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Child Abuse and Neglect: A Resource Guide for Professionals

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Overview

Statistics

According to the United States Department of Health and Human Services Child Maltreatment 2014 Report, there were many key findings. First, the number of children nationally who received an investigation or alternative response went up about 7.4% from 2010 to 2014. In 2010 3,023,000 children received an investigation or alternative response and in 2014 that amount went up to 3,248,000. The rate of victims of maltreatment went up about less than one percent from 2010 to 2014. In the United States, the cases of child abuse and neglect were 75% neglect, 17% physical abuse, and 8.3% were sexual abuse. It is also estimated that about 1,580 died of abuse and neglect in 2014 in the United States. That is a rate of 2.13 per 100,000 children nationally (Department of Health and Human Services, 2014). In Illinois, the number of children that were reported at being abused and neglected in 2014 was 109,784 children (Illinois Department of Children and Family Services, 2015). From the number of children who were reported, 26,785 cases were indicted as child abuse and/or neglect. There were a total of 35 indicated alleged deaths due to child abuse and neglect (Illinois Department of Children and Family Services, 2015).

Mandated Reporters

Mandated reporters are individuals who are required by law to report suspected cases of child maltreatment because of their occupation (McCoy & Keen, 2014). Some of the occupations that are mandated reports are the following: all medical personnel, teachers, day care providers, religious personnel, counselors, social service personnel, and police. Some states have longer lists of who is a mandated reporter (McCoy & Keen, 2014). In Illinois, mandated reporters are in seven groups (Illinois Department of Children and Family Services, 2015). These seven groups

are medical personnel, school personnel, social service/mental health personnel, law enforcement personnel, coroner/medical examiner personnel, childcare personnel, and members of the Clergy. These professionals are included because they may have contact with children throughout their duties. Also in Illinois, you are required to report suspected child abuse or neglect immediately. If an individual willingly fails to report (in Illinois) it is a misdemeanor on the first violation and then a class 4 felony for subsequent violations. It is important for mandated reporters in Illinois to know that they are granted immunity (Illinois Department of Children and Family Services, 2015). Immunity is a legal term that ensures confidentiality of records and exception from civil or criminal liability or prosecution (McCoy & Keen, 2014).

Types of Abuse

Physical

Although the definition of child physical abuse varies across the United States, all of the definitions agree that physical abuse occurs when a child's parent or caregiver physically harms a child or adolescent and leaves red marks, cuts, welts, bruises, muscle sprains, or broken bones (National Child Traumatic Stress, 2009). Even if the injury was unintentional, it is considered abuse. All children are at risk of being physically abused. Children who are between four and seven years old and twelve and fifteen years old are at the greatest risk of being physically abused. Also, very young children are more likely to receive serious injuries from physical abuse (National Child Traumatic Stress, 2009).

It is also important for professionals to understand how to determine if a child has been physically abused (National Child Traumatic Stress, 2009). The most certain way to know if a child has been abused is if the child tells you. However, there may also be physical signs that you can see. Some of these physical signs include welts, bruises in various stages of healing, fingernail marks, human bite marks, burns, lacerations, and abrasions in the pattern of an object. The child's clothing could also hide these injuries, which can make it difficult to tell if the child is being physically abused. There are many other indicators that suggest a child is being abused as well. Some examples are if a child has frequent physical injuries that are attributed to the child being clumsy or accident-prone, the injuries of the child do not seem to fit the explanation given by the parents or child, the child and parent provide conflicting explanations for the injuries, routine absence from school without reasons (National Child Traumatic Stress, 2009).

Sexual

"Child sexual abuse is any interaction between a child and an adult (or another child) in which the child is use for the sexual stimulation of the perpetrator or an observer" (National Child Traumatic Stress, 2009, p. 1). Sexual abuse may include touching behaviors such as touching the vagina, penis, breasts, buttocks, oral-genital contact, or sexual intercourse. Sexual abuse can also include non-touching behaviors such as voyeurism, exhibitionism, or exposing a child to pornography. Perpetrators typically use grooming tactics on their victims that are intended to confuse the victim and make them feel special. Abusers will often use play, deception, threats, or coercion to engage and maintain the child victim in the sexual abuse (Child Traumatic Stress, 2009).

There all also signs that can be shown in children who have been sexually abused and it is important for professionals to know these signs (Child Traumatic Stress, 2009). Children can display emotional and behavioral reactions to child sexual abuse. Some of these reactions are an increase in nightmares, sleeping difficulties, withdrawn behavior, angry outbursts, anxiety, depression, not wanting to be left along with a particular individual, sexual knowledge, language, or behaviors that are not appropriate for the child's age. Although many children will show signs of sexual abuse, there are many children who do not show these signs (Child Traumatic Stress, 2009).

Child Neglect

Put into a few words, child neglect is an act of omission (McCoy & Keen, 2014). This means that parents or caregivers are not meeting a child needs. Child neglect does not have a clear definition. Rather, it includes a variety of topics such as n act or failure to act that results in death, serious injury or emotional harm, sexual abuse, or exploitation. The subtypes of neglect

include physical, emotional, medical, mental health, and educational neglect. Abandonment is also a subtype of neglect (McCoy & Keen, 2014).

Physical neglect is when a parent or caregiver fails to meet the minimum physical needs of a child (McCoy & Keen, 2014). Physical needs include food, shelter, clothing, and protection from harm or danger. A child who is malnourished is a form of physical neglect. Inadequate shelter is more complicated to define for physical neglect. This includes the lack of or type of home and the condition of the home (i.e., cleanliness). The housing that the child has can be tricky to define what is acceptable and is often up to the state. Types of housing that are questionable are cars, tents, and tepees. The lack of cleanliness is also a type of physical neglect. Some examples include insect infestations, trash, extreme smells, and hording. Another part of physical neglect is adequate supervision (McCoy & Keen, 2014). In Illinois, the law states, "any minor under the age of 14 years whose parent or other person responsible for the minor's welfare leaves the minor without supervision for an unreasonable period of time without regard for the mental or physical health, safety or welfare of that minor" (Illinois Department of Children and Family Services, 2016, p. 2). Child endangerment is also included in physical neglect (McCoy & Keen, 2014). Child endangerment is when caregivers expose their child to situations that could possibly harm the child. Domestic violence is another type of physical neglect, which includes having a child who lives in a home with domestic violence (McCoy & Keen, 2014).

Emotional neglect is the parent or caregivers failure to meet a child's emotion needs (McCoy & Keen, 2014). This includes affection and emotional support. Although emotional neglect can be hard to prove, in extreme cases it may be clear (McCoy & Keen, 2014).

Medical neglect is the parent or caregiver's failure to seek medical treatment or to provide treatment that has been prescribed (McCoy & Keen, 2014). This can include parents who

refuse to permit their child to receive lifesaving medical interventions, although religious beliefs may be why parents are doing such. It can be tricky in those situations to define it as medical neglect. A judge on a case-by-case basis evaluates situations that do not involve religion. Another type of medical neglect is when a caregiver fails to get medical attention for the child in a timely manner. In order for a caregiver to be charged with delay of treatment, the injury or illness "must be serious and the delay obvious" (McCoy & Keen, 2014, p. 110).

Mental health neglect is the parent or caregivers failure to seek help for a child's severe psychological problems or to comply with recommended therapeutic procedures (McCoy & Keen, 2014). This can include school psychologists and medical doctors. In order to diagnosis mental health neglect, "a team of two or more appropriately accredited mental health professionals must conclude that the child has a serious emotional or behavioral problem, and the child's caregiver refuses to provide or maintain the suggested treatment" (McCoy & Keen, 2014, p. 111). Similar to medical neglect, mental health neglect also includes the delay of treatment as a type of neglect. An obvious time for a child to receive mental health treatment is after a suicide attempt. If a caregiver delays this treatment, they would be charged with delay of treatment (McCoy & Keen, 2014).

Educational neglect is the failure to meet legal requirements for school enrollment or attendance, or the lack of attention to special educational needs (McCoy & Keen, 2014). There are three situations that constitute educational neglect. These include permitted chronic truancy, failure to enroll/other truancy, and inattention to special education needs. Luckily, in the United States, schools keep accurate and excellent records of student's attendance. This allows for educational neglect to be accurately demonstrated (McCoy & Keen, 2014).

Psychological Maltreatment

Psychological maltreatment includes both psychological neglect (discussed in "Child Neglect" section) and psychological abuse (McCoy & Keen, 2014). Psychological abuse is also known as emotional abuse. This type of abuse is defined as "parental behaviors that actively harm their child's mental health" (McCoy & Keen, 2014, p. 123). These caregivers fail to meet the emotion needs of the child they are caring for. Some of these caregiver behaviors can include ignoring the child, fail to make emotional contact with the child, threatens their child, or yells at their child at an extreme level (McCoy & Keen, 2014).

There are six subtypes of psychological maltreatment (McCoy & Keen, 2014). The first is spurning which are "caregiver behaviors that are hostile toward and rejecting of a child" (McCoy & Keen, 2014, p. 129). This can include behaviors such as belittling, degrading, shaming, and publicly humiliating. A more basic word for this subtype is rejecting. The second subtype is terrorizing which is a caregiver who threatens the child or the child's loved ones or possessions with violence or abandonment. This places the child in a dangerous situation. The third subtype is isolating which includes "confining a child or not allowing a child to have the opportunity to socialize with others" (McCoy & Keen, 2014, p. 129). The fourth subtype is exploiting or corrupting which "encourages children to develop and engage in inappropriate behaviors" (McCoy & Keen, 2014, p. 129). This could be through modeling behaviors, permitting behaviors, or encouraging a child to take part in inappropriate behaviors. These behaviors could range from criminal activities to parentification of the child. The fifth subtype is denying emotional responsiveness. This is when the caregiver ignores the child's emotions or shows no emotional reactions when interacting with the child. The last subtype is mental health, medical, and educational neglect. These are parents who fail to meet mental health, medical, or educational needs of a child (discussed in "Child Neglect" section) (McCoy & Keen, 2014).

Risk Factors for Child Maltreatment

There are many risk factors for child maltreatment (McCoy & Keen, 2014). These come from family, child, extrafamilial, and cultural factors. There are many factors within these categories. Although these risk factors do not mean that a child will definitely be maltreated, each factor just increases the likelihood of a child to be maltreated. Child maltreatment is very complicated and there is not one definite cause of child maltreatment (McCoy & Keen, 2014).

There are many family factors that increase the risk of child maltreatment (McCoy & Keen, 2014). These include parental sex, parental substance abuse, parental mental illness, lack of parental preparation, intergenerational transmission, single parents, domestic violence, large family size, military families, and poor family functioning (McCoy & Keen, 2014).

The sex of the parent is a factor of the type of maltreatment that the parent might commit to the child (McCoy & Keen, 2014). Women are more likely to be guilty of child neglect. Of all neglect charges, 86% are towards women. However, when it comes to abuse, 62% of all abuse cases are against men. Men also make up 87% of sexual abuse charges (McCoy & Keen, 2014).

Parental substance abuse is often times associated with all types of child maltreatment (McCoy & Keen, 2014). It is known that almost 80% of all cases that come to child protection services have a substance abuse problem. It has also been shown that parental substance abuse is linked more closely with child neglect than other types of child maltreatment. It has also been shown that even if a parent is not currently using drugs, the likelihood of child maltreatment is still increased. In addition, the side effects of drugs while using and coming off can effect the parent's actions and lead to child maltreatment. This can be from aggressive behavior to impaired judgment (McCoy & Keen, 2014).

Parents with mental illness and problematic personality traits are more likely to abuse children (McCoy & Keen, 2014). Depression is the most common mental disorder with between 10% and 25% of women and between 5% and 12% of men struggling with the disorder at some point in their lives. People who suffer from depression have impaired social functioning and thus are more likely to maltreat children. Mother's that suffer from depression are less emotionally involved with their children, are more hostile, and use more harsh punishment than other mothers (McCoy & Keen, 2014).

There are also parents who are not prepared to be parents and end up maltreating their children. Some mothers might simply not know the needs that children have and end up neglecting or abusing their children. Often times when parents lack knowledge on parenting they might end up relying too much on physical punishment. This lack of preparedness is closely related to parental age and education levels. Mothers that are older and have higher education are less likely to maltreat their children (McCoy & Keen, 2014).

Intergenerational transmission is also a large risk factor (McCoy & Keen, 2014). Parents who were maltreated as children are more likely to abuse their children because it is a trait that was passed down to them from their parents. Research has shown a rate of intergenerational transmission of about 30%. There are many theories that explain intergenerational transmission of child abuse and neglect. One theory is that the parents are simply doing what they know. Most of what caregivers learn about parenting comes from watching their parents. Another theory goes along with the attachment theory. If you were abused as a child, you are more likely to have had poor attachment skills, lack of empathy, and social isolation. This in turn can make a person fail when it is their turn to parent a child. However, it is important to note that not all parents who

have a past of being abused will become abusers. Again, it is a risk factor (McCoy & Keen, 2014).

Some parents of family structure and functioning factors include single parents, domestic violence, large family size, and poor family functioning (McCoy & Keen, 2014). Being a child in a single parent household increases the likelihood of being abused. This risk also significantly rises when the child is also living with a single parent and their partner. The rate of maltreatment is at its lowest when a child is living with both of its biological parents. Domestic violence also is a large risk factor. Children who grow up in a household with domestic violence can be directly or indirectly harmed. The child might be harmed when they try to step in to stop the domestic violence or psychologically harmed by having to view this violence. Large family size is also a risk factor because there are more stressors and responsibilities. It gets harder for caregivers to monitor every child at all times if there are a lot of them in the house at the same time. Poor family functioning is also a risk factor. This relates to the families communication and interactions. Family roles might be unclear in the household and therefore less stable (McCoy & Keen, 2014).

There are also extrafamilial factors that increase the likelihood of child maltreatment such as lack of support and poverty (McCoy & Keen, 2014). A family who deals with a lack of support might be socially isolated and therefore have less community resources to receive. Support for family and friends might also be lacking which can lead to child maltreatment. Poverty also has many effects on families such as stress, unemployment, unstable housing, poor community support, dangerous environments, and minimal access to health care. All of these factors can be hard for an individual to cope with and therefore they are not able to adequately care for their children (McCoy & Keen, 2014).

There are also cultural factors that increase the likelihood of child maltreatment. For example, in some cultures corporal punishment may be seen as okay to do. However, at what level is corporal punishment below being abusive? In the United States, there is a high tolerance to violence and acceptance to corporal punishment (McCoy & Keen, 2014).

The Effects of Different Types of Abuse

Physical Abuse

The consequences of physical abuse are more than just physical marks on the child (McCoy & Keen, 2014). Some of the effects that are not physical are intellectual and academic problems, changes in cognitive processing, issues with interpersonal relationships, aggression, substance abuse, internalizing symptoms, posttraumatic stress disorder, depression, dysthymia, attention deficit hyperactivity disorder, conduct disorder, and oppositional defiant disorder (McCoy & Keen, 2014).

Intellectual and academic problems can be seen in the child's academic performance and behaviors at school (McCoy & Keen, 2014). Children who have been abused physically have lower test scores on measures of overall intellectual ability. They also score lower on math and reading tests. These children are also more likely to receive special education services and to be diagnosed with a learning disability. As far as behaviors in school, children who have been physically abused are more likely to be disciplined or suspended from school. These problems in school could be caused by brain damage during the abuse or due to them being distracted by their life at home. Sometimes the child is also missing school because the caregiver is trying to cover up the abuse by keeping the child home from school. This can cause the child to fail at school, too (McCoy & Keen, 2014).

Children who have been physically abused also struggle with forming strong interpersonal relationships due to their insecure attachment with their caregiver (McCoy & Keen, 2014). Having an insecure attachment sets a poor foundation for the child to build new relationships. These children also struggle with aggression due to being physically abused. This is due to aggression being modeled by their caregiver at home. This aggression can go along

with the child throughout their lives. There is a strong link between physical abuse during childhood and subsequent violent behavior in adulthood, according to research. They are also more likely to show violence toward dating partners, spouses, and their own children (McCoy & Keen, 2014).

Substance abuse has also been linked to child physical abuse (McCoy & Keen, 2014). These children are more likely to use both legal and illegal drugs. They are also more likely to become dependent on alcohol than their nonabused peers. Research has shown that teenagers with a past of physical abuse are more likely to have heavy episodic drinking from their teenage years into their early adulthood. It has also been noted that this is more about self-medicating to deal with the issues of depression and low self-esteem than it is of acting out. The internalizing symptoms that children who have been abused may show include lower self-esteem, depression, and suicide (McCoy & Keen, 2014).

Sexual Abuse

Although not all children are affected the same by child sexual abuse, there are some common consequences (McCoy & Keen, 2014). These consequences include depression, self-destructive thinking and behavior, anxiety, posttraumatic stress disorder, substance abuse, personality disorders, eating disorders, dissociation and memory impairment, cognitive distortions, social functioning, and sexualized behaviors. Among adults who were sexually abused as children, depression is the most reported symptom (McCoy & Keen, 2014).

Child sexual abuse victims are more likely to suffer from suicidal ideation or behaviors (McCoy & Keen, 2014). This is due to the depression and self-destructive thinking and behavior. There is an increase in suicide attempts among this population. Self-mutilation has also been

liked to child sexual abuse. This includes cutting, burning, or otherwise harming ones own body (McCoy & Keen, 2014).

Dissociation is "the separation of some mental processes from conscious awareness" (McCoy & Keen, 2014, p. 177). This allows for the child's mind to shield against full awareness of the abuse. Repressed memories can also occur. This is another one of the mind's defense mechanisms. It pushes memories to the unconscious. Due to repressed memory, the victim is no longer consciously aware of the abuse that occurred to them (McCoy & Keen, 2014).

Children who are victims of child sexual abuse are more likely to display sexualized behaviors (McCoy & Keen, 2014). The inappropriate acts include more intrusive acts such as insertion of objects, finger, or penis, and oral-genital contact. Among children who have suffered significant mental illness related to child sexual abuse, females are more likely to be hypersexual and males are morel likely to expose their genitals to other or use coercion. Victims of child sexual abuse that are adults are more likely to experience sexual dysfunction (McCoy & Keen, 2014).

Child Neglect

Resilient children may not be as affected by child neglect (McCoy & Keen, 2014). However, there are some common consequences of child neglect. These consequences appear different in the various periods of child development. The consequences of infant neglect include nonorganic failure to thrive, poor attachment, poor muscle tone, lack of smiling and babbling, rashes, infections, and lower intelligence. The consequences of neglect in childhood include language delays, intellectual and academic problems, impaired socialization, and trauma-related symptoms. The consequences of neglect in adolescents include runaways, social isolation,

intellectual and academic problems, delinquency, and psychiatric disorders (McCoy & Keen, 2014).

Psychological Maltreatment

There are five areas of concern for the psychological maltreatment of children (McCoy & Keen, 2014). Hart, Binggeli, and Brassard created these areas of concern in 1998. These five areas include the following: interpersonal thoughts, feelings, and behavior, emotional problems, social and antisocial functioning, learning problems, and psychical health. Interpersonal thoughts, feelings, and behavior include low self-esteem, negative life reviews, depression, and anxiety. Emotional problems include emotional instability, poor impulse control, substance abuse, unresponsiveness, borderline personality disorder, and eating disorders. Social and antisocial functioning includes attachment problems, poor social competence, aggression, violence, delinquency, social isolation, poor empathy, and sexual maladjustment. Learning problems includes children with lower mental competency, lower test scores, lower IQ, and delayed moral reasoning. Physical health includes asthma, respiratory problems, and hypertension (McCoy & Keen, 2014).

The Non-offending Caretaker

Research shows that most (57% to 82%) non-offending caretakers take some types of action (Cuppett, 2014). However, there is little research on non-offending fathers. The non-offending mothers are more likely to support their child if they are having angry or hostile feelings towards the perpetrator. The mothers are also more likely to believe that their child was sexually abused if the perpetrator was an extended family member, there was digital or oral contact with the child's genitals, the mother was not home during the time of abuse, and if the child was pre-adolescents (Cuppett, 2014).

There are also mother's who do no believe or support their child during child abuse cases (Cuppett, 2014). The non-offending caretaker may have a more difficult time believing and supporting their child was sexually abused if the perpetrator was their partner. Other factors that also influence them to not believe that their child was sexually abused is if the victim was an adolescent, the child was also physically abused, and if the perpetrator was known to abuse alcohol. When the non-offending caretaker fails to believe or support the child, the caretakers own past incestuous experience, passivity, domestic violence, or fear can cause this (Cuppett, 2014).

There are also a small percentage of non-offending caretakers who know of the abuse and tolerate it (Cuppett, 2014). Often times this has to do with the caretakers own mental illness. It is possible that they might also believe that child sexual abuse is a normal part of childhood. Another small percentage of non-offending caretakers will participate in the abuse with the perpetrator. It is important to note that the caretaker might be habituated to the abuse and allow it to continue to happen even without the perpetrators involvement (Cuppett, 2014).

As a professional working with non-offending caretakers, it is important to build a relationship with them so that you can continue to protect the child (Cuppett, 2014). Sometimes it is hard to understand why the non-offending caretaker did not stop or prohibit the abuse from happening. It can also be difficult to work with the non-offending caretaker when they do not immediately believe that the abuse happened. However, remember that it is normal for the non-offending caretaker to question the abuse that happened at first. They also need time to gather information about what happened and process their thoughts. If their partner was the perpetrator, this can mean that the family structure is going to change. The caregiver might go through denial, then anger, and then acceptance. The non-offending caretaker will also be pulled in multiple directions. There is the child on one side and the perpetrator on the other side. They are experiencing many emotions and it is important for you to understand that and continue to build your relationship with them (Cuppett, 2014).

Effective Therapies

Children

Children may experience many internalizing features after maltreatment such as anxiety, depression, and decreased self-confidence (Toledo & Seymour, 2013). They also may show different externalizing features such as aggression, sexualized behaviors, self-injury, and somatic complaints. Children can receive a variety of therapies to help them cope with this trauma (Toledo & Seymour, 2013).

Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT) is for children who have been sexually abused and their non-offending caretakers (Mannarino, Cohen, & Deblinger, 2014). It is also an effective therapy for children who are dealing with domestic violence, traumatic loss, and multiple traumas. This type of therapy can be used with children ages three to seventeen and with children who have developmental disabilities. It also includes parental involvement and has been shown to help caregivers cope, too. Children who receive TF-CBT have been treated effectively for "internalizing and externalizing behavioral difficulties, sexual behavior problems, general anxiety, abuse-related fears, depressive symptoms, and shame" (Mannarino et al., 2014, p. 173). Caretakers who participate in TF-CBT also have reduced depression and shame. TF-CBT can be implemented for up to 25 therapy sessions in the case of complex cases. The treatment is implemented in parallel individual sessions with the child and caretaker. It typically lasts between 8 and 16 weeks. TF-CBT usually begins with psychoeducation, then there is a skills-based component, then the trauma narrative and processing, and ends with enhancing safety and future development (Mannarino et al., 2014).

Game-based cognitive-behavioral therapy has been found as a successful group program for children who have experienced sexual abuse (Springer, Misurell, & Hiller, 2012). This type of therapy is a twelve-week program that uses three common approaches, including: trauma-

focused cognitive behavioral therapy, play therapy, and group therapy. The children benefit from psychoeducation on a variety of topics as wells as using developmentally appropriate games as a type of play therapy. It has been shown that these games are effective for addressing social skill deficits and symptoms of attention-deficit/hyperactivity disorder. Springer et al. (2012) used this curriculum with elementary aged children and examined the effects of the program immediately following and three months later. They found that game-based cognitive-behavioral therapy is effective in improving internalizing and externalizing symptoms, behavioral problems, trauma symptoms, sexually inappropriate behaviors, and personal safety skills immediately following treatment and at the three-month follow-up (Springer et al., 2012).

Non-Offending Caretakers

It is also important for non-offending caretakers to receive support and interventions following their children's disclosure to child maltreatment (Toledo & Seymour, 2013). These caretakers need support in order to properly provide for their child that was affected by the maltreatment. It can also be difficult for these caregivers to understand the different internalizing and externalizing behaviors that the child may display after being maltreated. The caregiver can also be impacted emotionally and through their support systems that they had prior to the child disclosing maltreatment. A caregiver may suffer emotionally because when their child discloses the maltreatment the caregiver can see it as a major life crisis. The caregiver might experience strong emotional reactions such as anger, despair, disbelief, and guilt. The support that the caregiver may have had before the disclosure may no longer exist following the disclosure. This often times relates to maltreatment that occurs within a family. Other family members may not believe that the perpetrator actually maltreated the child. The caregiver might also lose financial

support if the perpetrator was the partner of the non-offending caregiver (Toledo & Seymour, 2013).

There are also many needs of the non-offending caretaker (Toledo & Seymour, 2013). They might need information, emotional support, support for their past experiences, and for parenting assistance. Caregivers need information on a variety of topics including the following: the dynamics of abuse and disclosure, how to support their child appropriately, the investigation process, long-term consequences of the maltreatment on the child, and how the disclosure will affect the whole family. This information should not just be given to the caregivers, but it should also be explained by the professionals involved in the investigation so that the caregivers can better understand it. The emotional support that the caregiver's need is often personal in regards to coping with the disclosure and to work through what they are feeling. Sometimes caregiver may be left with no other support systems following the disclosure. It is important for them to have professionals for emotional support if they cannot get it from elsewhere. Sometimes a caregiver might have also been maltreated in their childhood and having their own child disclose abuse and bring up a lot of their past memories. Professionals must help these caregivers work through their past experiences so that the caregiver can continue to provide for their child. Caregivers need parenting assistance because of the different internalizing and externalizing features that the child might display following the maltreatment. It can be very difficult for the caregiver to know how to respond to these different types of behaviors (Toledo & Seymour, 2013).

There are a variety of different interventions for caregiver (Toledo & Seymour, 2013). Research has also shown that these interventions can benefit the caregiver positively. These interventions range from providing information to cognitive behavioral therapy. The therapies

most discussed in literature include provisions of information, support groups, psychoeducational groups, caregiver intervention incorporated in child's intervention, cognitive behavioral therapy, and child-centered play therapy (Toledo & Seymour, 2013). There are also a variety of books and workbooks that non-offending caregivers can use with their child or for themselves to help cope with the disclosure (see Appendix A for suggested readings).

The provision of information can be used alone or along with other interventions as reinforcement (Toledo & Seymour, 2013). It has been shown in research that caregivers prefer to receive the information in written form or visually rather than just verbally. Research has also shown that caregivers who receive written information retain more of the information than caregivers who receive it only verbally. Also, when the caregiver retains more information they are more likely to implement the information they learned with their child (Toledo & Seymour, 2013).

Support groups allow for caregivers to create new support systems with peers and the community (Toledo & Seymour, 2013). These support groups allow for caregivers to meet others who are also in the same situation as them. It allows for a common theme to arise in the group. "Caregivers reported that they benefited vicariously through other caregivers' disclosures and appreciated the non-judgmental environment of these groups, which enabled them to express their own emotions safely" (Toledo & Seymour, 2013, p. 776). Psychoeducational groups take support groups to another level. These groups allow for caregivers to continue creating new support systems along with learning valuable information for professionals. These interventions include information for the caregivers about the child's responses to abuse and parental advice on dealing with the child's responses (Toledo & Seymour, 2013).

Caregiver interventions incorporated in child's intervention are sometimes offered (Toledo & Seymour, 2013). An agency that typically provides this type of intervention is the Children's Advocacy Centers in the United States. These interventions are often based on cognitive behavioral therapy or filial therapy. Research has shown that involving the caregiver in the child's therapy increases the child's participating and completion of therapy. Interventions based on cognitive behavioral therapy can also be offered separately for both the child and caregiver. These interventions for caregivers decrease parental emotional distress, enhance parental support, and help caregivers manage their children's behaviors. Research has shown that these types of interventions for caregivers result in a decrease in intrusive thoughts and negative emotional reactions. Child-centered play therapy involving caregivers have only been used a small amount of times. However, they few samples have shown an increase in parent-child relationship improvements after the intervention. This is due to an increase in acceptance f the child, greater empathy, positive behavioral changes, and some improvements in the child's psychological well being (Toledo & Seymour, 2013).

Legal Issues

Forensic Interviews

A forensic interview is an important part of child abuse and neglect investigations (McCoy & Keen, 2014). A forensic interview is a technique used by professionals to elicit information from witnesses verbally to be used in a legal setting. It is important for the interviewer to use open-ended, unbiased questions. These will allow for the child to respond truthfully to the questions. Since children are susceptible to suggestibility, it is important for the interviewer to be properly trained (McCoy & Keen, 2014).

The use of anatomically detailed dolls has also become more customary during child sexual abuse forensic interviews (McCoy & Keen, 2014). It is essential for interviewers to understand that while the dolls can be helpful, sometimes the children might not understand the doll. Depending on the child's age, they might not understand dual representation. This means that the child may not be able to imagine that one of the dolls is to represent themselves. Some children might be straightforward and tell the interviewer that the doll is not them. Others may be confused by the doll and say untrue statements based on the doll. It is also important to not rely solely on the dolls because they are not a diagnostic test for child sexual abuse. There are other ways that the interviewer can use the dolls, though. They can use the doll as a model to learn what the children being interviewed call different parts of the body (I.e., buttocks, genitals, etc.). The interviewer can also ask the children the different functions of body parts to learn what the child understands about the human body (McCoy & Keen, 2014).

In order to conduct a good interview for a child abuse case, there are five general rules that should be followed based on Poole and Lamb's (1998) book *Investigative Interviews of Children* (McCoy & Keen, 2014). First, children should be interviewed as soon as possible. Second, there should be time chosen for the children to get used to the interview environment in

order to reduce anxiety. The interviewer should build a connection with the child. Third, use open-ended questions as much as possible. Fourth, the interviewer should be neutral and open. Lastly, depending on the child's age, the child should be allowed to review and clarify the information that was gathered during the interview (McCoy & Keen, 2014).

The Legal System

The United States court system is set up in a manner that is not fitting for children because it can be confusing and traumatic for them (McCoy & Keen, 2014). As a professional who works with children, it is important to understand that this experience is very difficult for children and that they need preparation for court. Children are less likely to experience added trauma and experience less distress when it comes to a court hearing if they are in a program to prepare them for court. The National Children's Advocacy Center has created a court prep group that prepares children for court through education, understanding of emotional issues, role-play, and getting a tour of the courthouse. This program is done with a group of children that are in a similar age range (I.e., six to twelve years old and thirteen to seventeen years old). The program includes six sessions that are lead by a variety of professionals, such as social workers, victim advocates, prosecutors, and therapists (McCoy & Keen, 2014).

The court process is not only overwhelming for the child; it can also be for the adults involved in the case (McCoy & Keen, 2014). There are many different types of charges that deal with child maltreatment, different court systems, and many different types of maltreatment. There are four legal settings that allegations of child maltreatment may be addressed. This includes juvenile court, domestic relations court, criminal court, and civil court (McCoy & Keen, 2014).

The juvenile court serves child and their families (McCoy & Keen, 2014). There are three types of cases that juvenile court deals with: juvenile delinquency, status offences, and dependency cases. Juvenile delinquency cases involve children that commit acts that if an adult would be charged with would be a criminal prosecution. These cases can be a part of child maltreatment cases if both children are minors. Dependency cases are also relevant to child maltreatment cases. These cases determine if the state needs to take permanent or temporary custody of the child based on if the child's guardian is meeting the needs of the child. These court hearings are often times not attended by the child (McCoy & Keen, 2014).

The domestic relations court is also known as family court (McCoy & Keen, 2014). It deals with issues in the family and with the rearing of children. This includes divorce, child support, and paternity. Caregivers and not the police or child protection services set proceedings in this court. This type of court is not set up to process child maltreatment cases and will likely refer those allegations to the juvenile court of child protection services (McCoy & Keen, 2014).

The criminal court is "the most powerful response to child abuse and neglect" (McCoy & Keen, 2014, p. 289). This court will hear cases of severe child physical abuse and sexual abuse. The criminal court does not serve to preserve families; rather it is for prosecution, punishment, and the protection for possible future victims. The cases in criminal court are typically put into motion through law enforcement and attorneys. When in criminal court the perpetrator must also be charged with an offence. These cases also have the possibility of going to trial. If a case of child maltreatment goes to trial, there is a chance that the child may have to testify in court. This can cause additional stress and trauma for the child. The criminal court has made attempts to make this process less traumatic for the children. Some other options that courts have made possible instead of having the child testify in court are: closed-circuit television testimonies and

letting adults testify about what the child disclosed to them. Courts have also been able to allow children who testify at court more recesses and shorter segments of speaking (McCoy & Keen, 2014).

The civil court hears cases that are noncriminal and the parties want to settle disputes and to be awarded for damages (McCoy & Keen, 2014). In the past, civil court did not hear cases of child maltreatment. More recently, they have been taking more cases as many states have a statue of limitations in the criminal court. Therefore, if an adult decides they want to take legal action on child maltreatment from their past, they may choose to have a civil court in order to receive awards for damages (McCoy & Keen, 2014).

Preventing Child Abuse and Neglect

It is known that the negative outcomes of child abuse and neglect can continue with a person throughout the lives (McCoy & Keen, 2014). Child abuse and neglect also has a lot of costs associated with it because of the medical care and interventions that are needed. These costs are oftentimes subsidized through state and federal funds. It is also known that child abuse and neglect is often perpetrated through generations. These a few reasons why child abuse and neglect should be prevented. Prevention can be done through a variety of programs using primary, secondary, and tertiary prevention (McCoy & Keen, 2014).

Primary prevention includes campaigns and programs for the general population in order to reduce the occurrence of all new cases of child abuse and neglect (McCoy & Keen, 2014). Public awareness campaigns bring awareness to the general population and provide education and awareness on the topic. A lot of campaigns inform the population on child maltreatment and to report and suspected cases. This allows for professionals to create an awareness of the problem, educate, and change behavior. These public service announcements could be on television, in print advertisements, on the radio, or on billboards. A recent primary prevention campaign from the U.S. Department of Transportation's National Highway Traffic Safety Administration in 2012 aimed at preventing vehicle related heatstroke deaths in children. It was titled "Where's the Baby? Look Before You Lock." There are also parental education campaigns, which are aimed at parents and are generally offered through certain venues. These venues could include schools or medical centers. These programs are available to all parents who choose to attend. This allows for a large, diverse group of parents to attend the programs. These programs are also welcoming because there is not a stigma attached to them because it is not a targeted program specifically for parents who are already involved in a child maltreatment

investigation. Two examples of this type of prevention that have been used in medical settings are the Detroit Family Project and Don't Shake the Baby. North Carolina has also implemented a more comprehensive program on shaken baby syndrome that is called The Period of PURPLE Crying: Keeping Babies Safe in North Carolina. Unlike the prevention programs for physical abuse and neglect, child sexual abuse programs are aimed towards potential victims rather than perpetrators. These programs are educational and are for children to learn and discuss how to protect themselves from and how to respond. These programs may be provided through the school district or through another community agency (McCoy & Keen, 2014).

Secondary prevention targets at-risk individuals (McCoy & Keen, 2014). This approach is more selective and less expensive. These programs allow for those in most need to receive services rather than offering the services to the general population. These selective programs may include single parents, teen parents, parents with psychiatric histories, parents who were abused or neglected as a child, or low-income families. Some examples of specific prevention programs are Hawaii's Healthy Start Program and the Nurse Home Visitation Program (McCoy & Keen, 2014).

Tertiary prevention is programs that are intended to minimize the negative effects of an already existing problem (McCoy & Keen, 2014). This can lower the intensity of the problems, complications, and recidivism. Tertiary prevention programs include parent training classes and intensive family preservation services and parent-mentor programs. These programs are intended for families who are already dealing with child maltreatment. These programs are more interventions, rather than prevention (McCoy & Keen, 2014).

Secondary Traumatic Stress

Secondary traumatic stress (STS) results from exposure of others traumatic experiences, often in the workplace (National Child Traumatic Stress Network, 2011). Professionals that work directly with children who have been abused and/or neglected are at great risk of developing STS. However, professionals that review case files and do not have direct contact with clients are also at risk of STS. This includes many individuals such as therapists, child welfare workers, and case managers. It is important for organizations and individuals to be aware of STS (National Child Traumatic Stress Network, 2011).

STS can be seen as symptoms that are very close to posttraumatic stress disorder (National Child Traumatic Stress Network, 2011). For example, individuals suffering from STS may re-experience personal trauma or notice their arousal increasing and an avoidance reactions that are related to the indirect trauma exposure. Hypervigilance, hopelessness, anger, sleeplessness, fear, and guilt are a few of the other symptoms and conditions associated with STS. If a professional is suffering from STS, it can be difficult to serve their clients to the best of their ability. Therefore, the clients experience may be compromised. Hence, it is important for professionals to recognize STS and participate in self-care to help prevent STS. Studies show that 6 to 26% of therapists working with traumatized populations and up to 50% of child welfare workers are at high risk of STS (National Child Traumatic Stress Network, 2011).

In order for professionals working directly with child maltreatment cases to know if they are suffering from STS, it is important for their supervisors and organizational leaders to help identify and address STS (National Child Traumatic Stress Network, 2011). Supervisors and organizational leaders can use informal self-assessment strategies. These assessments are in the form of questionnaires, checklists, or scales to help recognize individual's risk for STS.

Supervisors can also use a reflective supervision model. Through this model there is a greater awareness of the impact of indirect trauma exposer and allows for individuals to recognize their own risk and others risk for STS. There are also formal assessments for STS that relate to burnout, compassion fatigue, and compassion satisfaction. A common assessment for this is the Professional Quality of Life Measure (see Appendix B for complete measure). In the workplace, you can also set up different prevention programs. These can include a self-care group or buddy system, caseload balancing, and self-report assessments. When keeping track of your own risk for STS, it is important to remember proper rest, nutrition, exercise, and stress reductions activities to prevent STS in your own life (National Child Traumatic Stress Network, 2011).

References

Cuppett, B. (2014). *Non-Offending Parents or Caregivers.*

Illinois Department of Children and Family Services. (2015). *Child Abuse and Neglect Statistics*.

Illinois Department for Children and Family Services. (2015). *Manual for Mandated Reporters*.

Illinois Department of Children and Family Services. (2016). Preparing Your Children to Stay Home Alone. Retrieved April 07, 2016, from http://www.illinois.gov/dcfs/safekids/safety/Pages/Preparing-Your-Children-to-Stay-Home-Alone.aspx

Mannarino, A., Cohen, J., and Deblinger, E. (2014). Trauma-Focused Cognitive-Behavioral Therapy. *Child Maltreatment, 3,* 165- 185.

McCoy, M. L. and Keen, S. M. (2014). *Child Abuse and Neglect* (Second ed.). New York, NY: Psychology Press.

National Child Traumatic Stress Network, Physical Abuse Collaborative Group. (2009). *Child physical abuse fact sheet.* Los Angeles, CA & Durham, NC: National Center for Child Traumatic Stress.

National Child Traumatic Stress Network, Secondary Traumatic Stress Committee. (2011). Secondary traumatic stress: A fact sheet for child-serving professionals. Los Angeles, CA, and Durham, NC: National Center for Child Traumatic Stress.

National Child Traumatic Stress Network, Physical Abuse Collaborative Group. (2009). *Child sexual abuse fact sheet.* Los Angeles, CA & Durham, NC: National Center for Child Traumatic Stress.

Springer, C., Misurell, J., and Hiller, A. (2012). Game-Based Cognitive-Behavioral Therapy (GB-CBT) Group Program for Children Who Have Experienced Sexual Abuse: A Three-

Month Follow-Up Investigation. *Journal of Child Sexual Abuse, 21,* 646-664.

Toledo, A. and Seymour F. (2013). Interventions for Caregivers of Children who Disclose Sexual Abuse: A review. *Clinical Psychology Review, 33,* 772-781.

U.S. Department of Health and Human Services. (2014). *Child Maltreatment*.

Appendix A

Suggested Reading for Children, Teens, and Caregivers Affected by Child Abuse and Neglect

These books are only a suggestion. Parents are strongly encouraged to read each book before deciding to give them to their children.

Suggested Reading for Children

Book, L. (2015). *Lauren's Kingdom.* Sweetwater Press.

This story allows children to enter into a story that is safe, sound, and cozy while discussing the topic of abuse. The important lesson from this story is that it is okay to tell. This book is appropriate for young children of all ages.

Federico, J. (2009). *Some Parts of NOT for Sharing.* Tate Publishing.

This friendly book is a great way to introduce the idea of private parts and inappropriate touch. This story is appropriate for children from infancy to eight years old.

Kammersend, K. (1995). *Telling Isn't Tattling.* Seattle, WA: Parenting Press, Inc.

This easy-to-read book will help children learn the difference between telling and tattling. The book includes several situations for the child to determine if the character should go get an adult for help or if they would be snitching. This book is appropriate for children ages 4 to 10.

Moore-Mallinos, J. (2005). *Do you have a Secret? (Let's talk about it).* Barron's Education Series.

Every child has secrets, and some are fun to keep – for instance, a surprise birthday present for mom. But sometimes, children have secrets that make them feel sad or mad, and these secrets are best shared with parents, or with a trusted other adult. A child who was touched intimately and improperly by an older person will soon feel better if they

reveal the secret. This book helps kids distinguish between good and bas secrets. This book is appropriate for children ages 4 to 7.

Ottenweller, J. & Hewitt, S. (1991). *Please Tell! A Child's Story about Sexual Abuse.* Center City, MN: Hazelden Foundation.

This story is written and illustrated by a 9-year-old girl who was sexually abused by a family member. This story will help children understand that it was not their fault and that it is okay to tell. The author says, "It's o.k. to tell; help can come when you tell." This book is appropriate for children ages 4 and up.

Sanders, J. (2015). *No Means No! Teaching children about personal boundaries, respect and consent.* UpLoad Publishing Pty Ltd.

This book empowers kids by respecting their choices and their right to say, "No!" This book also includes discussion questions at the end to talk to your children about. This book can be read to children from 3 to 9 years.

Spelman, C. (2000). *Your Body Belongs to You.* Morton Grove, IL: Prairie Paperbacks, Albert Whiteman and Company.

The author of this book explains that a child's body is his or her own; that it is alright for kids to decline a friendly hug or kiss, even from someone they love; and that you can still be friends even if you don't want a hug now. This book is appropriate for children from 3 to 9 years old.

Starishevsky, J. (2014). *My Body Belongs to Me: A book about body safety.* Free Spirit Publishing.

This book guides young children to understand that their private parts belong to them alone. The overall message of this book is that if someone touches your private parts, tell

your mom, your dad, your teacher, or another safe adult. This book is appropriate for children form 3 to 8 years old.

Suggested Reading for Teens

Carter, W. (2002). *It Happened to Me: A teen's guide to overcoming sexual abuse.* New Harbinger Publications.

This workbook will help teens that are overcoming their past sexual abuse. Simple, effective exercises help teens learn about the different aspects of trauma, share the thoughts and emotions of other survivors, clarify their own ideas and beliefs, and explore new ways of feeling and relating.

Engel, B. (2015). *It Wasn't You Fault: Freeing yourself from the shame of childhood abuse with the power of self-compassion.* New Harbinger Publications.

Shame is one of the most destructive human emotions. If your teen suffered from childhood physical or sexual abuse they may experience such intense feelings of shame. It is important for teens to know that it wasn't their fault. By following step-by-step exercises in this book, teens will gain a greater understanding of the root cause of shame. And by cultivating compassion toward themself, they will begin to heal and move past your painful experiences.

Feuereisen, P. (2005). *Invisible Girls: The truth about sexual abuse – A book for teen girls, young women, and everyone who cares about them.* Seal Press.

This book puts together powerful first-person narratives with gentle guidance and seasoned insights to help girls through the maze of feelings that swirl around the abuse experience. This book is suggested for girls who are thirteen and up.

Harris, R. (2014). *It's Perfectly Normal: Changing bodies, growing up, sex, and sexual health.* The Family Library, Candlewick, 20th anniversary new edition.

This book is updated with information on subjects such as safe and savvy Internet use, gender identity, emergency contraception, and more. This book provides young people the information they need to make responsible decisions and stay healthy.

Mather, C. (2014). *How Long Does it Hurt: A guide to recovering from incest and sexual abuse for teenagers, their friends, and their families.* Jossey-Bass, Revised Edition.

This step-by-step guide speaks directly to victims of sexual abuse to help them come to grips with what is happening to them and overcome their feelings of isolation, confusion, and self-doubt.

McGee, K. (2003). *Unmasking Sexual Con Games: Teen guide.* Boys Town Press, 3rd edition.

This book will help teens learn how to protect themselves from being intimidated or conned into sex. This guide is a part of a powerful teen-relationship curriculum.

Suggested Readings for Caregivers

Adams, C. & Fay, J. (1992). *Helping Your Child Recover from Sexual Abuse.* Seattle: University of Washington Press.

This book offers practical guidance for parents who courageously face the days and months after a child's abuse. It discusses each stage of a child's recovery. The book presents the collective wisdom of numerous parents who have been through this experience and have learned how to help their children.

Bradshaw, J. (2006). *Healing the Shame that Binds you.* Health Communications, revised edition.

This book deals with the effects and causes of "toxic shame" and how we can escape the self-destructive cycle that accompanies the dark shame from our pasts. For survivors of sexual or emotional abuse, this book provides insight and solutions to break the shame spiral.

Brohl, K. & Potter, J. (2004). *When Your Child has been Molested: A parents' guide to healing and recovery.* Jossey-Bass, Revised First Edition.

This book includes research and information on the nature and effects of molestation on boys and girls, as well as proven techniques for therapy, healing, and recovery. This book uses everyday language to provide information, comfort, and advice on how to put the pieces bake together again after a child has been sexually molested.

Stone, R. (2007). *No Secrets, No Lies: How black families can heal from sexual abuse.* Harmony Publishing.

This book is a powerful and daringly honest resource guide for families seeking to understand, prevent, and overcome childhood sexual abuse and its devastating impact on adult survivors. It also demystifies the cultural taboos and social dynamics that keep black families silent and enable abuse to continue for generations.

Appendix B

Professional Quality of Life Measure

PROFESSIONAL QUALITY OF LIFE SCALE (PROQOL)

COMPASSION SATISFACTION AND COMPASSION FATIGUE
(PROQOL) VERSION 5 (2009)

When you *[help]* people you have direct contact with their lives. As you may have found, your compassion for those you *[help]* can affect you in positive and negative ways. Below are some questions about your experiences, both positive and negative, as a *[helper]*. Consider each of the following questions about you and your current work situation. Select the number that honestly reflects how frequently you experienced these things in the *last 30 days*.

1=Never	2=Rarely	3=Sometimes	4=Often	5=Very Often

_____ 1. I am happy.
_____ 2. I am preoccupied with more than one person I *[help]*.
_____ 3. I get satisfaction from being able to *[help]* people.
_____ 4. I feel connected to others.
_____ 5. I jump or am startled by unexpected sounds.
_____ 6. I feel invigorated after working with those I *[help]*.
_____ 7. I find it difficult to separate my personal life from my life as a *[helper]*.
_____ 8. I am not as productive at work because I am losing sleep over traumatic experiences of a person I *[help]*.
_____ 9. I think that I might have been affected by the traumatic stress of those I *[help]*.
_____ 10. I feel trapped by my job as a *[helper]*.
_____ 11. Because of my *[helping]*, I have felt "on edge" about various things.
_____ 12. I like my work as a *[helper]*.
_____ 13. I feel depressed because of the traumatic experiences of the people I *[help]*.
_____ 14. I feel as though I am experiencing the trauma of someone I have *[helped]*.
_____ 15. I have beliefs that sustain me.
_____ 16. I am pleased with how I am able to keep up with *[helping]* techniques and protocols.
_____ 17. I am the person I always wanted to be.
_____ 18. My work makes me feel satisfied.
_____ 19. I feel worn out because of my work as a *[helper]*.
_____ 20. I have happy thoughts and feelings about those I *[help]* and how I could help them.
_____ 21. I feel overwhelmed because my case [work] load seems endless.
_____ 22. I believe I can make a difference through my work.
_____ 23. I avoid certain activities or situations because they remind me of frightening experiences of the people I *[help]*.
_____ 24. I am proud of what I can do to *[help]*.
_____ 25. As a result of my *[helping]*, I have intrusive, frightening thoughts.
_____ 26. I feel "bogged down" by the system.
_____ 27. I have thoughts that I am a "success" as a *[helper]*.
_____ 28. I can't recall important parts of my work with trauma victims.
_____ 29. I am a very caring person.
_____ 30. I am happy that I chose to do this work.

YOUR SCORES ON THE PROQOL: PROFESSIONAL QUALITY OF LIFE SCREENING

Based on your responses, place your personal scores below. If you have any concerns, you should discuss them with a physical or mental health care professional.

Compassion Satisfaction _____

Compassion satisfaction is about the pleasure you derive from being able to do your work well. For example, you may feel like it is a pleasure to help others through your work. You may feel positively about your colleagues or your ability to contribute to the work setting or even the greater good of society. Higher scores on this scale represent a greater satisfaction related to your ability to be an effective caregiver in your job.

The average score is 50 (SD 10; alpha scale reliability .88). About 25% of people score higher than 57 and about 25% of people score below 43. If you are in the higher range, you probably derive a good deal of professional satisfaction from your position. If your scores are below 40, you may either find problems with your job, or there may be some other reason—for example, you might derive your satisfaction from activities other than your job.

Burnout_____

Most people have an intuitive idea of what burnout is. From the research perspective, burnout is one of the elements of Compassion Fatigue (CF). It is associated with feelings of hopelessness and difficulties in dealing with work or in doing your job effectively. These negative feelings usually have a gradual onset. They can reflect the feeling that your efforts make no difference, or they can be associated with a very high workload or a non-supportive work environment. Higher scores on this scale mean that you are at higher risk for burnout.

The average score on the burnout scale is 50 (SD 10; alpha scale reliability .75). About 25% of people score above 57 and about 25% of people score below 43. If your score is below 43, this probably reflects positive feelings about your ability to be effective in your work. If you score above 57 you may wish to think about what at work makes you feel like you are not effective in your position. Your score may reflect your mood; perhaps you were having a "bad day" or are in need of some time off. If the high score persists or if it is reflective of other worries, it may be a cause for concern.

Secondary Traumatic Stress_____

The second component of Compassion Fatigue (CF) is secondary traumatic stress (STS). It is about your work related, secondary exposure to extremely or traumatically stressful events. Developing problems due to exposure to other's trauma is somewhat rare but does happen to many people who care for those who have experienced extremely or traumatically stressful events. For example, you may repeatedly hear stories about the traumatic things that happen to other people, commonly called Vicarious Traumatization. If your work puts you directly in the path of danger, for example, field work in a war or area of civil violence, this is not secondary exposure; your exposure is primary. However, if you are exposed to others' traumatic events as a result of your work, for example, as a therapist or an emergency worker, this is secondary exposure. The symptoms of STS are usually rapid in onset and associated with a particular event. They may include being afraid, having difficulty sleeping, having images of the upsetting event pop into your mind, or avoiding things that remind you of the event.

The average score on this scale is 50 (SD 10; alpha scale reliability .81). About 25% of people score below 43 and about 25% of people score above 57. If your score is above 57, you may want to take some time to think about what at work may be frightening to you or if there is some other reason for the elevated score. While higher scores do not mean that you do have a problem, they are an indication that you may want to examine how you feel about your work and your work environment. You may wish to discuss this with your supervisor, a colleague, or a health care professional.

WHAT IS MY SCORE AND WHAT DOES IT MEAN?

In this section, you will score your test so you understand the interpretation for you. To find your score on **each section,** total the questions listed on the left and then find your score in the table on the right of the section.

Compassion Satisfaction Scale

Copy your rating on each of these questions on to this table and add them up. When you have added then up you can find your score on the table to the right.

3. _____
6. _____
12. _____
16. _____
18. _____
20. _____
22. _____
24. _____
27. _____
30. _____

Total: _____

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

Burnout Scale

On the burnout scale you will need to take an extra step. Starred items are "reverse scored." If you scored the item 1, write a 5 beside it. The reason we ask you to reverse the scores is because scientifically the measure works better when these questions are asked in a positive way though they can tell us more about their negative form. For example, question 1. "I am happy" tells us more about the effects of helping when you are *not* happy so you reverse the score

You Wrote	Change to
	5
2	4
3	3
4	2
5	1

*1. _____ = _____
*4. _____ = _____
8. _____
10. _____
*15. _____ = _____
*17. _____ = _____
19. _____
21. _____
26. _____
*29. _____ = _____

Total: _____

The sum of my Burnout Questions is	So my score equals	And my Burnout level is
22 or less	43 or less	Low
Between 23 and 41	Around 50	Average
42 or more	57 or more	High

Secondary Traumatic Stress Scale

Just like you did on Compassion Satisfaction, copy your rating on each of these questions on to this table and add them up. When you have added then up you can find your score on the table to the right.

2. _____
5. _____
7. _____
9. _____
11. _____
13. _____
14. _____
23. _____
25. _____
28. _____

Total: _____

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