mental health facilities (Barry et al., 2020; Eckert et al., 2004; Mental Health Commission of Canada, 2021). By understanding those added rural dimensions and how they interplay with how one experiences and navigates traumatic work, or how one attempts to support the child welfare worker through the lens of the counselor, one can more fully appreciate a rural child welfare worker's unique situation. This will only further enrich the conversations as to what is supporting those to mitigate STS and maintain a level of health and well-being to continue in a stressful, traumatic field of work, and lead to recommendations for program development to amplify the existing (or nonexistent) policy and practice initiatives for rural employees, as well as recommendations to support assessment and treatment planning for counselors supporting rural child welfare workers.

### **Purpose Statement**

With an appreciation for rural child welfare workers noting higher levels of STS according to Dilworth (2021), the purpose of this Capstone will center on their experience. The research question I am posing is: what factors mitigate or prevent the onset of STS in child welfare practitioners working in rural Canada?

The intended audience is twofold: leaders and change-makers within the child welfare field who can harness the recommendations to create impactful change to support practice and

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policy that mitigates STS for their staff and inform intentional supervision with their workers, and, current and up-and-coming counselors, who will benefit from understanding the interrelated systems and preventative factors and contexts of working rural to best support and mitigate STS symptoms themselves if they are supporting child welfare workers as clients. An understanding of these dynamics within a rural child welfare worker's life will better inform therapeutic approaches and the building of therapeutic rapport that will support successful clinical counseling practice.

### **Theoretical/Conceptual Framework**

The theoretical framework the Capstone will utilize is constructivist theory with a particular lens on systems theory (Bronfenbrenner, 1979). This framework will help analyze how one's individual factors (such as one's ability to prioritize self-care or engage in coping) interconnect with one's environment (both their work environment with peers and supervisors; and outside network and communities) and larger system (such as employment practices and policies) to influence one's well-being and understanding of one's situation concerning preventing and mitigating STS. Analyzing the different systems at play in a holistic view informed by systems theory, rather than in an individualistic siloed view, and understanding how they interconnect to inform an individual's well-being and how to protect it, will help to inform improvements to the systems. A complementary framework I will be engaging along with the systems theory is that of trauma theory: considering how trauma can alter one's emotions, thoughts, and actions, and ability to make sense of their world and themselves. Often this trauma can impact a person's functioning, attachment, relationships, and biopsychosocial functioning (Herman, 1992; van der Kolk, 2014). This not only informs this Capstone, but it can inform the implications for therapeutic practice when counseling rural child welfare workers. Counselors,

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utilizing these grounding frameworks, can identify issues in their clients' lives at multiple levels, while also considering the importance of external/environmental factors that influence a person's functioning. This can emphasize and support specific interventions to promote their client's mental well-being and foster self-sufficiency and resiliency, while also encouraging a broader community well-being.

Another theoretical framework that will be used to guide this Capstone is that of transformational leadership theory which premises itself on motivating and inspiring employees, to create a shared vision of work and a pathway to fulfill it. This theory considers the role of the leader and how that leader, their influence, and actions, can improve job satisfaction and morale while considering workers' individual situations (Bass, 1995). This becomes especially important when considering a workforce that is inherently stressed and in need of changes when it comes to supporting staff—which this Capstone will aim to propose. This framework will support informing recommendations that tie to intentional and meaningful clinical supervision for child welfare workers with the purpose to mitigate the trauma they experience.

### **Methodology**

For this Capstone, I reviewed both peer-reviewed published literature, along with current policy/programs/initiatives on public-facing domains of Canadian child welfare agencies as it relates to prevention programs for staff well-being as it relates to mitigating trauma.

For the academic literature, I utilized the City University of Seattle databases, such as PsycINFO, PsycBooks, Psychology and Behavioural Sciences Collection, ProQuest Dissertations, and SAGE Premier, along with Google Scholar. The searches were undertaken using keywords such as “secondary traumatic stress AND child welfare workers,” “burnout AND child welfare workers,” “child welfare workers AND vicarious trauma,” “child welfare workers

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AND Canada AND burnout,” “child welfare practitioners AND secondary traumatic stress AND Canada,” “vicarious trauma AND child welfare practitioners AND Canada,” “mitigating factors AND burnout,” “mitigating factors AND vicarious trauma,” “mitigating factors AND secondary traumatic stress,” “rural AND child welfare workers AND burnout,” “rural AND child welfare workers and vicarious trauma,” “rural child welfare workers AND secondary traumatic stress,” “preventative factors AND secondary traumatic stress,” “prevention AND vicarious trauma,” and “compassion fatigue AND prevention AND child welfare workers.”

The studies and literature were analyzed and assessed as appropriate in considering the relevance of the study to this Capstone, the year the material was published, if the material was scholarly and peer-reviewed, and if the study/material had academic citations to support their findings. I included papers that published quantitative studies, qualitative studies, systemic reviews, or mixed methods research describing mitigating factors or prevention methods for STS in child welfare workers. I included a study on mental health workers as well in rural settings and child welfare workers not in a Canadian context, given the low number of specific studies on rural Canadian child welfare workers and STS that existed. Literature written in another language outside of English was excluded, as were articles related to disability services workers. Exclusion criteria also included studies that were significantly dated (over 10 years old), despite a few that were grounding literature in the area of study, and studies that were focused on trauma and stress as it relates to the children and family, instead of the child welfare worker. For relevant studies and “grey” literature, I utilized Google to find public-facing domains of existing child welfare agencies, using my pre-existing knowledge of the provincial authorities and ministries. I scoured their websites for any information on prevention programs or initiatives that exist for child welfare staff to access to prevent and mitigate STS. I only included public-facing material

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and did not include material of which I have access as an internal employee of Alberta's Children and Family Services to mitigate bias.

The literature was then analyzed and organized into themes and subthemes using a synthesis matrix, which allowed me to systemically work through the plethora of research in an organized fashion (Writing and Speaking Tutorial Services, 2006). This included columns, with themes and subthemes noted, which were added as more articles were reviewed and themes were compiled, and rows with the identified source in each. As the literature was being reviewed, relevant outcomes and data were input into the matrix. The Capstone literature review was then written utilizing this matrix as a reference guide, synthesizing the information from the articles linked to each into a comprehensive analysis of the preventative factors and contextual factors as it related to STS. See the Appendix for the Synthesis Matrix.

This Capstone has also been consulted throughout, from the prospectus to the final product by faculty at the City University of Seattle, not only on the approach utilized but submitting various chapters for opinion and consultation. A faculty second reader was also engaged to provide feedback on the project, and subsequent revisions were made.

### **Contribution to the Field**

This proposed research project holds both a significant meaning for myself and for the plethora of colleagues I know who have been impacted by STS. The stress and indirect trauma child welfare workers carry, because of not being able to "shut off" when working in a rural and remote community is understated at best and can inhibit one's ability to feel successful and fulfilled, personally and professionally. By understanding the literature out there currently to point out what has been working, individually and organizationally, for child welfare workers in rural settings to stay healthy and manage their day-to-day stresses and traumas they witness or

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vicariously hear about, but to also point out significant gaps in the practice or what is missing currently within child welfare agencies, contributions to the field of mental health and wellbeing wellness can be attained concerning mitigation factors for STS. These understandings will draw on the systems lens, understanding one factor cannot exist without the other and their interaction must be fully understood, especially by those in leadership positions within child welfare, to support the psychological safety of those within their organization.

The other important finding regarding STS to note is stated by much of the research: STS is tied to high turnover within child welfare organizations (Strolin-Goltzman et al., 2024), and can have negative consequences on the families and children served by child welfare agencies due to the negative health consequences of STS on workers, meaning workers are away on sick days and mental health days and not engaged or present in the work to make critical decisions (Boyas et al., 2022; Delgadillo et al., 2018; Denne et al., 2019). Understanding what can mitigate and prevent STS for child welfare workers in rural Canada can lead to recommendations for program development within child welfare agencies, and lead to better outcomes for children and the organization. These recommendations could lend to those programs and practice initiatives to attract new talent and support maintaining a healthy workforce. As my title, “Secondary Traumatic Stress in Rural Child Welfare Workers: A Push for Change,” suggests, my aim, as motivated by my own social location, is to advocate for change and contribute to the field of child welfare and mental health. Ultimately, I aim to translate the findings of my literature review into recommendations for policy, programs, and practice initiatives, and push for more comprehensive clinical supervision from leaders, while integrating both systems theory and transformational leadership theory, to support rural child welfare practitioners’ health and wellbeing while undertaking inherently traumatic work.

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Counselors serving those who work in rural will also benefit from this Capstone. Not only will counselors gain a deeper understanding of the rural child welfare workers' particular context they are facing, counselors will also gain a more nuanced understanding of rural work and the barriers and boundaries that they themselves may have to overcome, which is parallel to those the child welfare worker endeavors with families with whom they work.

### **Clinical Practice Implications**

While said contributions can benefit child welfare agencies and ministries in mitigating STS in their staff, there are further contributions and implications for the therapeutic field as well. Understanding the preventative factors and having an appreciation for the inherently traumatic work will support the therapist who may be counseling a child welfare worker, in person or virtually, and could also strengthen the therapeutic relationship. The synthesized findings of the interrelated systems that mitigate this stressful work will contribute to recommendations, assessment, and treatment planning to ensure that trauma-informed evidenced-based interventions are best applied by counselors, whether they are contracted in by the organization following a traumatic event as a whole, or having their services sought out individually exclusive from the child welfare agency itself. This role, which could be both in individual therapy or via organizational training or consultation, either in person or virtual, needs just as much consideration regarding challenges providing therapy in an isolated, rural setting, such as confidentiality and dual relationships, and this paper aims to bring light to that. This Capstone aims to support not only a thorough discussion and recommendations for navigating these nuances but aims to inform trauma-informed approaches and understanding for counselors to draw from when supporting rural child welfare workers.

### **Reflexivity and Positionality Statement**

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Reflexivity will become especially important in who I am as I write this paper. Being employed by Alberta Children and Family Services for the past 9 years in various roles provides me a “look behind the curtains” at the current programs and practices in place. Along with that, I also bring to the table my own experience of working in rural child welfare for 9 years, both experiencing STS myself and the impacts on my well-being along with my professional role and family life. I have also witnessed and experienced many peers who have been impacted not only by STS and had varying degrees of responses from management. I have witnessed and experienced organizational and leadership responses, both reactive and preventative, from all angles, and have a first-person experience of the factors that have not only supported posttraumatic growth but mitigated stress and indirect trauma in a way that allowed me to engage in my own wellness. I have also experienced and witnessed the opposite. Seeing firsthand, how a worker’s wellness and mental health not only directly impact their own personal and family life, but also the fidelity of work in analyzing risk and safety and collaboration with a family is jarring and propels my motivation to advocate for a child welfare worker’s mental wellbeing and psychological safety.

Being clear about my social location and my own experiences with STS is something I cannot shy away from. Still, I need to be abundantly clear about how it may influence my research project and my hopes for the outcome of this project.

### **Definition of Terms**

Within the Capstone, many keywords will appear. They are operationally defined below.

#### ***Burnout***

Burnout is defined as reduced feelings of personal accomplishment, emotional exhaustion, and depersonalization as the result of stressful work conditions, such as child

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protection, including long work hours, and an overwhelming case load (Kahill, 1988). Burnout has also been described as the exhaustion resulting from the continuity of providing care and listening to traumatic events (Cieslak et al., 2014). Baugerud et al. (2018) indicate that burnout and STS can coexist, given burnout's broader construct and being more about disengagement and emotional exhaustion. It's important to note also that many studies point to burnout, especially when combined with a high caseload and less time in the position, being related to high turnover in rural child welfare workers (Fulcher & Smith, 2010) and feelings of lack of personal safety (Kim, 2012; Leake et al., 2017).

### *Child Welfare Workers*

Child welfare workers are defined for this Capstone as those who work within a child welfare agency working directly with children, youth, and families to simultaneously analyze risk and safety and support work alongside the families and children with case plans as necessary to create long-lasting safety for the children as defined by the child welfare authorities. These workers can include and have many specific titles such as intake workers, generalists, investigators/assessors, case workers, foster care workers, kinship workers, permanency workers, and child intervention practitioners, and depending on the agency and location they may have very specific role duties, or, on the flip side, very generalized and multiple role functions.

### *Compassion Fatigue*

Figley (1995) popularized the term compassion fatigue to de-stigmatize the experience of those experiencing STS but suggested it was interchangeable with the term STS. Figley (2002) in a later study defined it a bit more specifically as the negative reactions experienced while undertaking inherently empathetic work—which entails child protection—by stating: “the very

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act of being compassionate and empathetic extracts a cost under most circumstances. In our effort to view the world from the perspective of the suffering we suffer” (p. 1434).

Rivera-Kloeppe and Mendenhall (2023) and Sinclair et al. (2017) suggest compassion fatigue is its own separate entity—that burnout and STS together result in compassion fatigue. Compassion fatigue is experienced as the avoidance of reminders or a feeling of numbness in responses to reminders, hypervigilance and hyperarousal that persists, and re-experiencing of the traumatic event (Rivera-Kloeppe & Mendenhall, 2023).

### *Compassion Satisfaction*

Compassion satisfaction is the positive feelings a worker will experience because of helping others, such as feeling good about one’s direct work, feeling good about their contribution to society, and feeling good about their work within their team and agency (Dehlin & Lundh, 2018). It’s important to note that compassion satisfaction can be experienced alongside compassion fatigue, and compassion satisfaction can be a protective factor against it (Ray et al., 2013).

### *Rural*

Since this Capstone is not only written in a Canadian context but focuses on specific Canadian rural workers, rural will be defined using Statistics Canada's (2021) definition for rural areas, which includes areas, municipalities, towns, hamlets, and villages, along with rural and remote area outside of census metropolitan areas (which have 100,000 plus people) and outside Census Agglomerations (10,000–99,999 people).

Statistics Canada (2021) notes that living conditions can vary greatly in rural areas, as can population densities, ranging from towns with 10,000 population or less not far from a city, to very isolated to agricultural developed lands to remote wilderness areas.

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With an appreciation for Canada as a vast country, and child welfare agencies and ministries delineating coverage areas of offices and works in different arrangements, it will be important to consider that this could vary significantly from one rural worker to the next. The conditions faced—both personal and professional—will vary as a result, which could impact one's own well-being as well.

### ***STS***

STS includes psychological and emotional symptoms such as numbing, hyperarousal, changes in cognition and mood, disengagement, hypervigilance, and behaviors such as disinterest and disengagement from home, work, personal relationships, and activities acquired as a result of indirect exposure to clients/persons suffering from trauma or who have experienced the direct trauma, or their own direct exposure to traumatic descriptions or traumatic responses of those who experienced the primary trauma (Bride, 2004; Figley, 1995). STS can also include re-experiencing of the indirect exposure to or knowing of the traumatic event or material, and increased avoidance symptoms with a rapid onset (Figley, 1995). Sleeping difficulties, difficulty with concentration, and psychological distress were also noted as common symptoms of STS (Bride et al., 2007; Caringi et al., 2017). Rienks (2020) further describes STS symptoms as intrusive thoughts, avoidant responses, and physiological arousal, and notes in her study that 27.3% of child welfare workers experienced moderate to high levels of STS, while nearly 30% experienced severe levels of STS. Other numbers of STS found in child welfare workers appear to be varying to a degree with reports of one-third of workers experiencing symptoms (Baugerud et al., 2018), 70% of workers reporting at least one symptom (Bride, 2007), and 50% reporting high or very high levels of STS (Conrad & Kelleher-Guenther, 2006). However the variation in numbers, those who work in child welfare, as opposed to other social workers, have been found

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to have higher levels of STS and more severe STS due to the traumatic nature of the jobs (Sprang et al., 2011). STS, in all, is defined as the emotions and behaviors resulting from the indirect trauma child welfare workers experience because of hearing and seeing traumatic things from children, youth, and families, such as neglect and emotional, physical, and sexual abuse disclosures (Molnar et al., 2020).

Many have recognized STS as an occupational hazard in child welfare (Kim et al., 2023; Lizano et al., 2021), and have articulated how STS impacts not only a workers' health and well-being but can impact their intention to stay on the job, and the quality of services they provide (King, 2022).

### *Supervision*

Supervision in child welfare can take on many forms and has many names: reflective supervision, clinical supervision, case supervision, and practice supervision. Beddoe et al. (2021) define supervision as a forum for learning and reflection, wherein there is an interactive dialogue between worker and supervisor, which can include case management processes such as targets and timescales, but also include critical reflection and emotional support. Wilkins (2023) defines effective supervision as not only an essential component to child and family social work but suggests the effective piece lies in the principles of collaboration, thinking aloud, emotional reflection, exploring multiple perspectives, planning for what, why, and how's of the casework practice, explicit risk, harm and strength analysis, and a focus on parent and child perspectives on helping and outcomes. For this capstone, supervision will be an all-encompassing term to include all forms of supervision with the premise that the supervision noted in the literature review and analysis will be effective in both critical reflection, emotional support, and supportive in case management functions.

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### *Vicarious Trauma*

Vicarious trauma is defined as the psychological and affective changes—such as avoidant responses, reduced motivation, reduced empathy, re-experiencing negative emotions, and experiencing depressed mood—that occur to those who have been exposed to secondhand trauma, such as hearing about it, witnessing pictures, and discussing traumatic material (Jimenez et al., 2021). Jimenez et al. (2021) indicate vicarious trauma differs from STS in that it develops more gradually in comparison to STS, but note that the changes associated with vicarious trauma are persistent and permanent as they alter a worker's worldview, self-perception, and areas of identity, in negative aspects. Vicarious trauma can have huge impacts on organizations and the clientele served via shortened careers, missed phone calls, missed appointments, or reduced services due to the worker's symptoms of vicarious trauma (Ireland & Huxley, 2018).

It is important to note for the purposes of this Capstone, vicarious trauma, burnout, compassion fatigue, and STS will be used interchangeably, with consideration that in child protection work, one does not exist in a vacuum but inter-relate to another and influence the other, such as a systems framework suggests. While the core of the terms is different, the overall impacts when considered are generally the same, meaning prevention methods and mitigating factors should be influential on all.

### **Outline of Capstone Research Chapters**

The chapters that follow in this Capstone project intend to give the reader not only clarity on the factors that mitigate STS in child welfare workers but will provide an overview of the current literature that exists within the academic world, and within current agencies/programming around prevention methods when it comes to trauma. The literature review, Chapter Two, will be divided into themes—individual factors, organizational factors, and

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rural factors— and further subthemes. The current literature to support evidence-based practice and considerations in the counseling field will be highlighted, and using the systems lens to understand these themes and the interplay between them, an analysis will be drawn including a discussion of said interaction. In the final chapter, Chapter Three, I will draw on gaps in the literature, highlight current Canadian child welfare agency programs regarding staff well-being, and harness my experience of initiatives already in place to mitigate STS. I will then translate these findings and analysis of the literature review into recommendations for policy, programs, and practice initiatives within child welfare systems along with recommendations for the role of counselors to support trauma-informed approaches, while integrating both systems theory and transformational leadership theory, to support rural child welfare practitioners' health and well-being while undertaking inherently traumatic work.

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### **Chapter Two: Literature Review**

Understanding the relevant literature, both within academia and what currently exists within the real world, which I will endeavor to do below, is important to consider both best practices when it comes to mitigating factors and preventing STS in child welfare workers and making the best and relevant recommendations to current interventions/initiatives. With a systems lens as a guiding framework for this Capstone, a singular factor that impacts methods of preventing STS cannot be viewed in a silo. Each of the factors reviewed below, individual, organizational, and rural, with the themes broken down into more specific subthemes, need to be considered with the others in mind, as each influences and exists in relation to the other, and the interaction between the levels of systems cannot be dismissed on having an impact on the functioning of the person, especially when you consider one's best efforts to prevent STS in a trauma filled work environment. These factors can also not be viewed in isolation when it comes to the counselor assessing and treating the child welfare worker; the factors need to be considered in relation to one another as a fluent ever-changing interaction.

Through a systems theory lens, the factors that prevent STS in rural child welfare works can be understood as interconnected levels of influence. The microsystem level, which I will reference as individual factors includes personal coping strategies and self-care practices, individual counseling, and personal relationships and support systems. Organizational factors I deem the mesosystem level of influence, being the supervisor-worker relationships, peer support networks, workplace culture and climate, and the clinical supervision practice a leader provides. I consider the rural context at the exosystem level, understanding the influence of community resources and limitations, professional isolation, dual relationships in small communities, and access to mental health services. The macrosystem level is where I will consider the influence of

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broader contexts such as current provincial and territorial policies, cultural attitudes toward mental health, professional standards and guidelines, and funding structures of the times for rural services. These systems interact in complex ways. For example, while a child welfare worker might identify counseling as a coping strategy to mitigate their stress and feel supported by their supervisor, they may not be able to access it locally and in person, which would be their preference, as they work alongside the only two therapists locally and the therapists have indicated that is an ethical boundary and dual relationship that does not allow them to take them on as a client. This situation is one of many that exist for child welfare workers and demonstrates the constant interaction between the systems that exist and how they influence one another. With the interactions in mind, and understanding that each level and factor do not exist in a vacuum, I will further explore the literature on factors in each of the system levels and how they mitigate STS.

### **Individual Factors**

When workers can engage in appropriate work-life balance, not only will they be more fulfilled, but they will report lower levels of stress (Pistorius, 2006). While this depends on many things outside of oneself, much of creating work-life balance is an individual endeavor to find what one's needs are and how to meet them where they are at personally and professionally. Much of the individual factors would be considered their microsystem, keeping the systems theory in mind.

### ***Personal Factors***

Many studies have focused on individual factors as it relates to developing STS. Osofsky (2011) found workers with more empathy are at higher risk for developing STS, while others have found this level of empathy can help workers engage in better coping strategies (Wagaman

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et al., 2015). Other studies have found that workers who have a high awareness of their own history and susceptibility to trauma create buffers to STS (Bride et al., 2024).

Another factor important to consider is the child welfare worker's individual time with the organization. Ireland and Huxley (2018) pointed out that newer staff are significantly more at risk of developing STS symptoms than those who have been employed longer. As rural staff get older, their job satisfaction and burnout decrease, pointing out the need for more training supervision and peer support for younger employees (Walters et al., 2019).

### *Self-Care and Coping Skills*

Many studies have supported the finding that a child welfare worker who has and employs coping strategies and self-care techniques can better fare with stress, and this can mitigate, buffer, and reduce STS (Bloomquist et al., 2015; Rienks, 2020; Salloum et al., 2018; Steinlin et al., 2017), and trauma-informed self-care can even increase compassion satisfaction (Salloum et al., 2018). Middleton and Potter's (2015) study also found that as the use of coping strategies increases, the levels of vicarious trauma for child welfare workers decrease, which in turn improves feelings of efficacy, and subsequently, retention improves due to this increase in job satisfaction. On the other hand, when a child welfare worker lacks the use of self-care skills and lacks work-life balance, their STS increases (Ireland & Huxley, 2018).

Specific studies and literature have focused on specific self-care and coping strategies as they relate to child welfare worker health and wellbeing. Genc and Buz (2020), in their study of Turkish child welfare workers, noted two types of coping styles: emotion-focused—which was effective in reducing stress and enhancing resiliency—and problem-focused, which was effective in buffering stress; while Lee et al. (2011) focused their study on negative and avoidant coping styles versus engaged and active coping styles. Those types of coping styles have significant

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differences in one's experience of vicarious trauma: with those with avoidant styles having higher levels of vicarious trauma, and those with more engaged, problem-focused styles having fewer symptoms (Ireland & Huxley, 2018).

Boyas et al. (2022) found those child welfare workers who exercised more and had better self-report health ratings had lower STS symptomology. Fuseini (2024) found that those who took time off work and engaged in recreational activities and recreation holidays were especially helpful with dealing with burnout. Humour has also been found as a way to reduce feelings of stress and anxiety (Julien-Chinn et al., 2023; Westbrook et al., 2006), as was having a specific transition between work and home to "shut off" from the job, or decompression ritual (Ireland & Huxley, 2018; Julien-Chinn et al., 2023).

Beer et al. (2020), in their qualitative study of employees in child advocacy centres in the United States, asked how the employees coped with stress and the answers focused on physical coping, interpersonal coping, and intrapersonal coping.

Julien-Chinn et al.'s (2023) study surveying coping skills also noted physical self-care, or physical coping, as a regular effective strategy used by child welfare workers. They also noted having a diverse network outside of work, connecting with friends, being mindful of vicarious trauma, and having their supervisor's support of their noted self-care plan.

Much of the literature makes a call for organizations to ensure that each employee has an intentional self-care plan to maintain their health and well-being to both prevent and respond to their own individually identified STS symptoms, and have active plans for staff to use their vacation and paid time off (Lizano et al., 2021). While as Rivera-Kloppel and Mendenhall (2023) note there have been certain agencies that have put self-care prevention strategies and

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interventions in place, there is little research to support how they impact STS and compassion fatigue.

### ***Social Supports***

Caringi et al. (2017) found in their study of STS and clinical social workers, that family and personal/social supports can have a buffering effect on STS. This was furthered by a study examining coping strategies, which found those child welfare workers who had social support were present with family and friends, and those who had a connection to a spiritual or religious community were seen as most positively coping (Julien-Chinn, 2023). Many other studies have supported these findings and noted that interpersonal relationships are a way for workers to reduce stress (Beer et al., 2020), and those positive outside-work relationships were seen as protective factors against STS (Brady et al., 2019; Steinlin et al., 2017). While a worker may have social support, they may seek an external and nonjudgmental resource to support them when facing stressful times. Counseling, as a mitigating factor to STS, will be discussed below.

### ***Counselling***

When child welfare workers attend personal counselling/therapy, results have shown they report lower STS (Skar et al., 2023). This safe therapeutic space—where workers can engage about their struggles, whether it is discussing the trauma they have witnessed or experienced, or how they are managing—has been noted to support workers with handling work-life balance, negativity, establishing better boundaries, and support workers with gaining more fulfillment (Fuseini, 2024). When organizations and agencies make this available to workers, this further will break down barriers, support a worker's well-being, and reduce stigma (Middleton & Potter, 2015; Pistorius, 2006). Organizations that offer employee assistance programs or in-house

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therapists, and easily accessible resources have been found to mitigate STS symptoms (Dilworth, 2021).

Regardless of which individual factors a child welfare worker possesses, when one changes or interacts differently with another factor, this will have an influence. This mesosystem—the interactions between several factors at that microlevel—will continually be fluid, resulting in either negative or positive impacts as well for said worker. While individual factors play a crucial role in STS prevention, their effectiveness is inherently linked to structures of organizational support. The following section will examine how organizational factors either constrain or enhance individual coping strategies in rural settings.

### **Organizational Factors and Organizational Culture**

Any sort of STS prevention effort must be both at an individual level and at an organizational level (Sprang et al., 2019). These organizational factors could be considered both an exosystem or the macrosystem depending on their direct influence on the worker when considering the systems theory applied at this level. They could also be seen in the mesosystem as well, directly influencing one's individual coping strategies and how they engage them in the larger community via organizational support or direct leadership. Culture, specifically organizational culture is one of those factors that influence a worker but can ebb between the levels. Caringi et al. (2017) describe an organization's culture as the traditions, norms, and values, and one that outlives the employees, meaning it is hard to change. The entire culture of a child welfare organization can not only influence worker morale but can also influence worker attitudes and work performance, which can affect the outcomes of the job (Middleton & Potter, 2015). This culture, along with the climate, organizational support, psychological safety,

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leadership, and other organizational factors, such as caseload and supervision, have been found to reduce and prevent STS (Janczewski & Mersky, 2023; Singh et al., 2020; Sprang et al., 2021).

### ***Organizational Climate***

Middleton and Potter (2015) describe a positive organizational climate as one with low conflict, cooperation between staff and leadership, and one that includes role clarity. This role clarity has been found to improve satisfaction and buffer stress when it comes to child welfare work (Antonpoulou et al., 2017).

Fuseini (2024), in their qualitative analysis, found that much of the discord and feelings of failure in the workplace were the result of being ignored by management, management making decisions without taking the worker's opinion, and overall negativity in the workplace.

On the other hand, Glisson et al.'s (2012) study found evidence that organizations that created climates where positive work attitudes existed had higher worker engagement and low rigidity. This higher morale of the staff was positively associated with involvement in decision-making, less rigidity in bureaucratic regulations, and more functional work environments, which supported staff to provide more personalized services to youth, children, and families (Glisson et al., 2012) That climate leads to a feeling of support by the workers directly on the front line and can have a significant impact on their mental health which will be further discussed below.

### ***Organizational Support***

Organizations with prominent levels of support for their staff have lower levels of STS and vicarious trauma (Braley, 2010), along with higher job satisfaction and less intention to leave (Caringi et al., 2017). This support can include supporting workers with work-life balance, offering and accommodating flexible schedules, supporting with childcare options, and even potential tuition reimbursement or housing options—which could especially be relevant to a rural

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worker (Lizano et al., 2021). Workers will feel empowered when the organization recognizes the worker's unique situation. While it is the worker's responsibility to individually take responsibility for themselves, that mutual responsibility will empower and allow the worker to utilize their skills to create that work-life balance (Lizano et al., 2021).

This organizational support can also mean creating inclusive environments, providing social gatherings for staff, celebrations for one another, and utilizing a variety of modalities to ensure the rural worker is included—such as making things virtual—or bringing celebrations to them (Lizano et al., 2021). Support can also be in the way of alleviating the stress of administrative duties to allow child welfare workers to spend more intentional time with families (Antonopoulou et al., 2017). It can also mean prioritizing the workers' whole self and self-care—mental and physical—supporting time off, promoting self-care practices, reducing the costs of memberships for health/wellness clubs, and ensuring the ability to engage in self-care routines (Fuseini, 2024).

At the same time, a lack of organizational support and leadership leads to more STS (Rienks, 2020). Rienks (2020) notes in the applicability of their quantitative research study exploring STS and coping strategies that leadership needs to normalize these conversations around well-being and organization support—in terms of prevention and intervention programs for staff—along with prioritizing personal responsibility for self-care.

In Dilworth's (2021) study of rural child welfare workers in the USA, they found that only 41% of workers noted they knew how to even get help and access resources to process their trauma. When they did know how to get help, felt supported, and got clarity from their organization on how to access resources, they noted significantly lower STS. Like the above, while it is the worker's responsibility to utilize their self-care, resources, and coping strategies,

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when an organization supports, promotes, and reduces barriers to it, the worker can feel empowered to utilize it.

### ***Organizational Justice***

Organizational justice within an agency, such as child welfare can take on many forms, including informational justice, and interpersonal justice—which is fair treatment of staff (Kim et al., 2023). Kim et al. (2023) concluded that organization justice can be an effective way to address STS, which they note to be an occupational stress. Engstrom (2019) found that when child welfare staff can build trust and support amongst themselves and peers, via this interpersonal justice, it can both increase worker well-being, but also reduce stress. Other literature supports the same findings: child welfare organizations that include and embed justice rules within their processes and structures actually can better recognize trauma and its impact and respond to the trauma experienced by its workers by ensuring due process and fairness in those same structures, processes, and relationships (Esaki, 2020; Miller et al., 2022; Strand, 2018). That justice experienced leads to what many refer to as psychological safety, which will be analyzed below.

### ***Psychological Safety***

Organizational factors and the health of an organization—its values, norms, perceptions, and attitudes—link directly to worker’s feelings, work attitudes, and experience of psychological safety. This perception of, or lack thereof, safety can directly impact a child welfare worker’s experience of their workday and impact their ability to do their job (Middleton & Potter, 2015). If an organization is psychologically safe, this means a worker can openly share if a mistake was made, without fear of reprimand, negative consequences, or stigmatization. If a worker can have this sense of security and psychological safety, child welfare workers are more engaged in the

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work they do, take more interpersonal risks in their work leading to creative interventions with families, and experience lower feelings of distress and emotional exhaustion (He et al., 2021; Vogus et al., 2016). Organizations that have been successful in creating a climate of safety encourage their staff to feel confident in making decisions. These workers do not experience shame or blame when decisions are being made, and see their own mistakes as learning opportunities, which inherently supports the development and growth of the workforce in such a learning environment (Lizano et al., 2021). Mistakes are a human experience and will happen when working with a human population, especially in that of child welfare; an organization must implement a system that inherently creates a culture of safety from within and between to support workers to grow from these mistakes, instead of feeling the added burden of fear, shame or blame, especially when it comes to such trauma filled work. When the organization understands the hazards of working with trauma and understands how one's social locations intersect with that experience of secondary trauma, by listening, being reflexive, and offering support, training, well-being opportunities, and resources, it can build that sense of cohesion and safety (Bride et al., 2024). That intentional space and protected time to listen and offer support should not only be a bigger system priority but should be the direct priority of the worker's direct leader and take place in clinical supervision. That pivotal activity will be discussed in the following section.

### ***Supervision***

Supervision has been found to have a significant effect on the impact of STS on workers, with studies finding that those having regular supervision have lower levels of reported emotional exhaustion and lower STS (Endsjø et al., 2024; Ireland & Huxley, 2018; Skar et al., 2023). Feeling supported by a supervisor was one of the main coping strategies noted as well in a

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survey completed during the COVID-19 pandemic that was enquiring about intention to leave and coping strategies (Julie-Chinn et al., 2023). While one study noted the amount of supervision had no direct impact on STS symptoms (Dilworth, 2021), another study has noted intentional supervision can provide role clarity for workers which can decrease STS symptoms (Strolin-Goltzman et al., 2024), build a worker's confidence (Malik et al., 2024), and be a protector against STS (Dombo & Blome, 2016). Supervisors also play the important task of understanding their staff and what puts them at a higher risk of developing STS, and that purposeful type of supervision needs its own intentional time, beyond case supervision and a level of trust involved (Skar et al., 2023). Supervision when done in a trauma-informed manner, can normalize the experience of workers experiencing STS symptoms, and a supportive supervisor can normalize the experience of reaching out for help, like counseling, and can support a staff with navigating this experience that may feel foreign and stigmatizing to them (Bride et al., 2024). Having a high ratio of supervisors to staff, and supervisors having intentional, quality, and scheduled supervision has been noted to be more effective when it comes to buffering stress (Antonopoulou et al., 2017).

When it comes to supervision, it is not a one-size-fits-all. Newer staff are more at risk of STS, so supervisors need to be mindful of each individual staff and their abilities. More energy, resources, intentionality, and time should be put into these inexperienced staff to ensure they are educated about trauma, STS, the supports in place, and coping strategies to ensure they are adequately supported (Ireland & Huxley, 2018). Another factor that needs to be considered is the lack of onsite supervision for rural workers, which can pose a problem (Aguiniga et al., 2013). If this intentional, quality supervision does not occur, or there is insufficient supervision occurring to talk about difficult files or traumas that have occurred or been heard, the organization must

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look at why this barrier is occurring, as supervision is imperative in supporting a worker in their day-to-day work.

Middleton and Potter (2015) call on organizations to only screen and hire supervisors who have demonstrated the ability to provide a safe environment. This could fly in the face of many hiring practices that currently exist. Organizations need to ensure supportive, safe, and regular supervision is occurring, as the literature notes regular supervision as the key to survival when it comes to child protection work (Lizano et al., 2021; Westbrook et al., 2006).

The National Child Trauma Stress Network (2016) put forward guidance for supervision administrators of child welfare staff in relation to STS, waging that without intention STS can negatively impact individuals and organizations, even extending to children and families. That same network—from the work of a collaborative group—released a document for supervisors to guide them in core competencies to use when undertaking trauma-informed supervision (Haskell et al., 2022). Not only did it lay out benchmarks, but it also gave explanations and specific strategies for supervisors to utilize in their practice. The competencies include knowledge of the signs, symptoms, and risk factors of STS, and the ability to describe/support/refer options to deal with STS symptoms for team members in a culturally relevant way both referring to internal supports and external (such as counseling, EAP, informal supports); help team members struggling with STS (such as by normalizing using supports; setting the example themselves); advocate for STS training, supports; call attention to policy/practice supports that may be contributing to STS (such as case loads, on call, work conditions, inadequate resources); and identify how one's individual social locations (age, identify, race, gender,) may impact STS. Another competency centres on supervisors' ability to monitor and self assess their own STS, by analyzing their own social locations; assess how STS is impacting their own functioning

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personally and professionally; addressing STS symptoms (taking breaks, mindfulness, allowing to feel feelings rather than avoidance, healthy boundaries and supports); seeking informal and formal supports; and modeling and engaging in self-care practices and encouraging promotion of these for team members, even in team meetings settings. This guidance also sets a competency that supervisors will have the ability and knowledge to support workers to share the emotional experience to enhance workers' emotions faced—by actively listening, normalizing the responses, identifying, and building on workers' strengths and resilience by providing support. Supervisors will also have the competency to support their team, as individuals and as a group, as it results to increase job and compassion satisfaction, engaging in noticing and acknowledging positive moments in their work and reinforcing benefits of activities during work and out of work hours—restorative activities (Haskell et al., 2022).

Organizations, if truly wanting to implement strategies to mitigate STS impacts on their staff, need to invest in their supervisors first as one of the core buffering, prevention, monitoring, and responsive tools. Those supervisors and the supervision they provide will have a significant influence on the worker's ability to manage their caseload, which will be discussed in the following section.

### *Caseload*

Caseload, which a supervisor needs to be aware of, appears to be one of the factors significantly contributing to worker turnover (Kim, 2012; Leake et al., 2017). Increased STS is also directly associated to frequency of exposure to trauma and a high caseload volume (Hensel et al., 2015). In Dilworth's (2021) study of rural workers in the United States, lower caseload was significantly associated with lower STS. Kim et al. (2023) also found that manageable workloads were linked with lower STS.

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Caseload numbers also have other impacts. Fuseini (2024) conducted a qualitative analysis using a grounded theory approach to gather the perspective of child welfare workers in Newfoundland and Labrador, some in a very rural and remote setting, and found that high caseload, and tight time pressures often led to feelings of negativity, failure, and stress.

Supervisors and organizations need to be mindful of what their workers have on their plates and advocate/put into action ways to monitor, manage, and reduce caseloads. Pistorius (2006) found that those having what they defined as a mixed caseload—those with high demands mixed with those with less demands and trauma—to be supportive of workers' wellbeing. This, in turn, means the organization needs to focus on staffing appropriately to keep caseloads at a manageable level (Dilworth, 2021).

### *Peer/Colleague Support*

Much of the research suggests that having coworker support can also be a buffer to STS and improve job satisfaction and worker retention (Caringi et al., 2017; Dombo & Blome, 2016; Lizano et al., 2021). Kim et al. (2023) found that having a peer within the workplace created an avenue for people to connect with another who has experienced trauma themselves, thereby creating a safe space and relationship. This creates mutual coping, without the power dynamic of a leader/supervisor, and is connected to lowering STS. This also provides a dedicated support system for child welfare workers to discuss traumas, and process what they have just experienced or heard without the fear of breaching confidentiality, given the complex nature of their work, which alleviates a load in and of itself (Bride et al., 2024; Choi, 2011). Caringi et al. (2017) found that 84% of the workers surveyed in their study engaged in peer support, and it helped to increase feelings of safety and collegiality, with the use of humor and a place to vent unapologetically, especially in the context of workers in a rural community, where many do not

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understand the nuances of rural work. That peer support, specifically the emotional support of it—to be able to be validated, reassured, and have their experiences normalized—was found to be most encouraging in the study completed by Fuseini (2024). Along with that, peers can also offer practical support—such as helping with paperwork, assisting with going to a home with a volatile client, or helping make phone calls if a worker is feeling overwhelmed (Fuseini, 2024). Middle and Potter (2015) also found that peer mentoring, when framed as intentional debriefing rather than venting, can support child welfare staff in making meaning of the experiences they have had healthily. That peer can also function as an internal work support for workers to monitor symptoms of STS, and to notice, and respond when the child welfare worker themselves is not noticing STS symptoms. To have that peer support, unconditionally without fear of reprimand from a level above in the organization, is vital to buffer the ongoing traumas child welfare workers will inherently face. Regardless of peer and supervisor support, a worker must feel competent to build confidence and satisfaction within their job. In the following section, training for child welfare workers will be discussed as a mitigating factor.

### *Training for Staff*

A plethora of the literature has called for training on STS to be introduced to all staff early—such as at the onboarding of new staff—and regularly thereafter in workshops and trainings (Caringi et al., 2017 Julien-Chinn et al., 2023; Strolin-Goltzman et al., 2024). Braley (2010) found organizations that provided higher levels of training lowered workers levels of STS. Not only does this provide increased ability for staff to learn about trauma, its impacts, STS, and recognizing and identifying symptomology, but by introducing regular language about this, it can reduce stigma and normalize this experience (McElvaney & Tatlow-Golden, 2016). Training, to reduce STS, needs to focus on self-awareness of symptoms, self-awareness of one's

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own trauma experiences, one's responses, and emotional regulation both before, during, and after a traumatic experience (Bride et al., 2024; Wagaman et al., 2015). Caringi et al. (2017) even included a recommendation from their study about including education about STS in the postsecondary schooling most often recruited by child welfare agencies, so those potential employees are primed to understand trauma and its potential impacts. Younger and newer workers with less job experience are at a higher risk for STS, so training is integral to their success (Caringi et al., 2017).

Just as Middleton (2011) pointed out the correlation between coping strategies and decreased STS, they point to the need for education from the larger organization and training for staff on coping strategies and how to use them in their day, but also outside their day.

Training needs to take on other focuses as well. Staff, especially rural staff, are often isolated from others and need training, both initially, but also regularly, on how to access resources and support (Lizano et al., 2021). It's also important to note that as mastery of skills goes up, confidence in the role and job satisfaction also increases, and mastery of skills has a buffering impact on STS; if workers can be further trained, in an ongoing fashion, this will further mitigate STS (Caringi et al., 2017).

All this training suggested, both aimed at staff and leaders, needs to be offered in an accessible way—such as virtual training—especially for rural workers. By offering regular, and consistent accessible training on STS and self-care, workers have noted an improvement in their resilience and self-care strategies (Malik et al., 2024). That training needs to be ensured by leadership, and leadership, beyond ensuring appropriate training is available, will be discussed thereafter.

### ***Leadership***

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Leadership and leadership styles can have a direct impact on STS and staffing. Park and Pierce (2020) discovered that STS was related to high turnover, but when there was transformational leadership—a trauma-informed proactive leader in creating strategies to meet the needs of their staff—turnover was reduced.

Further, leaders and organizations that support shared decision-making have been advocated for by many studies (Fuseini, 2024; Malik et al., 2024). When leaders push for and encourage this shared decision making it can have profound impacts on the morale of staff (Malik et al., 2024).

Transformational leadership has also been linked to lower STS, meaning if a leader is able to lead effectively through change within a child welfare organization (which in child welfare is inevitable and often), it can bring about said change—such as a new program or initiative—with trust and stability and mitigate change fatigue (Strolin-Goltzman et al., 2024). Endsjø et al. (2024) found in their study of Norwegian child advocacy center workers that practitioners who had more transformational leadership rather than a laissez-faire style leader experienced less burnout, and those who had that including personal supervision (as opposed to case supervision) had higher levels of compassion satisfaction.

This type of leadership also models what it is asking staff to do by modeling awareness of wellness, leading by example, being active in a trauma responsive manner, being compassionate to their staff, and promoting staff wellness (Bride et al., 2024). Not only does leadership drive practice, but policy sets the stage for practice initiatives. In the following section, the rules that child welfare workers must follow will be explored as it relates to STS.

### *Policy*

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With the organization having a huge influence on the ability of child welfare workers to be able to engage in and feel empowered to utilize what is already in place—both within and also outside the organization—child welfare organizations must create and implement policies and practices that support the time and space for staff to engage in their self-care practices (Julien-Chinn et al., 2023). Research on STS has shown that when STS is viewed by an organization as an occupational hazard, policies can be informed and created to support staff and leaders within the organization to detect, prevent, and reduce symptoms (Ireland & Huxley, 2018; Middleton & Poter, 2015). Having the organization recognize and acknowledge STS, can be powerful for staff, along with the implementation of trauma-informed practices into the breadth of the culture of an organization (Boyas et al., 2022). This flips the script for workers from the organization viewing STS symptoms as a personal deficit, to a normal experience of trauma happening to the worker. Studies have noted a few policies worth considering: monthly health checkups, mandatory mental health workshops, routinely surveying staff about their safety, and planned policies following critical incidents to best support staff's emotional well-being (National Child Traumatic Stress Network, 2016).

By having trauma-informed policies and education in place that promote the health and well-being of its staff, this intentionality can mitigate STS. When collaborative training on coping skills, managing difficult emotions, and supervisory training such as reflective supervision, and mindfulness are offered, the workforce sees these trainings become policy which then becomes a part of the bigger organization's culture and values. Employees will feel their organization values a healthy workplace by promoting self-care practices, health, and well-being (Boyas et al., 2022).

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Molnar et al. (2020) point out that an organization as a whole needs to be trauma-informed to address the impacts of trauma via its policies and programs and evaluate what is already in place regarding protective and risk factors for STS. A recommendation by Sprang et al. (2014), before an organization is even considering implementing policy/programs, is to utilize the Secondary Traumatic Stress Organization Assessment tool, so the organization can identify how well they attend to and respond to STS.

As it relates to organizational factors one is not without the other: when a worker had supervisor support, peer support, and organizational support via culture and policies, that created organizational satisfaction, which was found to be a protective factor from STS (Baugerud et al., 2018).

While the organization is a provincial or territorial body within this country, the organization needs to acknowledge those who work in certain contexts within its jurisdiction and the differences that influence how one conducts their work and manages their stress. In the following section, I will explore rural factors, the outer systems of a child welfare workers' world, and how they relate to STS and one's ability to prevent and manage the development of vicarious trauma.

### **Rural Factors**

While individual and organizational factors are of utmost importance for child welfare workers, the uniqueness of this Capstone focuses on the geographical locale of its workers: rural Canada. This rural setting—its specific values, attitudes, norms, and nuances—influences at the exosystem level, macrosystem level, and chronosystem level as well, given the specific socioeconomic and isolated nuances that interact dynamically with all levels of a person's life. With that in mind, it would be remiss to dismiss a finding about this level of influence: rural

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workers have a higher risk for burnout (Sprang et al., 2007). Many of the studies reviewed discussed a large limitation in the gap in research focused on specific rural workers and called for further research in this area making this Capstone all the more important (Federico, 2017; Malik et al., 2024; Walters et al., 2019). Rural can mean many things in Canada, so with that in mind, the following will delve into the contextual factors that encompass that setting and how those impact workers as it relates to STS.

### *Rural Settings*

Sprang et al.'s (2011) comparative analysis of occupational distress across professional groups identifies STS as an occupational hazard and points out that working in rural settings, specifically the most isolated of rural settings, can increase one's chances of having STS and compassion fatigue. While "rural" is not specifically defined in their study, they do call on the child welfare system to consider rural child welfare workers' unique perspectives and call for the development of a trauma-informed welfare system to prevent STS (Sprang et al., 2011).

Aguiniga et al. (2013) sought to understand rural child welfare staff better in their study by comparing their intention to leave with geographical location while analyzing how it integrated with both personal and organizational factors. They defined rural and small towns in a way that can be generalized to Canada, despite their study being American, and what they found were extra barriers faced by rural child welfare staff: supervisors housed off-site, limited opportunities for promotion, lack of privacy, lack of resources and support services, lack of confidentiality due to working in rural areas, and added stress due to the inevitable dual relationships that child welfare staff face (Aguiniga et al., 2013; Federico, 2017; Malik et al., 2024).

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Kossek and Lee (2017) found comparable results: child welfare workers in rural settings experience increased conflict while trying to navigate their work and personal life, as work will often interfere with their private life responsibilities. Whether that's being "on call," struggling to "shut off," or having to leave a function because they notice a client and are trying to avoid conflict that may arise, inevitably the client's right to confidentiality needs to come first, and one's personal life will suffer as a result. This interplay between a rural child welfare worker attempting to engage in community as just that—a community member and person first—and attempting to put up appropriate boundaries, can always potentially be derailed by the lack of anonymity in a small community.

Federico (2017) calls this the "client scanning" that rural workers partake in (p. 92). Rural child welfare workers live in the same, small community their clients live in. This means they frequent the same doctor, the same grocery store, and their children may even be in the same school, classroom, or sports team. They may go to sweats together, or church together, and this invisible stress of having to maintain confidentiality while out in public "off-duty" is a heavy burden to carry, and one that a rural child welfare worker is so rarely able to take off. Whether that be picking up their child from a program or going out for supper with a partner or friend, they are perpetually scanning and mentally mediating situations that may arise. Not only is this for client confidentiality to be maintained, but this is also for a worker's own personal safety. By continually facing the added burden of exposure to clients or reliving traumatic events by seeing or interacting with said clients, or their families (which could be reminders), rural workers face continual exposure to trauma even after they are "off the clock" (Federico, 2017).

Ezell (2019) points out that rural workers face a low resource environment and threats to self-care, given the demand for community needs and the need for organizations to infuse

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leadership mechanisms to identify and screen for STS and burnout, develop and make routine self-care opportunities, and establish more appropriate case expectations when it comes to rural staff.

The rural setting itself and collaboration can also pose a significant barrier for child welfare workers in this geographical locale. Given the small number of resources, rural workers often must travel farther to do their work, work in areas with little to no cell reception at times, and cover the general duties of many given the lack of staff, meaning a heavier burden of generalist type work and the added juggling on to their shoulders (Walters et al., 2019). This geographical location can also pose a barrier for workers trying to access resources for themselves. Whether that be physical health support, such as a doctor, recreational activities, or mental health support, there is a likelihood that it will not exist, or will be limited, in their rural location, and the worker will have to travel farther for said resource, or not have access at all. It may also mean having to access things, like counseling, virtually; however, that is not always negative, especially in consideration of multiple relationships. Regardless, the pressure and burden of mental health supports and resources that may complement their individualized coping strategies have the potential to compound a worker's already stressed situation.

Not all the research on rural settings and child welfare are negatively associated with STS, however. While Walters et al. (2019) point to the many barriers that rural social workers can face, they note there can be many strengths if the rural worker understands the context of rural living: the highly connected community and strong ties. Carinci et al. (2017) noted in their study on child welfare workers in Montana that many rural workers noted the geographical location itself as good for their self-care and stress relief and having a plethora of outdoor activities and access to nature as contributing to their mental health and wellbeing.

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Aguiniga et al. (2013) also pointed out an interesting finding in their study: rural workers are often older and have more experience than their urban counterparts. While turnover is higher in rural areas, as supported by Fulcher and Smith (2010), a conclusion can be made from this: if rural workers are supported to stay, they will stay. Given their limited job opportunities, this should be more incentive for organizations to put in efforts to mitigate STS and increase job satisfaction, thereby increasing retention.

### *Interprofessional Collaboration*

While rural child welfare workers may not have many in their office, there are many other professionals in the community. Interprofessional collaboration, especially between child welfare and mental health agencies in rural settings can have a huge impact on STS (Strolin-Goltzman et al., 2024) Strolin-Goltzman et al. (2024), using an ecological model, discussed how partnership in rural communities can lead to less stress, and one feeling mastery in their field, leading to feelings of job satisfaction and competency.

In that same study, Strolin-Goltzman et al. (2024) in comparing mental health professionals to child welfare workers found that the child welfare workers actually did not benefit from the interagency collaboration, but when they dug further into the reasons why, noted that the child welfare workers noted a lack of time for this type of networking and teamwork, as they work on an emergency basis. This study noted that child welfare workers, like mental health professionals, could have reduced STS symptoms if they had the same opportunities to engage in the interprofessional network.

When organizations encourage this collaboration, support the ability of workers to make intentional time for this interagency partnership, and increase more effective communication

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between community organizations and agencies with their own, this in turn can reduce their own staff's undue added stress (McElvaney & Tatlow-Golden, 2016).

Returning to the factor of counseling, but with consideration from the lens of the counselor, it is imperative that a worker be supported to access these supports. While that can be supported, it is important to consider the half of this relationship for the approach to be successful: that of the role of the counselor and the contexts they must navigate to work with the child welfare worker. In the following section, I will explore just that: empirically supported interventions and approaches shown to support child welfare workers, and further explore the considerations for offering and working alongside those child welfare workers in rural settings.

### **Therapeutic and Counselling Considerations**

Many of the studies pointed out that therapy, when accessed, can mitigate, and reduce STS symptoms (Dilworth, 2021; Fuseini, 2024; Skar et al., 2023). Whether it be via organizational contract to a group setting, or an individual child welfare worker seeking support on their own, the therapist also plays a role in mitigating, preventing, and managing STS in child welfare workers. Understanding the literature, both specifically as it relates to evidence-based practices that have been shown to work, and understanding the other factors that interplay and interact within the systemic layers that make up an individual child welfare worker can support this role of counselor as they hold a place within those interactions. Therapists, notwithstanding the evidence-based interventions, need to take into account an individual's type of trauma, their own characteristics, and their particular backgrounds, service settings, and work experience to be successful (Nuttman-Shwartz, 2015).

Much of the research around interventions for STS has focused on the prevalence and etiology of STS, rather than effective trauma-informed interventions (Bercier & Maynard, 2015).

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Despite the evidence pulled from a literature review by Bercier and Maynard (2015), there are some notable findings that I have found on my own. Kim et al.'s (2023) systemic review of literature on effective therapeutic interventions for practitioners experiencing vicarious trauma found mindfulness and psycho-education-based interventions, and other nontherapeutic interventions such as acupuncture and recreational groups to be effective. Kim et al. also pointed out something that much of the literature points to: much of the existing interventions focus on self-care and stress management, rather than a tailored individual approach to addressing specific and individual symptoms, which can show up differently for individuals.

While limited, research into specific counseling methods to mitigate STS has provided some positive findings. Psychoeducation on reducing risks of STS and strengthening protective factors has been demonstrated to be successful (Sprang et al., 2019), as has motivational interviewing and cognitive therapy (Sprang et al., 2011). A traumatic episode eye movement and desensitization and reprocessing (EMDR) has also been explored as an approach to prevent vicarious trauma. Tsouvelas et al. (2019) focused on this piloted protocol—The Group Traumatic Episode Protocol—with a group of professionals who work in a mental health unit treating children and adolescents who are survivors of abuse and neglect. The EMDR group protocol provided two sessions, and the stressful event, for the groups, was not the same event for other group members. The results confirm that EMDR group protocol was effective: there was a significant reduction in avoidance, intrusion, and hyperarousal symptoms, and a significant reduction in the Subjective Units of Distress (SUD's) in relation to the stressful/traumatizing event. They also found the negative workplace affect was reduced, meaning that not just the traumatizing event was processed, but so were the workplace contextual factors. It is important to note however, that this study included only a small number of participants and its participants

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worked with children and youth who were abused but were not direct child welfare workers; meaning they could also have protective layers not experienced as such by child welfare workers.

While also not rural Canadian child welfare workers specifically, there are other studies and literature that offer guidance for counselors and mental health practitioners supporting those who work in child welfare or similar stressful fields. Haughtigan et al. (2024) found in their study that applying a mindfulness initiative to child welfare workers in Kentucky during COVID-19 was successful in reducing stress with the following recommendations: specific individualized timing and the need for convenience and flexibility within the timing of mindfulness sessions within their daily routines due to time constraints and their job demands. Their study noted many challenges, such as limited recruitment, and noted the large gap in research on effective interventions for child welfare workers. Another study, utilizing social workers with high levels of stress, by Brinkborg et al. (2011) found a brief stress management intervention based on acceptance and commitment therapy (ACT) principles had burnout and stress levels significantly decrease, but noted it was difficult in their study to determine which were the most impactful and active parts of their intervention, calling for more research. While this study focused on social workers in Sweden, and not specifically child welfare workers, the negative consequences of chronic stress due to their jobs would be comparable to that of Canadian child welfare workers.

While also not specifically Canadian child protection workers, Anger et al. (2024), in their systemic review of evidence-based interventions for healthcare workers who face similar levels of trauma and stress, showing mental health decline, found that therapeutic interventions that included mindfulness and coping skills development, via formal approaches, such as

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cognitive behavioral therapy (CBT) and ACT, to be linked to reducing STS. They also found that relaxation and reflection interventions, combined with mindfulness and coping skills training influenced burnout and emotional exhaustion.

Regardless of what evidence-based framework the counselor will pull from when working with the child welfare worker, the relationship and work must be done in a way that demonstrates cultural humility and creates a space of cultural safety (Arthur, 2018). While the child welfare worker may be of similar cultural background to the therapist, and/or the rural community members they serve, it is essential the therapist takes a not-knowing stance and remains curious about the child welfare worker's cultural identity and meaning for them. This also means the therapist needs to have a clear understanding of their own social locations and how those may be influencing their worldview and interpretations of the presenting client and their concerns (Mosher et al., 2017). This, in all, will work to strengthen the therapeutic alliance, regardless of the modality used.

Therapeutic alliance aside, just as child welfare workers must negotiate the dual relationships they are likely to face when working rural with families and children, a parallel scenario can potentially exist for the counselor and the child welfare worker. As Zur (2006) notes, given the remoteness, isolation, and characteristics of rural communities, rural practices of therapy cannot abide by guidelines that set out traditional approaches of firm boundaries and the avoidance of dual relationships is unrealistic. Zur also points out that joining clients, such as child welfare workers, in celebrations and rituals, is within the norm in certain cultures in rural communities. Chance encounters are likely to occur in rural settings, if a therapy is working in person and in the community, and accidental self-disclosure is likely.

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According to Nigro (2004) dual relationships are the second most reported ethical dilemma for therapists. The *Canadian Code of Ethics for Psychologists* discusses dual roles and relationships as a broad concept, also known as multiple relationships, as one where a psychologist may have the client in a different role outside of their relationships with them as a psychologist (Canadian Psychological Association [CPA], 2017). This is to mean while a therapist may counsel them, they may also have interactions with them in other areas of life—social, personal, business, and/or education. This will hold true for a therapist working with child welfare workers in a rural setting. It will be imperative the therapist, in this situation, manages these ethical situations with their ethical codes as a guide and a supervisor for a support (CPA, 2017; College of Alberta Psychologists, 2019).

### **Mapping the Interactions**

The systems framework, and its holistic nature, emphasize the need to understand all aspects of one's environment to grasp the interrelated factors that can influence their makeup (Bronfenbrenner, 1979). Mapping the interactions between these factors can create greater insight into the dynamic relationships between the levels and their connection to the individual's overall health, development, and well-being. This understanding of the interactions supports the role of the therapist in the entire ecosystem of a child welfare worker and supports the organization to understand and create prevention programs in consideration of STS and its staff.

In regards to a child welfare worker, a change in their home community, such as access to a resource in their small town, or economic changes that occur in society and within their lifetime (chronosystem), can influence either resources for their clients or resources for themselves that are available in their community (the exosystem), which then can play a role in the dynamics within how they are coping or attempting to access self-care. As was noted in a

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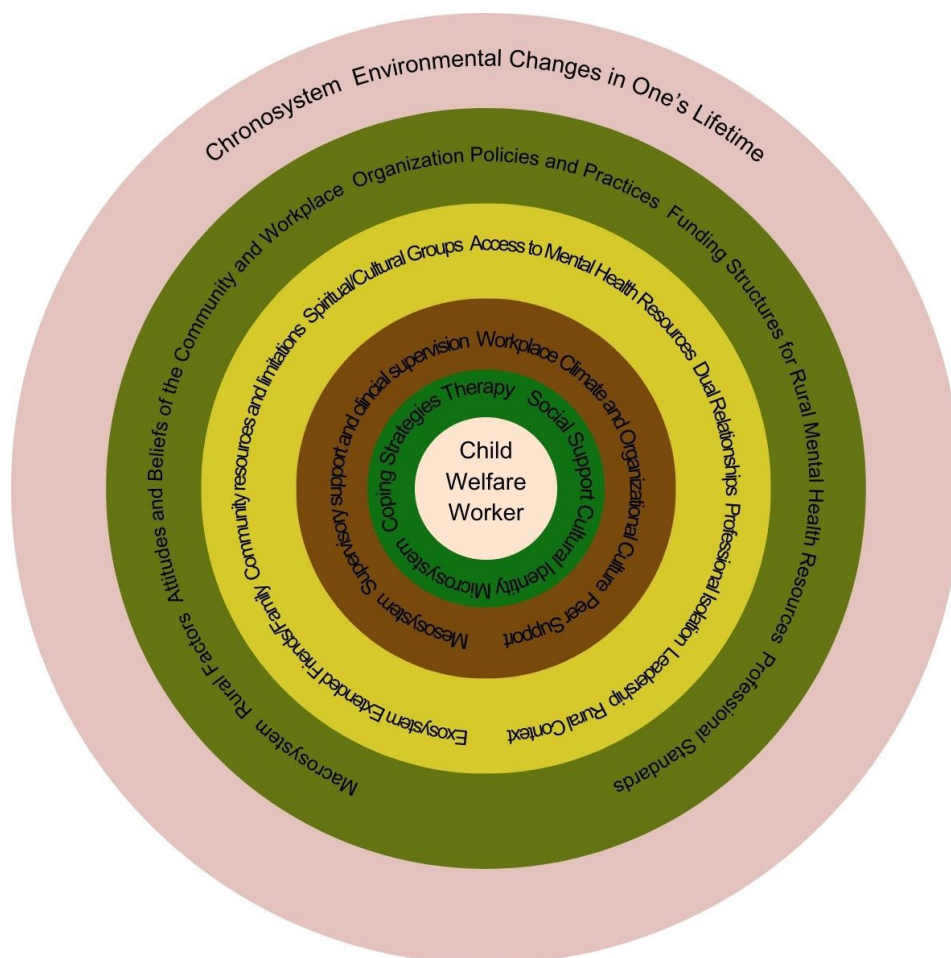
previous example, a simple idea such as caseload—which exists in one’s outer systems—can have a massive influence on how one accesses self-care or social support. The organizational training offered and its accessibility can also interact with one’s ability to increase their knowledge and competence, which can then lead to decreased job satisfaction and confidence and increased stress. This added stress can then interact up within levels, interacting with one’s relationships with colleagues, friends, family, and cultural groups, and have an impact in the workplace as well, or their ability to do their job. None of the factors that a child welfare worker interacts with or is influenced by can be considered in isolation, as the interactions between them play an important role in creating supportive interventions to mitigate burnout within inherently traumatic work. It is also important to acknowledge that the interactions and relationships between the systems will ebb and flow throughout a child welfare worker’s career, influenced by factors both within their control and many outside of their control within their lifetime.

A developed graphic, in Figure 1, integrating the systems theory and the factors that mitigate and influence STS is displayed below. This framework not only supports a holistic understanding of developing child welfare agency policy in supporting their staff to mitigate STS, but it also supports the counselor in understanding the personal, environmental, societal, and cultural factors when treating those with STS.

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**Figure 1**

*Systems Theory and the Factors Influencing the Child Welfare Worker as it Relates to STS*



### Gaps and Critiques of the Literature

While the literature search produced a reasonable number of studies of various types around STS, vicarious trauma, and burnout, little research was found as it relates to the specific population of this Capstone: rural Canadian child welfare workers. This also relates to finding little research as it relates to effective therapeutic interventions and counseling in this particular

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population group, especially that of rural workers in Canada, hence calling for more research in this area (Federico, 2017; Malik et al., 2024; Walters et al., 2019).

Despite that, there were important findings that could be pulled from the relevant research to be applied to this Capstone. The significant role that coping strategies, peer and social support, quality supervision, organizational culture, and transformational leadership play to create a safe and supportive work environment cannot be overlooked. The rural factors that can both be harnessed to relieve stress and understood as creating more complicated nuances impacting a worker to be able to “shut off” were discovered, and the role of the therapist to use evidence-based practices with an understanding of the layers of systems impacting a child welfare worker were made evident. What was also made evident were the gaps in said research. Looking at both quantitative and qualitative studies, one of the biggest gaps identified is that of self-report. Much of the reporting on STS comes from interviews or questionnaires, and it would be remiss to note that self-reporting can be influenced by many factors. Job satisfaction, for one, can have a direct impact on how one answers the survey, as can anonymity and fear of reprimand. These both could either influence the worker to either report less (in the case of reprimand) STS symptoms, or higher (in the case of job satisfaction), which may not reflect the accurate STS symptoms of said worker. How one “tests” and reports STS levels comes with this risk.

The other critique is that of the generalizability of the studies. While the scope of the research included both prevention factors along with evidence-based counseling practices that support, and had to include populations outside of the population for this specific Capstone, the results can be broadly applicable in many senses. What one should consider however is the range of what those recommended practices look like in each given site, supervisory-worker

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relationship, or even locale within rural Canada. What one rural office might boast, or the worker may have access to in their community to support them in coping, the next rural worker might experience something completely different. Quality supervision, for example, can have a different meaning for each worker depending on their needs, and the recommendations and outcomes found in the literature review need to be tailored to the individual needs of the child welfare worker. In all, it is not a one-size-fits-all.

With the individual, organizational, and geographical factors considered, along with the counseling methods to support a worker facing STS, informed analysis and discussion resulting from the findings can emerge. This literature review reveals three key patterns in STS prevention for rural child welfare workers. First, individual factors such as coping strategies, self-care practices, individual counseling, and personal family and friend support networks play a pivotal role in mitigating STS. Second, effective prevention of STS requires effective organizational support to allow workers to access their individual coping strategies in an individualized, culturally responsive way; this also includes intentional clinical supervision for the workers to feel supported in their work with consideration for their locations. Third, rural-specific challenges such as dual relationships, lack of mental health resources, and challenges in confidentiality and anonymity exist not only for the rural child welfare worker in order to navigate their inherently stressful work, but can influence the counselor's ability to provide counseling for the child welfare worker in the same rural context.

Within the next chapter, I will discuss the findings further, with consideration for each individual worker as their own entity requiring their own individualized approach and propose my own recommendations for child welfare organizations and for the role of therapist propelled

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from this analysis, harnessing my own experience as a child welfare worker and supervisor, and up and coming therapist.

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### **Chapter Three: Discussion and Application**

The literature review in the previous chapter provided a succinct and thorough understanding of the factors that prevent STS, while considering the workers navigating their worlds via a system theory framework, along with an appreciation for leadership and the role of therapists in preventing vicarious trauma in child welfare workers. To further that analysis, I will discuss the findings, pointing to limitations in the research, highlighting appreciation of what was discovered, and linking to structural powers that maintain the existing gaps. I will then highlight current applications and interventions before presenting my recommendations for applications for both the field of counseling, but also child welfare leadership and organizations. I will conclude this chapter and the Capstone with my reflections and a final overview.

#### **Discussion**

While the literature review brought light to many established mitigation factors as they relate to STS—from individual to organizational—there was little literature focused on the specific rural Canadian child welfare worker. That worker, especially when considering the systems and trauma theory and the myriads of layers that can influence and interact to impact one's functioning, can have vastly different experiences than the next rural worker, especially given the large geographic architecture of this country. What is also lacking within the overall literature review is a consideration of culture. While an individual child welfare worker's culture will influence their worldview and how they walk within the world, the culture within the community they work in will also influence the systems at play, as well as when working within an inherently oppressive system such as child welfare, or working within a rural community where one is a minority. These complex nuances of power, hierarchal dynamics, and systems can further impact one's job, and the stress they experience, as well as the support they receive.

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In consideration of that, it brings upon further discussion: the rural experience. While many experiences and barriers will be faced to similar degrees in all Canadian rural areas, there are rural areas far more desolate than others, and that individual's experience of their rural location and the work they experience should not be minimized. While this Capstone aims to make suggestions to child welfare agencies and counselors in supporting child welfare workers as it relates to mitigating STS, the person, as an individual within their interacting systems, can not be depersonalized and must be understood from their locations and perspectives.

While the individual experience and rural and cultural experience need further consideration, what was highlighted is the role of the leader in mitigating STS in their staff. With an understanding of the power of a leader—whether that be a direct supervisor, or senior leadership manager—a leader can not only influence decisions at a higher level to impact policy and practice initiatives, a leader can model the behavior they want to see in their staff when considering vicarious trauma, and can influence the culture of a workplace. When considering how small some workplaces will be in rural Canada, a leader has the potential to build an authentic relationship with their child welfare staff and start to have an appreciation for both their coping strategies, but also factors that may put them at higher risk of STS, and can work alongside them to support them accordingly.

With that said, some barriers exist systemically within organizations that warrant discussion. Political factors can influence decisions around policy and resource allotment—including training dollars and resources for mental health supports, along with hiring and retention—which can therefore influence caseload and office culture. Resource constraints, bureaucracy, and red tape often also take precedence over change and change that involves resources, dollars, and commitment. These constraints can show up for child welfare workers in

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many ways—limited counseling sessions, maximums on benefit premium for specific supports, and lack of access internally to specific supports or training. This can be a persistent and overwhelming systemic barricade and one that takes persistence and advocacy on many levels, especially that of leaders. Resistance to change and stigma are also factors that can exist that can prevent any sort of change, especially when discussing mental health. The stigma in accessing mental health support, or even talking about one's mental health, is something that needs to be addressed and is the prime opportunity where transformational leadership can intervene and model the behaviours and attitudes they want to see within their staff. With that said, even with sound leadership, the staff themselves may fear being labeled or judged, and that stigma can prevent them from utilizing available support. Another real-world barrier discussed in the literature review is that of time constraints and workload pressures that exist in virtually every rural child welfare worker's world. The long hours and high caseloads often lead to staff having little time to access mental health supports, have proper supervision, or debrief with others, and those can even be seen as an extra burden rather than an individual priority. While these are all worthwhile discussion points, this should not inhibit proposing initiatives, practices, and applications to support child welfare workers with the aim of vicarious trauma prevention, which I will do in the following sections.

### **Applied Practices**

#### ***Current Initiatives and Applications***

Before suggesting any specific intervention or programming, it is important to understand the applications related to STS that currently exist within rural Canada for child welfare workers. With that said, public-facing domains that detail Canadian child welfare agencies and their current programs/initiatives to support staff undergoing the inherently traumatic work they have

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experienced have resulted in limited outcomes. It is important to consider there could be more resources and focused prevention strategies to STS offered on internal forums, as I myself am aware of, however for the purposes of this Capstone, only what was made available was able to be presented. One must also appreciate that child welfare is a provincial mandate in Canada, not a federal one, so how the agencies are organized may vary between province and territory—with some delegating authorities to individual agencies, and even First Nations and Indigenous Governing Bodies, while others take a provincial ministry approach.

In Ontario, the Ontario Association of Children's Aid Societies (OACAS) provides their staff with training on trauma to understand the stress and emotional strain of working alongside abuse and neglect as families and children face it. The training focuses especially on understanding secondary trauma, compassion fatigue, and vicarious trauma, along with building self-care skills and emotional resiliency. The OACAS also notes that some individual agencies offer wellness initiatives—such as stress management training, mindfulness workshops, and yoga. Most of the agencies within Ontario offer EAPS—employee assistance programs—where staff can access counseling and mental health support. OACAS (n.d.) also indicates peer support and regular clinical supervision are encouraged across agencies, and there is a vast resource library offered to staff that includes things like trauma-informed supervision and the STS supervisor core competencies that were mentioned previously.

The Children's Aid Society of Toronto (CAST), which is a specific child welfare agency in Ontario, has a specific workplace mental health initiative, which supplies its staff with regular mental health check-ins, workshops on stress reduction and emotional resilience, and counseling supports. CAST (2024) also notes its support of reflective supervision for staff to process their cases.

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British Columbia (BC), which runs its child welfare under a provincial ministry—the Ministry of Children and Family Development (MCFD), also has an EAP available to all its staff if they need to access counseling, psychological services, and wellness programs. They also offer peer support networks, but it is important to note that these are only offered in some regions. The MCFD in BC also offers critical incident stress management (CISM) which supports staff to cope with traumatic or critical incidents they face on the job. The Government of BC also offers training on trauma-informed practice, with specific training related to worker wellness and safety, along with vicarious trauma (British Columbia Ministry of Health, 2024).

Alberta Children and Family Services (CFS) offer similar supports to BC: both the EAP and critical incident stress support, which focus on immediate access to counseling and debriefing. Alberta CFS also indicates they offer supervision and peer support programs to support their staff in preventing burnout. Alberta CFS indicates it has a mental health and wellness strategy, including regular training on mindfulness and mental health education (Government of Alberta, 2024).

Saskatchewan CFS indicates it offers employee wellness programs—which include workshops on stress reduction, offering counseling, and mental health days, along with regular debriefing and reflective supervision. This province also offers its employees access to the Employee and Family Assistance Program (EFAP), which specifies its accessibility not only for rural and remote workers but also offers access to Knowledge Keepers and Elders (Saskatchewan Public Service Commission, 2024).

Nova Scotia's Department of Community Services offers critical incident support, which includes debriefing after traumatic events; peer support programs and supervision systems; and workplace wellness programs that focus on mental health training and stress

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management/reduction workshops, along with its own EFAP program, which is like other jurisdictions (Government of Nova Scotia, n.d.).

The Yukon Government also offers the EFAP program as well to all its employees, including child welfare workers. Their website states that a worker can get seven counseling visits a year, and these can be accessed virtually, in person, or via the phone. Their website further discussed offering their staff flexible work arrangements to accommodate personal needs (Government of Yukon, 2024).

Another mostly rural jurisdiction—the Northwest Territories—follows suit by also offering EFAP for their staff, but also offering a traditional health approach, using the Medicine Wheel and Seven Sacred Teachings, intertwined with CBT called “A New Dawn, a New Light,” which can be accessed by staff via an app (Government of Northwest Territories, 2024b). The employer also offers a list of emotional and mental health resources on their website, along with support for staff such as brochures on managing anxiety, recognizing the impact of trauma, and helping employees after a critical incident (Government of Northwest Territories, 2024a).

While not in Canada, there are pilot intervention programs that exist that should be mentioned. Ezell’s (2019) case study included interviews with rural child welfare practitioners who worked in a pilot trauma-informed practice intervention program that aimed to address STS and its symptoms. The trauma-informed pilot focusing on “do no harm to self” focused on implementation, capacity building, and leadership training, along with “refresher” sessions and trauma-informed resident expert debriefing sessions held after crisis-level events. Ezell’s findings pointed to the fact that trauma-informed practice not only supports the children and families the child welfare agencies are working with to have less traumatic interactions in terms of their experience, especially in terms of child removals, but it lessens the burden of secondary

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trauma of workers if the trauma-informed implementation strategies were organizationally supported.

### *Applications for Leadership and Child Welfare Organizations*

With the current initiatives in mind, along with learnings from the literature review, it would be remiss to state the changes within the child welfare organization need to be led from the top. Organizations need not only to invest in their leaders but must have their leaders model the way, drawing from the transformational leadership framework. While no organization or leader can protect their workers fully from the traumatic material they will hear, see, or experience, either firsthand, or vicariously, there are things the organization and the leaders can do to mitigate STS from occurring.

With an appreciation for a trauma-informed perspective, leaders need to be trained and demonstrate a level of competency as it relates to STS in a general sense. They also must “walk the walk” by leading to these practices within their own lives. Then, leaders need, first and foremost, to understand who their staff are as individuals pulling from the systems lens—culturally, psychologically, emotionally, physically, and in relation to their own supports—recognizing both times when they may be more at risk of developing STS, and also understanding their unique coping strategies and self-care plans. Leaders need to take it one step further, understanding a worker’s red flags and warning signs that they are both doing well on the job, and when they are not coping, and act preventatively and responsively as needed. Leaders need to intentionally make this part of everyday discussion both in one-to-one supervision, but also as a team ensuring that the staff can lean on not only their supervisor for nonjudgemental space but can also lean on their colleagues to debrief as needed. Leaders must also actively ensure employees have the space and time to take their paid time off, attend

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appointments, and have appropriate coverage for their caseload, so as not seen as a burden on the employee taking the time off. A leader may also have to support the staff with finding the appropriate support outside of the workplace, whether that be connecting them with an Elder, finding a therapist where a conflict does not exist given the rural location, or helping find a counselor in another community that provides online services.

Not only does the leader need to take initiative in this, but the larger organization needs policies and practices to ensure that all workers receive this level of support from their leader. The organization needs to ensure its staff receive proper training and education about STS, both initially but also on an ongoing basis; and ensure that training extends upwards. By offering training and tools to their leaders, such as skill-building sessions on both STS but also quality supervision, dashboards to track their supervision and support, mentorship to grow in their skills and navigate situations, and quality assurance measures, the organization will ensure its fidelity within its supervisory practices to ensure this type of leadership and supervision occurs, and staff, no matter their location, is experiencing the same level of support as it relates to managing STS.

With the interacting systems in mind, a worker must also take individual steps to ensure their wellness. While a leader can encourage and support a self-care plan and identify and teach coping strategies, it is ultimately up to the individual to integrate those strategies and other systems into their wellness plan—leaning on family, engaging with friends, participating in community, recreational outings, encompassing their spiritual and cultural community, among many things. That individual will of course have to navigate their wellness within their rural community, but this again is where the leadership and coworkers can support an individual with

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guidance on how best to do this to ensure a worker can “shut off” from their role, given their own experience in the rural field.

A supervisor will be able to understand and support this with intention and meaning when space and time are given for supervision outside of case management duties. It is essential that organizations ensure and make this standard and an expectation: there is protected space for a supervisor to check in on their workers and actively engage in conversations of individual wellness and job satisfaction. Along with strategies and planning for times when a worker is not coping will ensure that the worker feels supported, no matter the circumstance, supervision needs to be about more than just an employee completing their job duties, but is time and space for an individual with a myriad of needs in a highly stressful field to feel valued, and like their own wellness and health matters.

Beyond the supervisor and direct leadership, the organization is responsible for other areas as well. Investing in appropriate training is key for both new staff and seasoned staff. This means training for the job duties to increase feelings of competency and success, but also training in mental health and wellness. Regular and accessible workshops and sessions need to be made available to rural staff, and leaders need to ensure they are actively demonstrating their own attendance. This, again, will normalize the discussion

As an organization, leaders, management, and policymakers need to ensure retention and staffing remain a priority, as caseload and time pressures exist to be one of the biggest barriers for front-line staff to not only attend to their own self-care, training, wellness, and even supervision but also needs to be a priority to ensure supervisors themselves can have the appropriate time to provide intentional support for their staff and have their own space and time for their own wellbeing and mental health, tying back to a leader modeling the way. These same

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leaders need to ensure that the supports currently offered—via benefits, in-house crisis management debriefing sessions, and ongoing wellness sessions—are sufficient for the type of work their employees engage in. Advocacy for contractual support, increasing benefits, and increasing access, especially to those within rural areas should not go without mentioning. Understanding that many benefit programs max out at a certain dollar amount, and with the ever-increasing hourly rate of a trained psychologist, many employees will only be eligible for a set number of sessions before they have to pay out of pocket; this in and of itself can become a barrier for those needing the most support in not being able to access it. An organization cannot expect its staff to be well and produce meaningful outcomes for families and children if it does not take care of its own and their wellbeing by providing adequate resources and support.

When organizations and child welfare agencies can draw from the key premises of transformational leadership theory by having the leader serve as a role model, offering hope and inspiration while demonstrating individualized considerations for one's development and mental wellness, the child welfare worker will be buffered from the stressors of the job and STS.

### *Applications for the Counseling Field*

Just as the literature points out, the role of the counselor is also an integral one in supporting a child welfare worker to cope with the inherent secondary traumas they will endure. This can mean many things—either in a group setting within the workplace, in a private setting in person, or virtually as sought out by the child welfare worker independent from their employer.

What is key, regardless of the avenue sought, is the intention the counselor must make in understanding the rural child welfare worker's intersecting worlds, drawing from influences of the systems theory. These worlds, may in fact, even overlap with the counselor's own to some

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degree if they also work within the rural field, and this is where the counselor needs to make certain that their own worldviews do not influence that of the client—in this case, the child welfare worker—and they seek to understand the position of the one they are serving. This can be nuanced in a rural world, and a counselor needs to leverage the therapeutic relationship to build an authentic connection and create a nonjudgemental empathetic space.

This neutral curiosity to understand the child welfare worker's world, needs to come from a place of cultural curiosity as well. Asking questions to seek to understand the client as an expert within their own realm will support the counselor in building rapport, but also facilitate conversation in a way that supports change in a culturally relevant way. It can also ground understandings of how they view their challenges, how they view their healing, and how they view coping strategies, which can further support therapeutic approaches. It also can create an added layer of understanding of the oppressions the worker may be facing due to their culture, especially living within a community that may not be as diverse. This, combined with all of the above, supports the counselor in hearing the worker's story and being the expert in their lives.

Coming from a trauma-informed approach, with a curiosity about the worker's social locations, identity, and role, and how those intersect, this information will support the counselor to work alongside their client in building a therapeutic alliance, endeavoring in psycho-education, developing treatment goals alongside the client, and applying the most appropriate therapeutic approach. While barriers and conflicts may arise, such as dual roles in this relationship, the counselor plays a meaningful role in preventing and managing STS symptoms. The role of the counselor can also extend one step further in advocating and liaising with their client to resources they may not know about, navigating and advocating for further support if a

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client's benefits do not cover specific services, and ensuring the child welfare worker gets the support they deserve.

With all this in mind, the counselor who is supporting rural child welfare staff needs to ensure they are:

- Ensuring that dual relationships do not exist with the child welfare worker as a client, or mitigating this to the best of their abilities through ethical decision-making and supervision. If dual relationships exist that prevent the counselor from offering support, ensuring appropriate referrals are completed to ensure the child welfare worker receives appropriate care.
- Completing a thorough bio-psycho-social assessment to understand their client, the child welfare worker, and the interplay of systems that influence their lives. A focus on the rural environment and how this influences their functioning needs to be included.
- Assessing the child welfare worker's presenting issues, challenges, healing, and coping strategies through a lens of cultural curiosity, ensuring that the child welfare worker is the expert in their lives. The use of the Cultural Formulation Interview (CFI) could be a support in this assessment (APA, 2022).
- Ensuring that all approaches are informed via a trauma-informed lens, and the counselor's work follows all ethical guidelines to ensure the client can receive the support they need in a space of empathy, benevolence, and nonjudgement
- The counselor themselves engages in critical self-reflection and supervision to navigate their rural dynamics if they interfere with the therapeutic relationship and approach.

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### **Reflections and Conclusion**

While this Capstone was started from a place of personal experience and seeing many child welfare staff in rural locations experience STS, while completing the research, I was nonetheless fueled with inspiration and drive for change within a large system. This research has amplified my understanding of the mitigating factors and preventative supports that can protect child welfare workers and transformed my understanding of the interacting systems at play that can impact this. That learning has extended into my own role as a counselor to explore these interacting layers using that systems lens to not only understand the worker in a person-centred, culturally relevant way but to support meaningful therapeutic approaches while being cognizant of rural challenges that may exist. Throughout this research process, I have also gained a deeper appreciation for a transformative leader, and the impact that can have on not only one worker but a system and practices to support a worker's wellbeing. The research supports that with appropriate prevention, sufficient support, and leadership who are willing to advocate and transform an organization, child welfare workers can, in fact, at the very least, have some of the vicarious trauma they experience mitigated.

Having worked in the rural setting in child welfare for the whole of my career as a social worker, I have experienced firsthand leaders who have shifted or shattered my entire ability to cope and exist in the stressful workplace. It is my own experience on the front lines with varying caseloads, shifting barriers, and a sheer lack of resources that has also shone a direct light on things that have supported, and those that have been a "nice to have" versus a "need to have." I have experienced leaders who make space for their staff, understand their worker's needs, and encourage them to take care of themselves and make changes within the system to see it through. I have seen leaders bravely go up against the norm and show up when needed to ensure their

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workers can take care of themselves in times of crisis. I have seen firsthand the outcomes for children when workers are at their best selves, utilizing their supports within their worlds, and I have seen outcomes for children and families when workers are burnt out due to various reasons.

This Capstone brought back many first-hand experiences for me, and to remain neutral, I will admit, was a challenge. What this Capstone has resulted in me though is inspiration: that rural Canadian child welfare workers, when supported by the interacting factors in their worlds, can prevent STS, and it is up to those within the field, leaders within the organizations, and counselors supporting those to advocate for the changes to better support this population, not only for the child welfare workers themselves but for the rural children and families they serve.

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## SECONDARY TRAUMATIC STRESS IN RURAL CHILD WELFARE WORKERS

**Appendix****Synthesis Matrix**

Topic: \_\_\_\_\_

	Source #1	Source #2	Source #3	Source #4
Main Idea A				
Main Idea B				