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An examination of the relationships between professional quality of life, adverse childhood experiences, resilience, and work environment in a sample of human service providers

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ABSTRACT

The current study investigated the relationship between ACEs, resilience, and work environment and professional quality of life including compassion satisfaction, burnout, and secondary trauma stress among a group of child welfare professionals working with children in the foster care system. Participants were 192 professionals representing 48 organizations providing a range of services for children residing in foster care within a large metropolitan area in the southern USA. Data showed that professionals had more ACEs than the norm sample (4 or more ACEs: 25.1% v. 12.5%). However, contrary to our hypotheses, regression analysis revealed that individuals with more ACEs had higher compassion satisfaction and lower rates of burnout. Moreover, number of ACEs was not significantly related to secondary traumatic stress. The variables found most predictive of poor professional quality of life were low levels of resilience and controlling organizational leadership. Ways to improve professional quality of life amid human service professionals and practical implications of these findings are discussed.

1. ACEs and its effects

The adverse childhood experiences study established a connection between childhood trauma or adverse childhood experiences (ACEs), and adult behavioral and health outcomes. The Adverse Childhood Experiences Study questionnaire includes 10 questions that ask respondents to report whether they had experiences considered to be psychological, physical, and/or sexual abuse; or exposure to violence against the respondent's mother, mental illness, criminal behavior, alcohol abuse, and/or drug abuse during their first 18 years of life (Felitti et al., 1998). Exposure of the developing brain to stress can result in lasting impairment in multiple neurological structures and functions. Specifically, a wide range of long-term neurobiological and epidemiological effects of ACEs can follow individuals throughout adulthood, and as the ACE score increases, so do some of the major risk factors for the leading causes of illness and death as well as poor quality of life conditions. These include general health issues, panic reactions, anxiety, social functioning, depressed affect, hallucinations, sleep disturbance, pain, severe obesity, multiple somatic symptoms, smoking, alcoholism, illicit drug use, injected street drugs, impaired memory of childhood, early intercourse, promiscuity, sexual dissatisfaction, high level of perceived stress, difficulty controlling anger, and risk of perpetrating intimate partner violence (Corso, Edwards, Fang, & Mercy, 2008; Felitti et al., 1998; Strine, Dube, et al., 2012; Strine, Edwards, et al., 2012). In women, ACEs are also associated with higher risk of migraines and inflammatory biomarkers that predict migraines (Tietjen, Khubchandani, Herial, & Shah, 2012). ACEs can also affect socio-economic well-being in adulthood. This includes increased risk for unemployment (Liu et al., 2013) and homelessness (Roos et al., 2013).

1.1. Secondary trauma

Social service providers have been found to have a higher prevalence of ACEs than those experienced in the general population (Esaki & Larkin, 2013). It is important to look at ACEs in social workers, including child welfare providers, because their professional duties include interactions involving the traumatization of the clients they serve. Such service providers may be at increased susceptibility for experiencing vicarious traumatization, or a re-enactment of their own history, through activities involving client histories (Esaki & Larkin, 2013). In addition, social workers who have exposure to clients' traumatic experiences and stories, may develop symptoms of posttraumatic stress themselves, often called vicarious traumatization or secondary traumatic stress. Secondary Traumatic Stress (STS) has been defined as "the natural

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consequent behaviors and emotions resulting from knowing about a traumatizing event experienced by a significant other — the stress resulting from helping or wanting to help a traumatized or suffering person" (Figley, 1995, p. 7). STS has been considered an occupational hazard for those providing direct services to traumatized populations. In one study, 55% of social workers who provided direct services to traumatized populations met at least one of the diagnostic criteria for post-traumatic stress disorder (PTSD), 20% met two criteria, and 15.2% met the three criteria threshold required for a diagnosis of PTSD (Bride, 2007). When compared to the lifetime prevalence of PTSD in the general population, estimated at 7.8% (Kessler, Sonnega, Bromet, & Nelson, 1995), evidence suggests that social workers meet the criteria for PTSD diagnosis at twice that rate (Bride, 2007).

In addition, research has shown that social workers who have experienced one or more traumatic events in their own lives are at higher risk of developing secondary traumatic stress, with those experiencing more types of personal traumatic events demonstrating more severe levels of secondary traumatic stress (Choi, 2011; MacRitchie & Leibowitz, 2010). Also, female social workers (Choi, 2011), social workers with higher levels of empathy (MacRitchie & Leibowitz, 2010), and those with lower levels of perceived social support (MacRitchie & Leibowitz, 2010) have been found to have higher levels of secondary traumatic stress.

1.2. Compassion fatigue

Social workers or those in the helping professions, experience ongoing demands for their compassion and empathy with clients, increasing their risk of developing compassion fatigue. Specifically, social workers must investigate and examine their clients' issues; communicate these issues to others; maintain significant contact with distressed families; demonstrate empathy; make decisions that could have life threatening or life changing consequences for children and families; manage conflict involving families, agencies, or society; and make adjustments based on changing systems, stress responses of others, scarce resources, lack of competence in others, or their own lack of confidence (Richardson, 2011). Compassion fatigue is associated with a sense of helplessness and confusion, including a greater sense of isolation from supportive individuals. Compassion fatigue can also lead to high staff turnover, poor service delivery, boundary violations, and unresolved countertransference issues among staff (Sexton, 1999). However, because the symptoms are not connected with first-hand experiences, it is highly treatable once workers recognize this and act accordingly (Figley, 2002).

While it is important to have clear and measurable standards for the care of social workers' clients, it is also important to have standards of self-care for social workers themselves (Bride & Figley, 2007). STS, compassion fatigue, and vicarious trauma are all terms that have been used interchangeably in social work research, but have been described differently as well, depending on the particular researcher who is using each term. However, while the body of literature may contain some inconsistencies in defining these terms, they have all been associated with symptoms similar to post-traumatic stress disorder (PTSD), increased stress, and reduced capacity for empathy (see Nilsson, 2014 for a review).

1.3. Secondary trauma effects on work environment

Emotions of any type, expressed through an individual or group, can affect others and even be contagious (see Cozolino, 2014 for a review), compassion fatigue and burnout can result. In particular, social workers can be influenced by the emotional cues of others, which can impact their judgment in a variety of ways (Cozolino, 2014; Doherty, 1998). Those in counseling professions who are impaired due to stress or burnout could cause harm to clients due to poor decision-making (Lawson, 2011; Lawson, Venart, Hazler, & Kottler, 2007). Those who work with victims of trauma often utilize empathy and emotional concern to better serve their clients, however, this carries a risk of emotional contagion that can occur within the organization, resulting in traumatic stress spreading among co-workers (Braiker, 1986; Figley, 1995; Herman, 1992; Pearlman, 1999). Thus, organizations themselves can be susceptible to the indirect trauma experienced by the nature of the services its workers provide. Through the mission of the organization as implemented by its employees, organizational trauma can permeate a system. Social services agencies are at particular risk for cumulative trauma stemming from ongoing, continuous exposure to the pain and suffering of clients (Hormann & Vivian, 2005).

However, in one study, social workers who provided direct services to victims of family violence or sexual assault demonstrated lower levels of secondary traumatic stress when they had more access to their organization's strategic information, and experienced more support from their co-workers, supervisors, and work teams (Choi, 2011). Other organizational factors that can lessen STS in workers include sociopolitical support (e.g., support from organizational membership and networks), access to information (e.g., work flow, productivity, external environment, future direction, and mission and goals), access to resources (e.g., time, space, materials, and funds), and organizational culture (e.g., culture that values human capital and participation; Spreitzer, 1995, 1996; for a review see Choi, 2011). In addition, social workers with a master's degree or higher have been found to experience lower levels of compassion fatigue or STS than found in a typical population of social workers. In addition, social workers employed by public agencies have a greater risk of developing compassion fatigue than those working for private agencies (Harlan, 2004).

This trauma can influence an organization's identity, worldview, and culture, which can be sustained over time and passed on to subsequent generations of workers. This cultural climate can include conscious and unconscious socialization and communication processes such as the development of unique jargon and organizational shorthand to explain experiences of stress. Thus, staff are embedded in a culture that emphasizes stress that is independent of their own individual stressors experienced on the job. Characteristics of traumatized organizational systems include (a) closed boundaries between organization and external environment, (b) centrality of insider relationships, (c) stress and anxiety contagion, and (d) loss of hope (Hormann & Vivian, 2005).

Also regarding organizational climate, having supportive supervisors and an increased sense of power and agency over the work are related to less employee burnout. Both burnout and empowerment are impacted by organizational climate. Thus, making improvements in organizational climate can be an important factor in creating conditions that provide employees an increased sense of control. In addition, research indicates that employees who feel empowered are more adept at handling the psychological stress associated with providing direct services to traumatized populations (Lee, 2013). Because emotional fatigue and STS are not only a threat to individual social workers but also to the organizations in which they work, it is important for human service agencies to provide preventative and ongoing training to their employees to combat these issues.

1.4. Resilience and its importance to the field

Organizations should provide ways for social workers to develop resilience in the face of the circumstances they encounter each day in the course of their duties. McElwee (2007) suggests that a resilient person possesses "a set of qualities that foster a successful process of adaptation and transformation, despite significant risk and adversity in their lives" (p. 59). Thus, resilience involves a change and assimilation in regards to trauma, rather than a return to the original state (Hernandez, Gangsei, & Engstrom, 2007). The Grotberg framework of resilience (Grotberg, 1995) identifies three domains that contribute to resilience in children. These are "I am" (inner strengths), "I have" (external supports and resources), and "I can" (social strengths). Kearns and McArdle (2011) found that social workers with strengths that fall